

Health Sector Plan
FOR HIV AND STI
2015-2020

Disease Prevention and Control Bureau

TABLE OF CONTENTS

ACKNOWLEDGMENT	1
ACRONYMS	3
EXECUTIVE SUMMARY	6
INTRODUCTION	10
Guiding Principles and Core Values	13
Methodology and Process	14
BACKGROUND & RATIONALE	16
HIV & STI SITUATION	20
Epidemiological Background	23
Country's Response	36
Health Sector Response	40
THE PHILIPPINE HEALTH SECTOR PLAN FOR HIV AND STI	47
The Vision	48
The Goal	48
The Purpose	49
The Strategies	49
IMPLEMENTATION FRAMEWORK	68
Strategy Implementation	69
Costing Scenarios in HIV/STI HSP	70
Monitoring, Evaluation and Reporting	77
HSP Costed Plan	81
ANNEX	88
1. Summary of Processes and Activities conducted in the development of HSP	
2. List of Different GF – ATM Rounds Activities and Budget Support for the HIV and STI Health Sector Response in the Philippines	
3. Summary of recommendations from 2013 External Evaluation of the Health Sector's Response to HIV in the Philippines	
4. Key Recommendations from the Evaluation of HIV and STI Program and Strategies for MSM, TG and PWID in the Philippines, May 2014	
5. AIDS Epidemic Model Impact Modeling and Analysis 2014 Philippine Case Study Executive Summary	
6. Detailed Operational Planning Matrix of the Health Sector Plan for 2015-2017	
7. Monitoring & Evaluation of the Philippine Health Sector's Strategic Plan for HIV 2015-2017	



Message


In the Philippines, the number of people infected with the Human Immunodeficiency Virus (HIV) has been notably increasing among key populations such as males who have sex with males (MSM) and people who inject drugs (PWID). Despite the gains of the program, it seems that the HIV epidemic has outpaced current interventions.

With such alarming trends, the key findings and recommendations in the midterm review of 5th AIDS Medium Term Plan (AMTP) 2011-2016 point to the need for a strategic response to the HIV threat, one that is both multi-sectoral and principally anchored on the health sector. Hence, this Health Sector Plan (HSP) on HIV and STI has been developed by Department of Health in coordination with key stakeholders to create a comprehensive and effective response to HIV and other sexually transmitted infections.

The major strategic thrusts of this HSP are to reduce new HIV infections and improve the quality of life of people living with HIV. This includes various innovative interventions to address the gaps in the health system and enable access of the key populations to health services.

However crucial, a comprehensive HSP is just the starting point in our drive against HIV. It is just as important to put this plan into action. Hence, we encourage all government agencies, technical agencies and development partners, members of the Philippine National AIDS Council, non-government organizations, civil society organizations, local government units as well as the key populations to unite their efforts with ours in halting and reversing the trends of HIV infection in our country.

Maraming salamat po, at mabuhay tayong lahat!


JANETTE P. LORETO-GARIN, MD, MBA-H
Secretary of Health
Republic of the Philippines

ACKNOWLEDGMENT

The development of this document was commissioned by Philippine Department of Health (DOH) National AIDS STI Prevention and Control Program (NASPCP) and World Health Organization and written by Dr. Ethel Daño under the technical directions of Dr. Jose Gerard Belimac, manager of NASPCP, Dr. Wiwat Rojanapithayakom (Technical Advisor and WHO Consultant), Dr. Maria Nerissa Dominguez of WHO and HIV TWG members . Funding to support this work was provided by WHO.

HIV TWG members:

Dr. Rosalind Vianzon/ Dr. Jose Gerard Belimac	DOH DPCB
Dr. Genesis Samonte/ Mr. Noel Palaypayon	DOH EB
Dr. Maria Nerissa Dominguez	WHO
Ms. Maria Lourdes Quintos / Mr. Zimmbodilion	UNAIDS
Mosende Dr. Rossana Ditangco	RITM
Dr. Elizabeth Telan	SLH-SACCL
Dr. Rosario Jessica Tactacan-Abrenica Dr. Ferchito Avelino	SLH
Dr. Emerose Moreno	PNAC Secretariat
Dr. Amelia Medina	DOH RO-MIMAROPA
Dr. Verdades Linga	DOH RO-NCR
Mr. Eddy Razon/ Mr. Noel Quinto	QCHD
Ms. Lorna Garcia	Pinoy Plus
	Babae Plus

HIV TWG Secretariat/ NASPCP Team:

Dr. Antoinette L. Evangelista
Ms. Mary Joy A. Morin
Ms. Yasmin Ann L. Pimentel
Mr. Hilario Umali

The valuable insights and contributions of other partners from non-government organizations active in HIV work and advocacy, development partners, and private sectors who attended several consultation meetings and workshops were also appreciated. Special mention goes to those representatives from groups of key population at risk for HIV who participated in the consultation meetings to voice out their needs and concerns that were considered vital in this plan.

Special thank you to Ms. Helen Paaño, Project Coordinator of Global Fund TFM for her significant contribution in the crafting of the detailed operational plan.

ACRONYMS

AEM	AIDS Epidemic Model
AMTP	AIDS Medium-Term Plan
ANC	Antenatal care
AO	Administrative Order
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behavior Change Communication CBO Community Based organization
CESO	City Epidemiology and Surveillance Unit
CSO	Civil Society Organization
CUP	Condom Use Program
DILG	Department of Interior and Local Government
DOH-RO	Department of Health – Regional Office
DOTS	Direct Observation Treatment Short-Course
DPCB	Diseases Prevention and Control Bureau
DRRM	Disaster Risk Reduction Management
DSWD	Department of Social Welfare and Development
EB	Epidemiology Bureau
EE	Entertainment Establishment
EPP/Spectrum	Estimation and Projection Package / Spectrum (projection software developed by Avenir Health used by the UN Joint Programme on AIDS (UN-AIDS) and the World Health Organization)
ESU	Epidemiology Surveillance Unit
EQAS	External Quality Assurance Scheme
FBO	Faith-based Organization
FHO	Family Health Office
FSW	Female Sex Worker
FFSW	Freelance Female Sex Worker
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis & Malaria
HACT	HIV/AIDS Core Team
HARP	HIV/AIDS and ART Registry of the Philippines
HBC	Home -based care
HCT	HIV counseling and testing, see VCT
HCW	Health Care Worker
HIS	Health Information System
HIV	Human Immunodeficiency Virus

HIV IMPAC	Inventory and Mapping of at-risk Populations, Areas & Current Response
HIV-RO	HIV Regional Office Program Coordinator
HRT	Hormone Replacement Therapy
HSRA	Health Sector Reform Agenda
HSP	Injecting Drug Users, same as PWID
IDU	Health Sector Plan for HIV and STI
IEC	Information, Education and Communication
IHBSS	Isoniazid Preventive Therapy
IPT	Integrated HIV Behavioral and Serologic Surveillance
KP/KAP	Key population / Key Affected Population
LaBS	Laboratory and Blood Bank Surveillance for HIV and STI
LAC	Local AIDS Council
LGU	Local Government Unit
MARCY	Most-At-Risk Children and Youth
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MOP	Manual of Procedures
MSM	Men who have Sex with Men
MSW	Male sex worker
MTCT	Mother-to-child transmission
NDHS	National Demographic and Health Survey
N/S	Needle & Syringe
NASA	National AIDS Spending Assessment
NASPCP	National AIDS and STI Prevention and Control Program
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NGO	Non-Governmental Organization
NGI	Non-gonococcal infection
NVBS	National Voluntary Blood Service Program
OE	Occupational Exposure
OFW	Overseas Filipino Worker
OI	Opportunistic Infection
OHAT	OPD HIV AIDS Treatment Package of PhilHealth
OOP	Out-of-Pocket (expenditures)
PAHI	Priority Areas for HIV Intervention
PCR	Polymerase Chain Reaction
PAHI	Peer educator
PCR	Philippine Health Insurance Corporation
PE	Provider initiated counseling and testing PIR Program Implementation Review
PhilHealth	People living with HIV
PICT	Prevention of Mother to Child Transmission
PIR	Philippine national AIDS Council

PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PNAC	Philippine national AIDS Council
PreP	Pre exposure Prophylaxis
PSM	Procurement and Supply Management
PWID	People who inject drugs
QA	Quality Assurance
QCHD	Quezon City Health Department
RAV	Rapid Assessment of HIV Vulnerability
RESU	Regional Epidemiology and Surveillance Unit
RFSW	Registered female sex workers
RH	Reproductive Health
RHWC	Reproductive Health and Wellness Center, see SHC
RITM	Research Institute for Tropical Medicine
ROTC	Rest of the Country
SACCL	STD/ AIDS Central Cooperative Laboratory
SDSS	STI Denominator Surveillance System
SSESS	Sentinel STI Etiologic Surveillance System, same as SESS
SHC	Social Hygiene Clinic
SHCRepS	SHC Reporting System
SIO	Site Implementation Officer
SLH	San Lazaro Hospital
SOGIE	Sexual Orientation and Gender Identity and Expression
SOP	Standard operating procedure
STI	Sexually transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TCS	Treatment care and support
TG / TGW	Transgender / Transgender Women
TWG	Technical Working Group
UA	Universal access to HIV prevention, treatment, care & support
UIC	Unique Identification Code
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Sessions for HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing, see also HCT
WHO	World Health Organization
YAFS	Young Adult Fertility and Sexuality Study
YP	Young People

EXECUTIVE SUMMARY

For more than a decade DOH has been actively taking the lead in establishing the important priorities in response to the HIV situation in the Philippines.

The rapidly changing scenario of the HIV epidemic in the country and the Key findings and recommendations in midterm review of 5th AIDS Medium Term Plan (AMTP) 2011-2016 has underscored the need for greater shift in strategic directions to respond appropriately to the alarming nature of the epidemic. The Health Sector Plan for HIV and STI (HSP) serves to provide a clear and comprehensive plan and direction on how the health sector could contribute to the national response. It serves as a guide to the health sector in addressing the changing epidemic situation of the key affected individuals and communities.

The HSP clearly defines how and what the health sector could contribute in the over-all national response. While the plan covers a period of 6 years from 2015-2020, it sets doable plans and targets for its operation for 3 years (2015-2017). A monitoring plan will be developed to ensure periodic review through a medium-term and progressive assessment relative to the achievement of the expected results. The midterm assessment will not only focus on progress of the implementation of the plan and but will also assess the appropriateness of the overall strategic direction.

The strategy elaborated the health sectors' contribution toward a broader, multi-sectoral response to HIV. It is anchored on the 5th AMTP and consistent with the over-all direction of the country's health agenda as embodied in the Universal Health Care. The major strategic thrust of the Plan is to reduce new HIV infections and improve quality of life of people living with HIV. The HSP shall be guided by the following key strategic framework:

VISION:

Zero New Infections, Zero Discrimination, Zero AIDS-related Deaths

GOAL:

By 2020, the country will have maintained a prevalence of less than 66 HIV cases per 100,000 populations by preventing the further spread of HIV infection and providing treatment care and support to reduce the impact of the disease on individuals, families, sectors and communities

PURPOSE (OUTCOME):

The further spread of HIV in key populations is prevented through strengthened delivery of essential prevention, treatment and care interventions

Targets to achieve from 2015 to 2020

1. Reduction of HIV incidence among MSM to < 50%
2. Maintain HIV Prevalence of <1% among young (<20yo) childbearing women in NCR cities and Cebu city from baseline
3. Reduction in percent of KP with STI (syphilis) to <1.5%
4. Reduction of HIV-related deaths by 80%
5. Reduction of TB-related deaths to <1%

MAJOR STRATEGIES:

Strategy 1: Continuum of HIV/STI prevention, Diagnostic and treatment Services to Key Populations (KP)

This strategy aims to improve the linkages and expand coverage of services from prevention to treatment and care among the key populations. Pertinent activities focuses on increasing awareness on HIV and STI information and prevention services. Likewise, the projected expansion of access to treatment intends to improve survival rates among the infected thus improve their quality of life.

Strategy 2: Health Promotion and Communication on HIV and STI prevention and care services

In order to increase the demand and access to available HIV and STI services, a scaled-up information campaign shall be implemented to reach the target population directly. Community-based information and education activities shall focus on HIV prevention and lessening risky behaviours among key population. Under this strategy, a national HIV Communication plan and ICT-based BCC tools will be developed and appropriately disseminated.

Strategy 3: Enhanced Strategic Information Systems

A systematic and efficient information system shall be installed to monitor the implementation of health policies and programs at various levels. Evidence-based information shall be generated through HIV surveillance and monitoring. Researches and special studies will be conducted to help define and redefine program interventions for a more appropriate response to the needs of the targeted population.

Strategy 4: Strengthened health system platform for broader health outcomes

The delivery of quality STI and HIV services requires the installation of a stronger health systems platform. This will include setting –up of the necessary legal and social framework anchored on respect for human rights and consistent with the overall public health goals. Additionally it hopes to revitalize stronger linkages and partnerships with various sectors and institutions to generate broader health outcomes.

Philippine HEALTH SECTOR HIV AND STI STRATEGIC FRAMEWORK (2015-2020)

VISION: Zero New Infections, Zero Discrimination, Zero AIDS-related Deaths



GOAL: By 2020, the country will have maintained a prevalence of less than 1% of the total population by preventing the further spread of HIV infection and reducing the impact of the disease on individuals, families, sectors and communities



PURPOSE: The further spread of HIV in key populations is prevented through strengthened delivery of essential prevention, treatment and care interventions



STRATEGY 1:
Continuum
of HIV/ STI
prevention,
diagnosis
treatment and
care service to
KP

STRATEGY 2:
Health
promotion and
communication
on HIV and STI
prevention and
care services

STRATEGY 3:
Enhance
Strategic
Information
systems

STRATEGY 4:
Strengthened
health system
platform for
broader health
outcomes



INTRODUCTION

The Philippine HIV epidemic has been described by national experts as rapidly expanding and evolving seen initially among female sex workers and their clients to male who have sex with males (MSM), Transgender (TG), People who inject drugs (PWID) and freelance sex workers who are mostly injecting drug users themselves. Though the response of the country is multi-sectoral, it is however principally anchored in the health sector. The health sector is described by WHO as wide ranging and encompasses organized public and private health services, health ministries, nongovernmental organizations, community groups and professional associations, as well as institutions that *directly input* into the health-care system.

For the health sector to better respond to the current scenario and epidemic, a health sector strategy on HIV and STI was developed by Department of Health together with key stakeholders to guide a comprehensive and efficient response to human immunodeficiency virus (HIV) and other sexually transmitted infections. The health sector strategy in turn contributes to a broader multi-sectoral country's response as defined in the 5th AIDS Medium Term Plan.

1 WHO. Global health sector strategy on HIV/AIDS 2011-2015.

The Health Sector Plan also back global UNGASS – UN General Assembly Special Sessions for HIV/AIDS and interphase ASEAN vision of zero new infections, zero discrimination and zero AIDS- related deaths as it seeks to promote a long-term, sustainable HIV response by strengthening health and community systems, tackling the social determinants of health that both drive the epidemic and hinder the response, protecting and promoting human rights and promoting gender equity as its essential elements. It strengthens integration between HIV and other health services, improving both impact and efficiency² . It is also consistent with the overall direction of the country's health agenda as embodied in the Universal Health Care or Kalusugang Pangkalahatan (Figure 1).

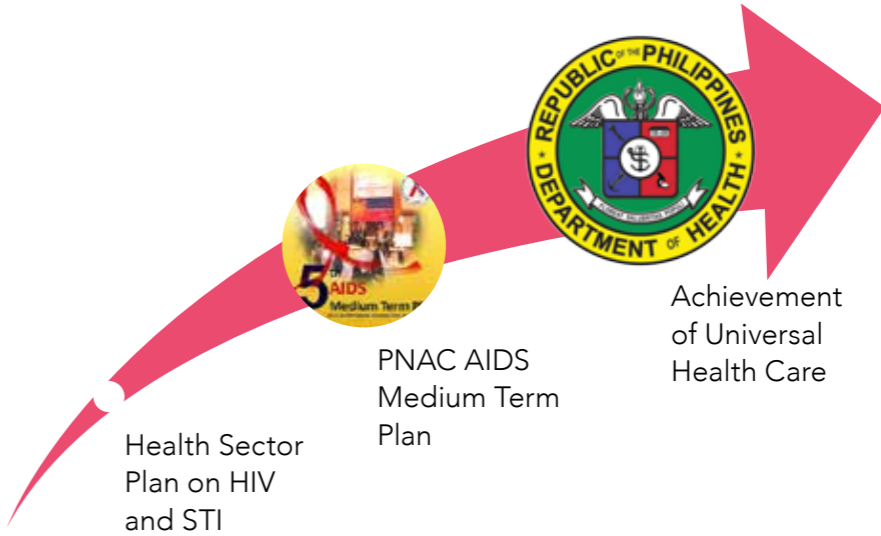


Figure 1. Framework of HIV Response

2 Ibid

This health sector plan also deliberated and considered the recommendations from the 2013 **External Evaluation of the Health Sector's Response to HIV in the Philippines** as a component of the midterm review of 5th AMTP.

This document will be a reference guide for program managers, health care providers, CBO and NGO for key populations, civil society and development partners including funding agencies/donors as it set up directions and illuminates focus of work, roles, contributions and provides funding priorities to achieve universal access³ to prevention, diagnosis, treatment and care services that hopes to eventually reduce the burden of HIV.

Guiding Principles and Core Values

The Philippine Health Sector strategy adapts the principles of WHO Global HIV Strategy 2011-2015 that HIV response should be embedded in broader health and development agenda, with programmatic linkages, improving overall health outcomes and based on progress and evidence addressing current gaps which was clearly reflected in the report of 2013 External Evaluation of the Health Sector's Response to HIV in the Philippines as component of midterm review of 5th AMTP.

Other guiding principles and core values are:

1. Protection and promotion of human rights principles of equality, gender equity and non- discrimination;
2. Stigma free attitude of service providers;
3. Integration of HIV and STI with other health services;
4. Client satisfaction in accessing services;
5. Internal and external communication strategies bridging service provision and access to services through meaningful participation empowerment of community;
6. Sustainable HIV responses through a strengthened health and community systems;
7. Meaningful involvement of KP in all efforts that aims to address their health

³ Universal access' means establishing an environment in which HIV prevention, treatment, care and support interventions are available, accessible and affordable to all who need them. It covers a wide range of interventions that are aimed at individuals, households, communities and countries (WHO)

needs from policymaking, programming, service delivery to monitoring and reporting;

8. Credibility in provision of quality services by implementing evidence-based guidelines and comprehensive standards of care for KP;
9. Quality standards in every level of service delivery points;
10. Review and evaluation of progress;
11. Address environment barriers as support to implementation of program strategies;
12. Research based approach to establish evidences to address key populations needs, improvement on policies and programming;
13. Administrative policies and systems to enhance staff's performance.

Methodology and Process

Adaptation of the findings and recommendations of the 5th AMTP midterm evaluation.

The findings on review of 5th AMTP midterm implementation especially on the health sector component highlights the need to revise the country's strategy to better respond to current epidemic scenario. This has led to updating the Health sector strategic component of the country's HIV response. Series of activities were undertaken to update the Philippine Health Sector HIV and STI strategy for 2015-2020 (Annex 1).

The Dissemination of the 5th AMTP midterm review findings and recommendations was followed by several consultation meetings with HIV TWG on the need to consider the findings and recommendations of the evaluation and that is to initially update the National Strategic Plan (NSP, also refers to AMTP). After series of consultation meetings, it was agreed primarily by DOH, PNAC Secretariat and HIV TWG to update first the Health sector component of AMTP also known as the National Strategic Plan, which details the country's multi-sectoral strategic plan.

Consultation with Kep Populations at the beginning of planning process.

For a more meaningful engagement and to derive a bottom up approach in updating the health sector component, consultation meetings with the target community were conducted (FSW, MSW, MSM, TG, PWID, PLHIV). This is to better understand their needs ensuring its assimilation into the updated document. The initial output to discussions with DOH, HIV TWG, and target community were then presented and validated in a national stakeholders meeting with attendees and representatives/ members from various NGO/ CBOs, faith-based organizations, private and government institutions, DOH, PNAC, developmental partners, Local government unit, health service implementers (SHC and treatment hubs), donors and medical/ allied professional societies and also those from the target community (eg. PWID, MSM, TG).

Further refinements to the content of new/ updated health sector strategy were done through series of workshops and consultation meetings with DOH, HIV TWG and other stakeholders. This was also followed up with series of workshops for Operational Planning of HIV/ STI Health Sector Plan.



BACKGROUND & RATIONALE

It has been over 50 years since the Philippine government started responding to the STI problem through the creation of a specialized STI clinic known as the Manila Rapid Treatment Center. The center was created because of the apparent high incidence of STI among the civilian population and members of the U.S. Armed Forces. More clinics were established from then on⁴. When HIV/AIDS was detected in other countries, the Philippines was quick to recognize its own socio-cultural risks and vulnerabilities to HIV/AIDS and immediately responded to the threat.

In 1986, the DOH-EB (formerly known as National Epidemiology Center) established the National HIV/AIDS Registry, a passive surveillance system that collects data on HIV infections and AIDS cases from health facilities around the country that are capable of conducting HIV antibody tests. In 1988, the DOH-National AIDS/STI Prevention and Control Program (NASPCP) was created for the Health Response on HIV AIDS. On March 13 1992 an Administrative Order (AO) No. 119 s 1992 entitled: "Changes in the management of the National AIDS Prevention and Control Program" was issued in view of the need to widen the coverage and expand the implementation of the National AIDS Prevention and Control Program beyond traditional areas and to introduce AIDS prevention and control as of the routine functions of all operating health units.

The Department of Health, taking the lead in preventing the spread of HIV/AIDS in the Philippines, established the National AIDS Prevention and Control Program in August 1988. By virtue of Administrative Order No. 57-A, s. 1989, the 12 policy statements for the prevention and control of HIV/AIDS in the Philippines were adopted to become the basis for national strategies in the country's fight against the disease. Recognizing the strong association of STDs in the transmission of HIV, the National STD Control Program was integrated into the National AIDS Prevention and Control Program in 1994. Both programs are now being implemented with complementing strategies and approaches. The merged program is now called the National AIDS STI Prevention and Control Program (NASPCP) of DOH, now primarily responsible in managing health sector program towards

HIV. The DOH Epidemiology Bureau (EB), on the other hand, monitors and evaluates the HIV programs in the country. It is expected to raise the flag whenever it picks up warning signs for impending epidemics. It generates three strategic pieces of

⁴ Department of Health, USAID. Manual of Procedures for Social Hygiene Clinics in the Philippines. 2011

information: the National HIV and AIDS Registry, the Integrated HIV Behavioral and Serologic Surveillance, and special studies. The health sector reports its annual programmatic accomplishments through the Health Sector's Progress towards Universal Access (UA). This report serves as the country's reminder on how close it is to providing universal access to HIV prevention, treatment, care and support.

In 1998, the country moved a step further in promulgating a national policy on prescribing measures for the prevention and control of HIV/AIDS, institutionalizing a nationwide HIV/AIDS information and educational program, establishing a comprehensive monitoring system and strengthening the Philippine National AIDS Council (PNAC), the national multi-sectoral policy making body for HIV/ AIDS. This national law is known as Republic Act 8504 or the **"Philippine AIDS Prevention and Control Act of 1998."**

With enabling national policies and guidelines, the health sector fast tracked implementation of its visions to contribute to the greater country goal to halt the spread of HIV in the Philippines. For this, NASPCP needs to ensure that new infections are prevented, people in need of treatment are linked with other health-related services, and the quality of life of people living with HIV (PLHIV) is improved.

The DOH reinforces the WHO position that health systems should be founded on the principles enshrined in the Declaration of Alma-Ata: UA, equity, participation and multi-sectoral action—all within the framework of gender equality and human rights. However, inspite of the DOH's comprehensive reform strategies through the Health Sector Reform Agenda (HSRA) launched in 1999 and the resulting substantial health sector gains, the poor Filipino families have yet to experience equity and access to critical health services. Thus, the Department of Health developed and implemented the Aquino Health Agenda: Achieving Universal Health Care for All Filipinos. Its implementation supports the achievement of the goals of better health outcomes, sustained health financing and responsive health system by ensuring that all Filipinos, especially the poor and disadvantaged groups, including people living with HIV, shall have equitable access to affordable and quality health care services.

Despite the achievement of gains, it seems the HIV epidemic have outpaced the current responses. The country is now faced with a steep rise in the HIV epidemic that calls for a more robust and better responsive strategies. Based on recent

program evaluation of the health sector component, gaps and challenges were identified such as:

- Current indicators were unable to document program outcomes
- Vertical components of program (prevention/diagnosis/treatment) implementation that limits coverage
- Communication Strategies that are targeted and focused were limited
- Quality assurance systems were inadequate
- Emerging at risk populations (prisoners, transgender) needs to be evaluated
- Waiting period for HIV test results hinders access for timely treatment and care
- Retention of volunteers is a concern for continuity of services
- Engagement of private sector
- Funding to scale up interventions
- Tolerance/Acceptance of the community to address barriers to service delivery

The need to respond to these gaps and challenges with hopes to overtake the epidemic stride called for updating the health sector strategy. As such, the 5th AMTP and results of its midterm review especially on the health sector component and, the Department of Health's (DOH) *National Objectives for Health* are the main guiding documents for the development of updated HSP.



HIV & STI SITUATION

HIV is the human immunodeficiency virus. It is the virus that causes Acquired Immune - Deficiency Syndrome, or AIDS. The National Epidemiology Center estimates that there are 25,000 Filipinos living with HIV in 2012, and this will grow to 40,035 by 2015⁵ with the current pace of interventions and country resources.

HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS). It can take an average of 8-10 years for an HIV- infected person to develop AIDS; Anti- Retroviral (ARV) drugs can slow down the process even further.

HIV is spread primarily by:

- Not using a condom when having sex with a person who has HIV. All unprotected sex with someone who has HIV contains some risk. However:
 - o Unprotected anal sex is riskier than unprotected vaginal sex.
 - o Unprotected oral sex can also be a risk for HIV transmission, but it is a much lower risk than anal or vaginal sex.
 - o Among men who have sex with other men, unprotected receptive anal sex is riskier than unprotected insertive anal sex.
- Having multiple sex partners or the presence of other sexually transmitted infections (STI) can increase the risk of infection during sex.
- Sharing needles, syringes, rinse water, or other equipment used to prepare illicit drugs for injection.
- Being born to an infected mother—HIV can be passed from mother to child during pregnancy, birth, or breast-feeding.

⁵ DOH NEC, PNAC, DOH NASPCR, NEDA, GFATM, UNAIDS, HAIN, EWC. AIDS Epidemic Model Impact Modeling and Analysis. Philippines Case Study 2014.

It is important to note that globally, every day, nearly a million people acquire STI including HIV. The results of infection include acute symptoms, chronic infection, and serious delayed consequences such as infertility, ectopic pregnancy, cervical cancer, and the untimely deaths of infants and adults. The *presence in a person of other STIs* whether ulcerative or non ulcerative such as syphilis, chancroid ulcers or genital herpes simplex virus infection greatly *increases the risk of acquiring or transmitting HIV*.^{6,7} New research suggests an especially potent interaction between very early HIV infection and other STIs. This interaction could account for 40% or more of HIV transmissions.⁸ Because of this substantial relationship between other STI and HIV, interventions that prevent and controls STI will have a significant impact in the control and decline of new HIV cases.

⁶ Fleming, DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections*. 1999. 75:3-17.

⁷ WHO. Global Strategy for the Prevention and Control of STI: 2006-2015. Breaking the chain of transmission. 2007. Geneva, Switzerland

⁸ Ibid

Epidemiological Background

The Philippines tracks its HIV epidemic through passive and active surveillance system. The Philippine HIV & AIDS Registry is a passive reporting system with nationwide reach that includes newly diagnosed cases and mortalities. On the other hand, active surveillance among key affected populations called the Integrated HIV Behavioral and Serologic Surveillance (IHBSS) is conducted every 2 years. The country uses information from these systems when developing the Philippine Size Estimates of the Most At-Risk Population/ key population and the Philippine Estimates of People Living with HIV (PLHIV) (Table 1).

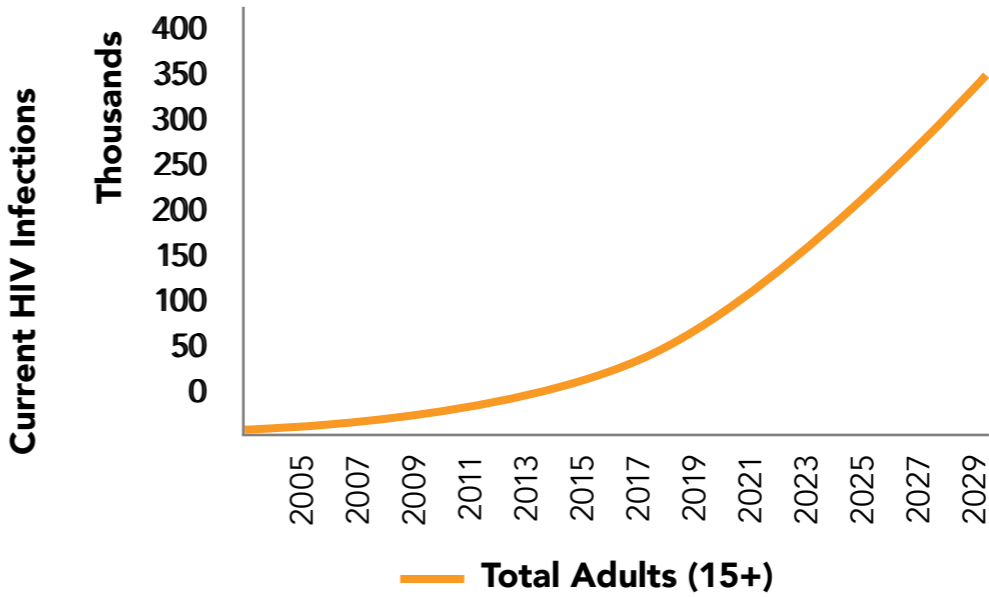
Table 1. National Population Size Estimates for Most At-Risk/ Key Populations, 2011

MARP	LOW ESTIMATE	PROPORTION TO TOTAL POPULATION	HIGH ESTIMATE	PROPORTION TO TOTAL POPULATION
MSM	390,733	1.70% of adult males	689,529	3.0% of adult males
IDU	12,304	0.03% of adult males	16,607	0.04% of adult males
Total FSW	70,167	0.31% of adult females	89,175	0.40% of adult females
*RFSW	54,485	0.24% of adult females	54,485	0.24% of adult females
*RFSW		0.24% of adult females	54,485	0.24% of adult females
*FFSW	15,682	0.07%	34,690	0.15%
Clients of FSW	436,702	1.90% of adult males	1,149,215	5.0% of adult males

***Adult population: individual ages 15 to 49 years based on the 2007 Census of the National**

Statistics Office

The HIV epidemic in the Philippines has been rapidly changing in the past five years. The increase in the number of new HIV infections is at a pace the country has never seen before, from one new case every three days in year 2000, to thirteen (13) cases every day by December 2013.



While the projected national HIV prevalence remains below one percent of the general adult population estimated at 0.036 percent in 2011, based on the current trend, HIV prevalence will likely increase but remain below one percent by 2020, or 0.086 percent (Figure 2).

Figure 2. Total Number of Projected PLHIV 2005-2030 (based on 2014 AEM)
Despite a stable HIV prevalence among registered female sex workers, a significant increase in prevalence was observed in other key at-risk population (Figure 3).

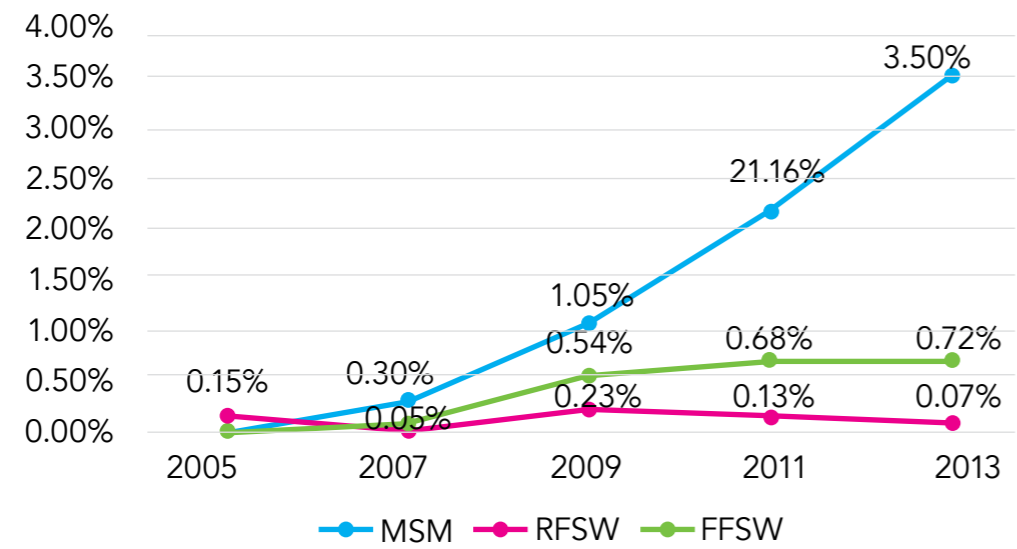


Figure 3. HIV Prevalence among MSM and FSW. IHBSS 2005-2013

HIV transmissions are now mostly concentrated among men who have sex with men and people who inject drugs in certain geographic areas.⁹ See Figure 4 and 5.

⁹ DOH NEC. 2013 Integrated HIV Behavioural and Serologic Surveillance

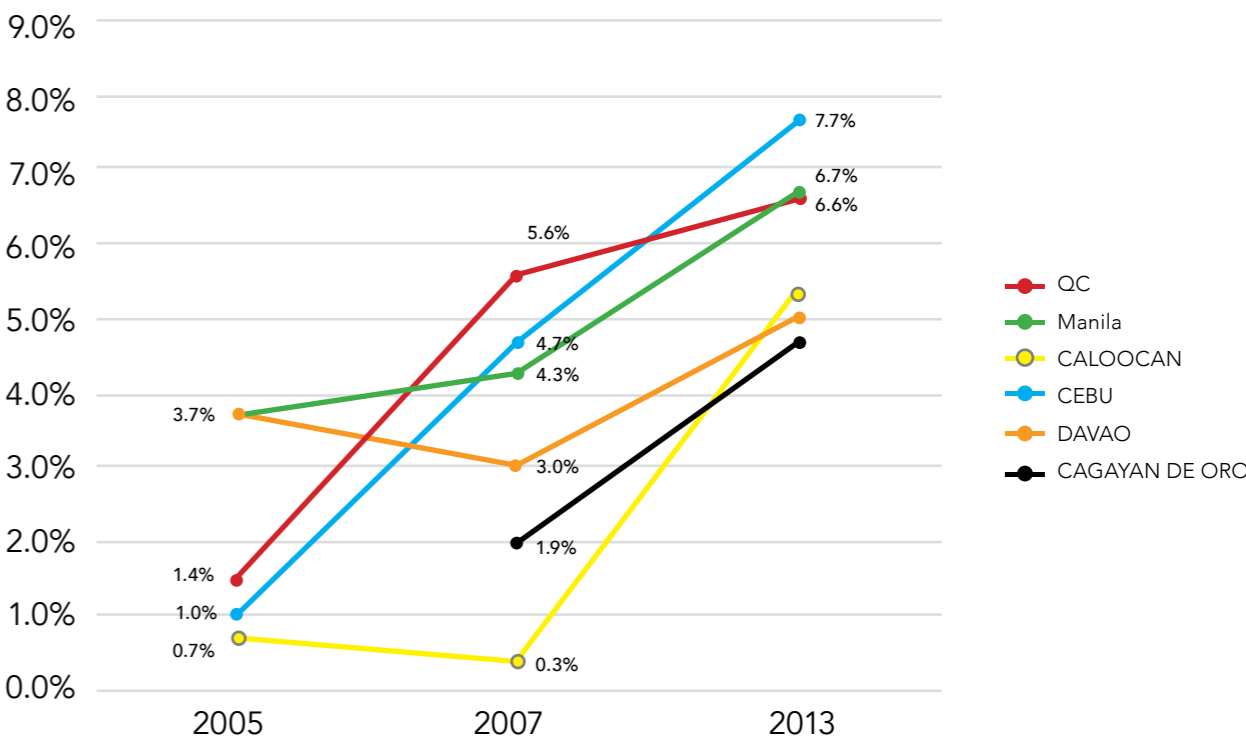


Figure 4. Cities with highest prevalence among MSM. 2009-2013

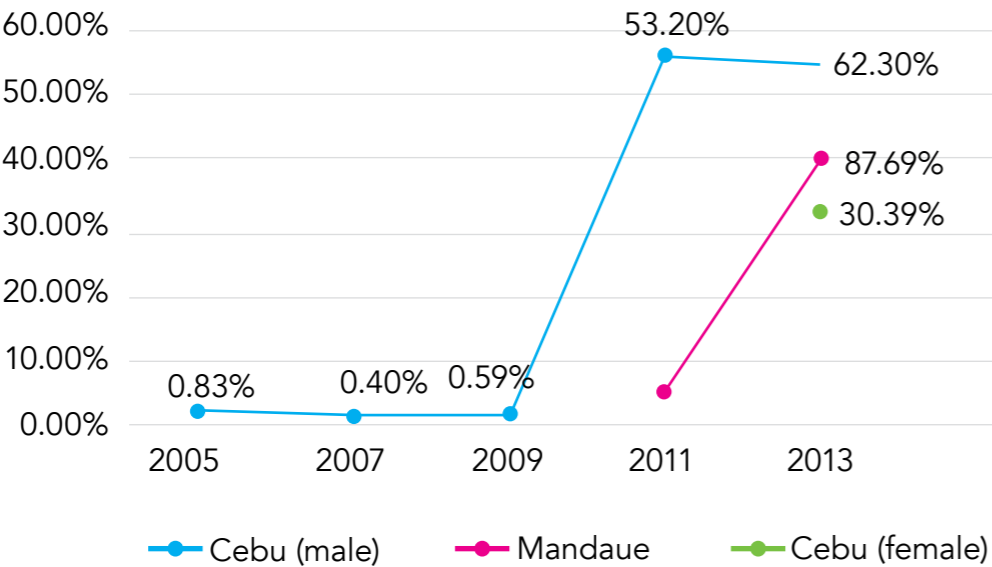


Figure 5. HIV Prevalence among IDU, 2005-2013

From 1984 to the end of December 2013, there were 16,516 newly diagnosed HIV cases reported to the Philippine HIV & AIDS Registry (Figure 6). Majority (59%) of the reported cases in 2013 were 20- 29 years old.

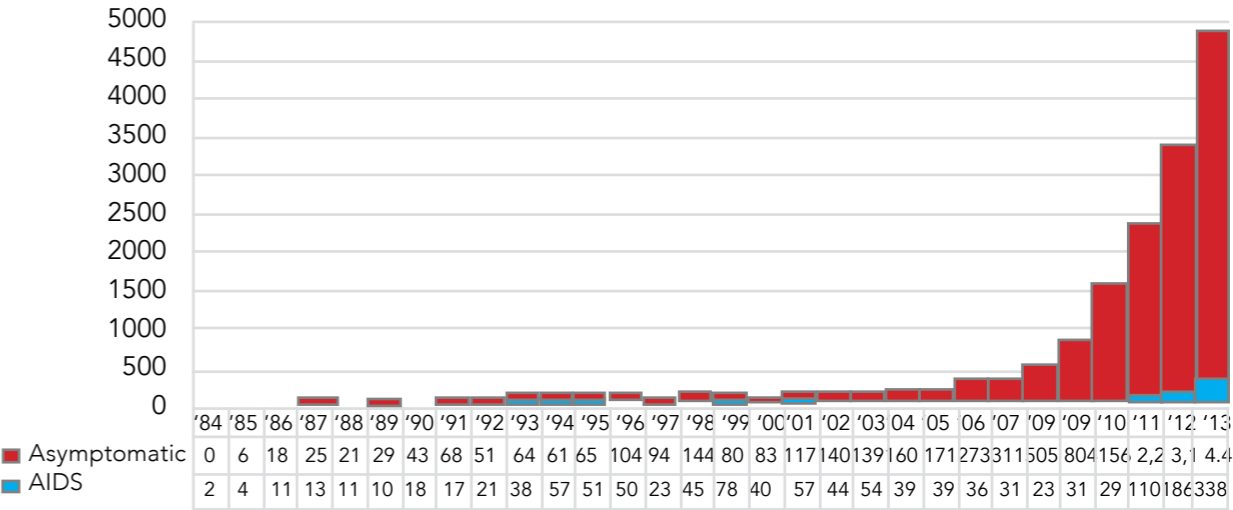


Figure 6. Number of HIV/AIDS Cases Reported in the Philippines by Year, January 1984 to December 2013 (N=16,516)

It was reported that by 2013, about 27,721 are living with HIV. With 16,516 reported in the AIDS Registry by December 2013, we can deduce that only 60% of those living with HIV at this time know their status.

Modes of Transmission

Overall, *unprotected sexual contact* has consistently been the most common mode transmission (94% December 2013), with other modes of transmission including: (i) needle sharing among injecting drug users or PWID (6%), (ii) mother-to-child transmission (1%) (iii) blood transfusion (<1%) and needle prick injuries. (1%) The males are predominantly infected (from 64% in 1984-2006 to **95% in 2013**), and unprotected sex between males are the increasing cause of transmission (28% in 1984-2007to 82% in 2013. Figure 7 also reflected the shift in the mode of sexual transmission from heterosexual contact to contact among MSM (homosexual and bisexual).

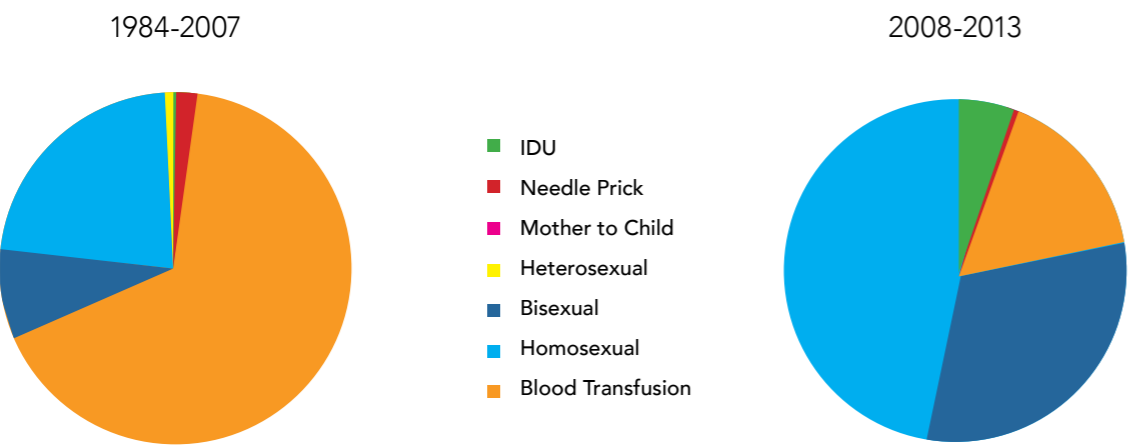


Figure 7. Predominant Mode of Transmission of HIV in the Philippines

HIV and the Youth¹⁰

In **2013**, there were estimated 19.2 million youth in the Philippines, of these 10.2 million were aged 15-19 and 9 million were aged 20-24 year of age.¹¹ In the last five years, one-third of the newly reported cases in the NEC HIV registry are among the young population, specifically between ages 15 – 24 years old. Although a report from 2013 YAFS4 noted an improvement in the non-sexual risk behaviors such as smoking, drinking and drug use, the sexual risk behaviors indicated a worsening trend in terms of the prevalence of premarital sexual activity (**1 in 3**) has increased but the use of contraception/protection against STI remains low (78% in 1st premarital sex is unprotected) and unchanging from its 1994 level. The study also notes the narrowing of the gap in the prevalence of premarital sexual activity between young men and women, amidst increasing pre marital sex prevalence in general and is likely a major contributor to the sharp increase in teenage fertility.

Further, the new technologies have given rise to new forms of sexual activity and new means of meeting sexual partners that could increase the risk of adverse consequences under a context of low prevalence of the use of protection.

The serological and behavioral study by DOH (IHBSS 2009) also reported a lower knowledge on HIV prevention including health seeking – behavior among youth compared to older age groups. This finding was also reflected in 2013 IHBSS. Further, it showed that among MSM 15-17 years old surveyed, 47% of them are practicing *oral sex only* and with the reported median age of condom use at 18 years of age, this findings highlights a significant opportunity for young people in general to be provided right information and education to reduce risky practices in the future.

¹⁰ The UN, for statistical consistency across regions, defines 'youth', as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member States. Available at <http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth-definition/>
¹¹ Natividad, JN. The 2013 Young Adult Fertiity and Sexuality Study (YAFS 4)
¹² DOH. National Objectives for Health 2011-2016. Manila, Philippines

These information highlight the need for the program to find better ways and innovation to reach the youth and lower their risks, as they deserve the best possible care, including sexual health. Otherwise, Filipino adolescents will continue to experience unwanted pregnancy and acquisition of HIV/STI, or succumb to substance addiction and be unhealthy in general.¹² The young peoples, considered as future gems of a country, should be considered in any health responses that should undertake to protect them from all harm and to safeguard their health. Programs should invest judiciously in their health for whatever happens to them in this phase of their lives will have a significant impact not just personally but also to the future of the country.

Mother to Child Transmission of HIV

National Demographic and Health Survey (NDHS 2013) reported that the total fertility rate (TFR) per woman was 3.0 children per woman. The same report showed that education has a positive relationship with HIV/AIDS knowledge among Filipino women. At least 80 percent of women with some form of education have heard of HIV/AIDS as compared with 44 percent of women with no education. However, in terms of HIV knowledge, only 57% of these women knew that limiting sexual intercourse to one uninfected partner and using condoms are ways of avoiding HIV infection.¹³

¹³ Philippine Statistics Authority. National Demographic and Health Survey. Preliminary Report. 2013. Available at: <http://dhsprogram.com/pubs/pdf/PR47/PR47.pdf>

In December 2013, a total of 65 pediatric HIV cases (age less than 15 years old and below) were reported to DOH since 1984. Of the 237 estimated HIV-positive pregnant women in the 2011, a total of 18 HIV-positive pregnant women received ARV. Thirteen (13) infants born to these HIV-positive women received virologic test (using PCR) within 2 months of birth and all were tested HIV negative.

Although HIV infection among pregnant women in antenatal clinics (ANC) is considerably low, DOH will monitor the levels of HIV infection in this population in sites where significant epidemics are seen in key populations. This will not just allow robust implementation of PMTCT program but will also allow early detection of rising levels of HIV in the general population.

A Summary of the Philippine HIV epidemic:

- a. Over-all, the country’s HIV prevalence is low at about 0.06% with pockets of concentrated epidemic (i.e. >5% among MSM and/or PWID in certain cities)
- b. Males are predominantly affected
- c. Unprotected sexual contact remains the most common mode of transmission
- d. Transmission has shifted from heterosexual to homosexual and bisexual contacts (MSM)
- e. Transmission through sharing of injecting needles and syringes is increasing in certain geographical site

HIV and other Sexually Transmitted Infections

Managing Sexually-Transmitted Infections (STI) is important as their occurrence represents prevailing HIV risk – taking behaviors particularly among the most-at-risk populations. The presence of STI in a particular community and population do not only serve as early warning indicators that suggest HIV may occur at any given time, they also facilitate entry of HIV into the human body, thus magnifying the probability of HIV transmission. On top of this, untreated STI results to infertility, ectopic pregnancies, spontaneous abortions, post-partum infections, cancer and pelvic inflammatory diseases, which can also be fatal in itself. To infants, STI acquired from mothers result to congenital syphilis, conjunctivitis and blindness and pneumonia, among others.

Tracking STI¹⁴

Tracking STI cases in the Philippines remains a challenge because many cases are undiagnosed, misdiagnosed and/or unreported. This is due to a number of reasons: (1) the stigma attached to having STI which hinders the infected person from seeking medical attention; (2) the inability of service providers to come up with diagnosis; and (3) the failure to submit reports to public health authorities as required by law. To institutionalize a national system of STI surveillance that will provide sufficient information for the planning and management of the national STI and reproductive health program, the Department of Health-Epidemiology Bureau (DOH-EB) set up the Sentinel STI Etiologic Surveillance System (SSESS) in 2001. Despite the limitations of the system and the operational difficulties, the SSESS reports provided data for a number of important findings on STI, such as the following (Figure 8):

- 1. In 2009, as in previous years, almost all SSESS reports came from SHCs and majority of SHC clients were female (96%). Of these, 94 percent belonged to the 19-24 age group.
- 2. There was a decline in gonorrhea positivity rate among males from 11% in 2005 to 5.4% in 2009 as shown in Figure 8.
- 3. Although the rates for male non-gonococcal infection (NGI) showed a downward trend, a saw- tooth pattern was noted among females.
- 4. There was a spike in syphilis cases in 2009. From 0.0 in 2007, the positivity rate increased to 3.3 in 2009. The SSESS findings in 10 sentinel sites were consistent with overall STI burden in the country. Between 2007 and 2009, a total of around 150,000 STI cases were reported in key facilities nationwide through clinical and/or laboratory-based diagnosis. This does not include cases seen in non-SHC facilities. As in the SSESS sites, majority of the consultations were by females who accessed the clinic regularly.

14 OH. USAID. Manual of Procedures for Social Hygiene Clinic. 2011

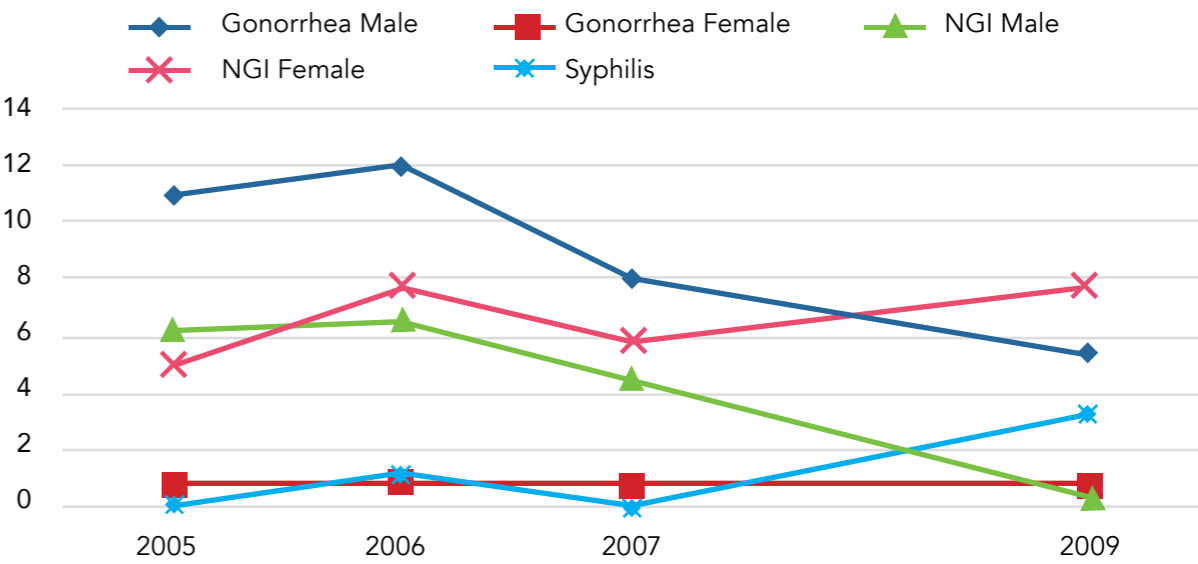


Figure 8. Positivity rates of Major STI (10 SSESS sites, DOH-NEC. 2005-2009)*

The most common STI seen among FSWs in Social Hygiene Clinics are gonococcal and non– gonococcal infections, trichomoniasis, and syphilis. See Figures 9 (regional data) and 10 (data from sentinel sites).

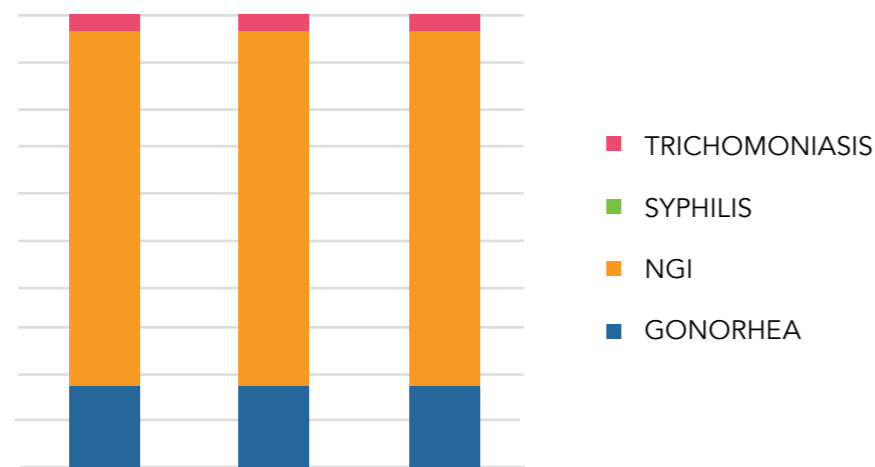
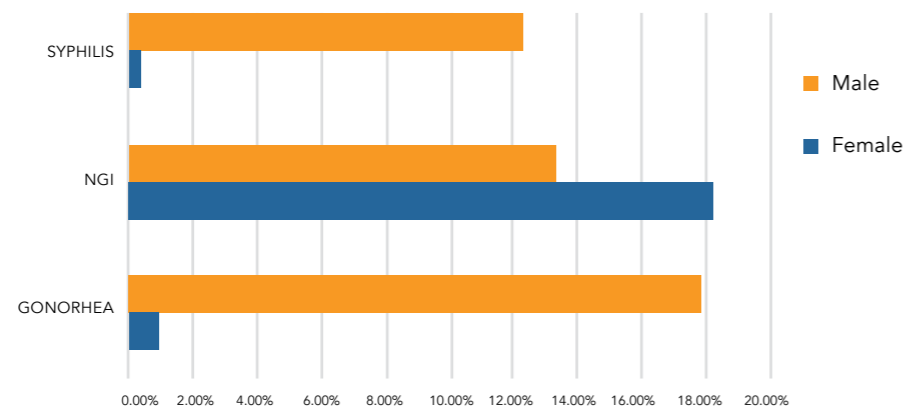


Figure 9, Distribution of STI according to Types, All Regions (NASXP, 2007-2009)

***Data for 2008 was incomplete so this year was not included.**



*Reports as of Sept 2013 from STI Etologic Surveillance System

**Positivity rate was computed by total no of STI cases divided by the total no of diagnostic test performed

Figure 10. Positivity Rate by Type of STI and Sex. SSES, 2013

Syphilis is particularly important due to its strong correlation with HIV infection, and severe maternal and neonatal mortality and morbidity implications. It is consistently low in the most-at-risk population/ key population and pregnant women (as proxy indicators for the general population). It remarkably increases the chance for HIV infection. For the key populations, syphilis is high among PWID, MSM and TG, since 2009 (see Table 2).

Table 2. Prevalence (%) of Syphilis by key populations, 2009-2013

Key Populations	2009	2011	2013
PWID	2.3	1.73*	4.82*
MSM	2.54	1.57*	1.95*
Freelance FSW	2.96	1.97	no data
Registered FSW	0.3	0.3	no data
Transgender women	no data	no data	2.4**

*IMBSS 2013 Briefer (DOH NEC) ** TGIHBSS Cebu City (Preliminary unpublished report)

Country's Response

Anchored on the Philippine AIDS Prevention and Control Act of 1998 (Republic Act 8504), the country implemented in 2005 the "Principle of Three Ones" including the components of one national coordinating body, one strategic framework, and one national monitoring and evaluation system as its national response. The Philippine National AIDS Council (PNAC) as the primary policy- making and coordinating body launched the 5th AMTP of 2011 – 2016. This plan aims to further reduce new infections among most-at-risk populations and the vulnerable population through the provision of comprehensive prevention, treatment and care services to infected and affected individuals.

Corollary to this relevant national strategic framework is the Philippine Health Sector Plan for HIV and STI that is basically anchored on the PNAC's 5th AMTP and DOH's Universal Health Care program.

The Country Strategy (AIDS Medium Term Plan or AMTP)

Following the plans embodied in 5th AMTP (2011 – 2016), the country made important advances in the fight against HIV and AIDS. With considerable financial support from the Global Fund, significant steps in prevention interventions have been taken among MSM, PWID and SW as well as a major scale up of quality treatment, care and support services.

The 5th AMTP sets a national goal of maintaining a prevalence of less than 66 HIV cases per 100,000 (or 0.066%) by 2016, with the following strategic objectives:

- (1) To improve the coverage and quality of prevention programs for persons at most risk, vulnerable and living with HIV;
- (2) To improve the coverage and quality of TCS programs for people 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 capacities of the PNAC and its members to oversee the implementation of the 5th AMTP; and
- (5) To strengthen partnerships and develop capacities for the 5th AMTP implementation of LGUs, private sector, civil society, including communities of at-risk, vulnerable, and living with HIV.

Although HIV infection among pregnant women in antenatal clinics (ANC) is considerably low, DOH will monitor the levels of HIV infection in this population in sites where significant epidemics are seen in key populations. This will not just allow robust implementation of PMTCT program but will also allow early detection of rising levels of HIV in the general population.

While the country was able to maintain the prevalence rate at less than one percent in the general population, an exponential increase in numbers of reported HIV cases among MSM and PWID were noted. This has led to a clarification of the national needs and strategy at this critical point in the HIV epidemic. Hence, in 2013, a midterm review on the 5th AMTP was conducted by team of external evaluators, where findings and recommendations called for a strategic shift in the country's over-all response especially on the health sector component. Snapshots to the results of review calls for enhancing the country's strategic information

system, strengthening the delivery of intervention packages ensuring continuum of prevention, care and treatment services, boosting and supporting policies for scaling up HIV programs, expanding the capacity of PNAC and bolstering capacities of LGU and communities.

HIV Control and Prevention Interventions

The health programs implemented to date are built on a foundation of broad-based partnerships.

Due to decentralized health systems, it is critical to involve the Local Government Units (LGUs), the primary implementers of health programs. The increased awareness of local political leaders on HIV/AIDS as a major health problem is evident based on the existence of social hygiene clinics where HIV and STI prevention services are lodged (119 Social Hygiene Clinics). To some extent, LGU with far deeper appreciation of the need for multi-sectoral response established Local AIDS Councils – a local policy-making and coordinating body for HIV/AIDS program.

Prevention interventions in the country are primarily focused on targeted education, risk-reduction counseling and condom promotion by health workers and their trained volunteer peer educators in high-risk cities. The target populations include sex workers, men having sex with men, STI clients of Social Hygiene Clinics, and people who inject drugs. Most at risk children and young people (MARCY) and migrant workers are also included in the priority populations at risk in some LGU.

Regarded as the biggest and earliest contribution of LGU, even before the emergence of global AIDS epidemic, is primary support on STI case management and risk reduction in Social Hygiene Clinics. For many years, since the addition of HIV in the list of STIs, services of SHC have expanded to cater for counseling and HIV testing to its clientele. In general, due to poor staffing and very limited funding, LGU interventions are limited to SHC-based interventions, occasional outreach program, and awareness campaigns. The usual reach of LGU are entertainment establishment workers (male and female), female/male sex workers in cruising sites, young people through school-based awareness campaigns, and pregnant women in antenatal clinics. Presently, there are few community-based organizations, and non-government organizations that conduct mobile events-based HIV testing in coordination with DOH.

Stigma and discrimination are still largely documented in the country. The community of People Living with HIV regularly conducts community fora to fight stigma and discrimination. These efforts complement the regular awareness campaign driven by PNAC especially during World AIDS Day and AIDS Candlelight Commemoration conducted annually.

The foreign grant GFATM Projects (see Annex 2 for complete list) have been instrumental in the institutionalization of provision of Anti-Retroviral Drugs (ARV) treatment for HIV the country. From 2004 (Round 3) until June 2014, the cumulative number of PLHIV enrolled to treatment is 6,935¹⁵ . For its part, the Department of Health historically procured ARV since 2008 as shown in the table below.

Table 3. DOH Procurement of Antiretroviral Drugs from 2008-2014

Year	Amount procured for ARV	No. of PLHIV on Art
2008	USD 79,511	
2009	USD 161,257	
2010	USD 363,400	1274
2011	USD 149,155	2174
2012	USD 545,375	3570
2013	USD 593,966.50	4464
2014	USD 1,473,362.72	8481

From 6 treatment hubs in 2004, DOH has expanded ARV services to 18 Treatment Hubs in the country as of December 2013. It is noteworthy that to address treatment accessibility, the national program has expanded primary HIV care services to Satellite treatment hubs in SHC of some high burden sites (eg. Quezon City, Manila, Cebu City) increasing further the number of facilities providing ART. The total number of PLHIV on ART is 2,094 in 2011, 3,492 in 2012 and 5,564 in 2013.

One important sustainability measure in ensuring continuous access to treatment, care and support services of PLHIV is the provision of medical and financial support through the Philhealth Outpatient HIV and AIDS Treatment (OHAT) Package amounting to Php 30,000 per patient per year to cover for laboratory examinations

15 DOH NEC. Monthly AIDS Registry. December 2013

including CD4 and viral load determination, and professional fees of service providers.

The WHO-USAID supported surveillance system in the country is a self-sustaining system today implemented by National Epidemiology Center. It has so far guided the country on prioritizing the populations at risk as the latter generates timely and evidence-based reliable epidemiologic profile in the country. Recently, it has included qualitative data in the system to give more meaning to the data especially among MSM, and PWID.

The DOH has committed to achieve global targets of Zero new HIV infections, Zero AIDS-related deaths and Zero discrimination by focusing on cost-effective interventions that ensure universal access to prevention, treatment, care and support among key affected populations and persons living with HIV. The greatest challenge is to make all these interventions scaled-up and sustainable, accelerating them in priority areas.

Health Sector Response

According to WHO, the health sector is “wide ranging and encompasses organized public and private health services, health ministries, nongovernmental organizations, community groups and professional associations, as well as institutions that directly input into the health-care system”. For the health sector HIV response, the Disease Prevention and Control Bureau (DPCB) of DOH led the response providing technical guidance, resource mobilization, monitoring and capability-building. Together with partners from developmental organizations, regional counterparts, LGU and NGO/CSO, it sets direction for the implementation of strategic objectives and activities that will greatly contribute in the attainment of national goals towards halting and reversing the HIV epidemic.

Program Outcomes

Since the start of HIV epidemic, the Philippines was able to maintain its HIV epidemic at a low prevalence rate. Lead implementers of HIV and STI response are primarily the SHC, whose efforts in controlling STI among entertainment establishments workers reflects a continued low prevalence of HIV among its registered female sex workers. The emergence of HIV epidemic in other key populations however, entailed determinations to expand services beyond the registered female sex workers.

The 2012 country's report indicated key indicators¹⁶ of its progress to HIV response reflecting a situation that calls for a more vigorous intervention.

1. *Consistently low HIV knowledge among populations surveyed (FFSW, RFSW, PWID, MSM). Proportions of these populations who correctly identified ways of prevention and rejected major myths and misconceptions remained below 45%.*
2. *Use of condoms among populations surveyed was very low, especially among MSM and PWID (<30%).*

Current data from DOH, however, not only show poor coverage and limited access to prevention services but also reflects gaps and missing data on those PLHIV to be enrolled in care. This can reflect missed opportunities for intervention not only to make them healthy overtime but also prevent transmission of infection to others. These findings were reflected in the midterm review of 5th AMTP Health sector component, which shows the cascade of HIV care and treatment in the country (Figure 11). In 2012, out of the estimated 22,840 PLHIV, only 11,729 (51%) had been diagnosed with HIV by the same year cumulatively, excluding deaths reported by health facilities. Of these, there is currently no information on the number of PLHIV who have been linked to care. However, 5,564 individuals (20% of the estimated PLHIV) were newly-enrolled in ART as of December 2013. Finally, based on on the treatment hub reports around 86% (1,311 out of 1,525) of individuals enrolled in ART continue treatment at 12 months. These numbers are suggestive of "lost to follow-up".

¹⁶ PNAC. The Philippines Global AIDS Response Progress Report (GARPR). 2012

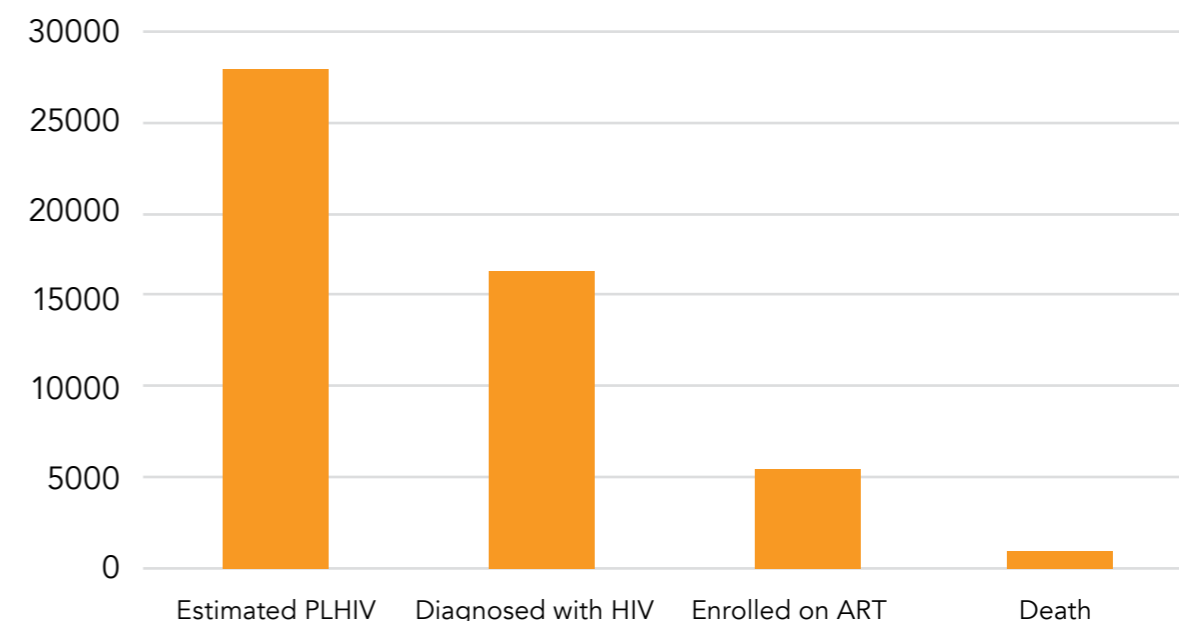


Figure 11. National cascade of HIV care and treatment, and data gaps, Philippines (January to December 2013)¹⁷

Aptly, key findings and recommendations from the Current Health Sector Response as reported in 2013 midterm review of 5th AMTP health sector component can greatly contribute to the development of new health sector strategy that would be better responsive to current HIV scenario. Summary to key findings and recommendations were (details in Annex 3):

1. On strategic information, population mapping, monitoring and evaluation
 - a. IHBSS – The DOH Integrated HIV Behavioural and Serological Surveillance Survey is the cornerstone of surveillance and is key to detecting the recent increase in HIV but the analysis, dissemination and use of IHBSS is limited.
 - b. PWID sites are few considering that PWID is at the center of current epidemic. Guidance to assess local presence of PWID is also limited.
 - c. Mapping of most risk behaviors (condom use, number of partners, syringe sharing) to guide local prevention is also limited
 - d. HIV data from antenatal women to detect an increase is lacking in most regions
 - e. No systematic screening or surveillance of behaviors or HIV in prisons
 - f. Monitoring data of health services limited in analysis, dissemination, supportive
 - g. supervision (due to limited number of staff) with services functioning with limited
 - h. strategic information for quality improvement.

¹⁷ DOH NEC December 2013 ART Database

- i. g. Epidemiological surveillance and the application of new laboratory technologies
 - j. along with greater dispersion of existing technologies (e.g. rapid tests for HIV and STIs, CD4 count, Viral Load) and stronger data linkages from individual entry into active prevention programmes, HIV testing and counselling, enrolment in the care and treatment continuum, and eventually through the end of life needs to be strengthened
2. Insufficient coverage and quality of current response to convert the rising trend. There was a huge gap in implementing national strategy/ guidelines at local level.
 3. There's a need to develop a Master Health Sector Plan to streamline the continuum of prevention, care and treatment, simplify HTC (rapid test by using finger blood prick), strengthen linkages and build partnership with KP communities.
 4. Making the best use of Social Hygiene Clinics by reducing STI screening frequency to increase the efficiency and effectiveness and expand the scope of services to cover other KPs beyond FSW.
 5. Improve communication and data sharing and data utilization to cultivate local planning, monitoring and evaluation
 6. Strengthen operational research and encourage local innovations to set up effective service delivery models/approaches
 7. Focus on key populations (and focus on high impact interventions such as harm reduction for PWID and condom promotion for MSM, TG and SW) and KP community mobilization.
 8. DOH is strongly advised to seek additional human and financial resources at a time when the fast spreading epidemics among key populations threatens to spin out of control.

Understanding Health Structures for the Delivery of Services

To better respond to any given national health concerns, it is appropriate to also examine and look closely on existing service structures for the delivery of services. Table 3 details the management structure, staffing and roles and functions at different levels of health sector from national to local implementers. Better understanding of existing health structure for the delivery of services helps to analyze bottlenecks and identify areas of focus where improvement of responses will gain the most impact.

Table 4. Management Structure of Health Sector (government-led services)

Levels of Imple-	Permanent Position	Temporary Position/ Job Order/Project	Functions / Responsibilities
NATIONAL	Program Manager, NASPCP	3 GF staffs- Prevention, Treatment, Procurement; 2 ADB staffs- BCC and TCS	Policy and Advocacy; Strategic directions- evidence-based programming; Guidelines and standards; Technical support – training of regional coordinators; National coordination; <ul style="list-style-type: none"> • Monitoring program outcome and impact
	EB (2)	EB (2) 5 GF staffs – SSESS, Registry, ARV, Estimation, IHBSS 1 ADB- Registry	Strategic information – IHBSS Surveillance, M&E, KP and PLHIV size estimation, HIV/ AIDS Registry, ART database
	SACCL	SACCL 9 staff (from sub-allotment of EB)	National Reference Lab for STI, HIV and Hepatitis; Confirmatory test, Accreditation, Lab proficiency
SUB - NATIONAL	Center for Health Dev't (RO) Regional Coordinator Asst. Regional Coordinator	ROI – 1, ROII – 1, ROIII – 1, RO-NCR – 1, RO IVb – 1, RO IX – 1; ROX – 1, RO XIII - 1	Dissemination of national policies, guidelines and standards; Technical support – training and supportive supervision; Coordination with implementing facilities
	Regional Treatment Hubs HACT team	Peer educators, Site Implementation Officers	Distribute ARV; Management of patient on ART, OI and referrals; CD4 count; Coordinate with private practitioners; Provide training within hospital; Link to care
LOCAL	Social Hygiene Clinics MD, nurse, Med Tech, Support staffs	Peer educators, Site Implementation Officers	Implement Prevention; STI management; Advocacy; Satellite centers for ART; Local AIDS Council secretariat; Link to care; NGO partnership

Classification of Problematic HIV Areas for Prioritization

Given the limited resources and financial gaps in HIV response, there is a need to focus and leverage the resources in areas considered as high risk for HIV epidemic. Critical decisions in the implementation of priority interventions are believed not only to be cost-effective but also efficient. To successfully curtail transmission, effective prevention services must reach geographic areas and populations where HIV is spreading most rapidly and the interventions must be at sufficient scale and intensity to achieve impact.¹⁸

In 2012, DOH and other members of PNAC identified 70 priority areas for HIV intervention for MSM, PWID, and FSW (Table 5). The areas were then divided into 3 categories based on the immediacy and need for intervention. The 22 cities/municipalities in Category A were the highest priority for HIV intervention, followed by the 18 in Category B then the 30 in Category C.

The following criteria were then considered for prioritizing and selection of intervention sites where the greatest impact can be seen:

- Number of reported cases from 2009 to 2011 reflected in HIV/ AIDS registry
- HIV prevalence in selected sites (IHBSS sites)
- MARP population size specifically MSM

Estimated size of Key Affected Populations: Based on the 2007 Census of Population, the adult population of males and females were projected through to 2011. From the projected population, the size of the MARPs was calculated as a percentage of total population of adult male or female age 15-49 using the 2011 Philippine Estimates of Most At-Risk Population of the PNAC. (Source of data: DOH-EB November 2011)

- Results of the Rapid Assessment of HIV Vulnerability (RAV)
- Presence of multiple risks (FSW-IDU, MSM-IDU).
- Based on these criteria, the sites (cities and municipalities) were classified:
- Category A - contributes to almost half of the epidemic, with multiple risks, high prevalence
- Category B - contributes to 30 to 40 percent of the epidemic, with multiple risks
- Category C - contributes about 10 percent of the epidemic, with presence of multiple risks

18 18 World Health Organization. Priority interventions: HIV/AIDS prevention, treatment and care in the health sector. Geneva, Switzerland. 2009

Table 5. Philippine Priority Areas for HIV Intervention, 2012

Category A	Category B	Category C
Manila City	Lapu-Lapu City	Lapu-Lapu City
Mandaluyong City	(Cebu)	(Cebu)
Marikina City	Talisay City (Cebu)	Talisay City (Cebu)
Pasig City	Antipolo City , Rizal	Antipolo City , Rizal
Quezon City	Cainta, Rizal	Cainta, Rizal
San Juan City	Bacoor, Cavite	Bacoor, Cavite
Caloocan City	Imus, Cavite	Imus, Cavite
Malabon City	Dasmarinas, Cavite	Dasmarinas, Cavite
Navotas City	Lipa City, Batangas	Lipa City, Batangas
Valenzuela City	Batangas City	Batangas City
Las Pinas City	Bacolod City	Bacolod City
Makati City	Puerto Princesa City	Puerto Princesa City
Muntinlupa City	Baguio City	Baguio City
Paranaque City	Iloilo City	Iloilo City
Pasay City	Olongapo City	Olongapo City
Taguig City	Cagayan de Oro	Cagayan de Oro
Pateros	City	City
Danao City	Zamboanga City	Zamboanga City
Angeles City	General Santos City	General Santos City
Davao City	Butuan City	Butuan City
Cebu City		
Mandaue City		



THE PHILIPPINE HEALTH SECTOR PLAN FOR HIV AND STI

The Disease Prevention and Control Bureau (DPCB) as supported by the HIV TWG tapped various health agencies and key stakeholders to formulate a Health Sector Plan geared towards achieving the vision of arresting the growth of HIV-AIDS as discussed in the AMTP.

THE VISION BY 2020

The Health Sector HIV and STI Plan is a major contributor to the attainment of the vision of the overall multi-sectoral response articulated in the national multi-sectoral Strategic Plan (5th AMTP). It is also in line with the global recommendation that calls for Zero new infections, Zero AIDS-related deaths and Zero Discrimination.

THE GOAL

To link with the realization of the vision, the health sector has identified the goal by 2020 for its HIV and STI response. The goal is for the country to maintain a prevalence of less than 1% in 2020 by preventing the further spread of HIV infection and reducing the impact of the disease on individuals, families, sectors and communities.

This goal will be attained through a focused program purpose that the further spread of HIV in key populations is prevented through strengthened delivery of essential prevention, treatment and care interventions which can be achieved through four (4) strategies with priority interventions and activities in each strategy as shown in the Figure 12 below.

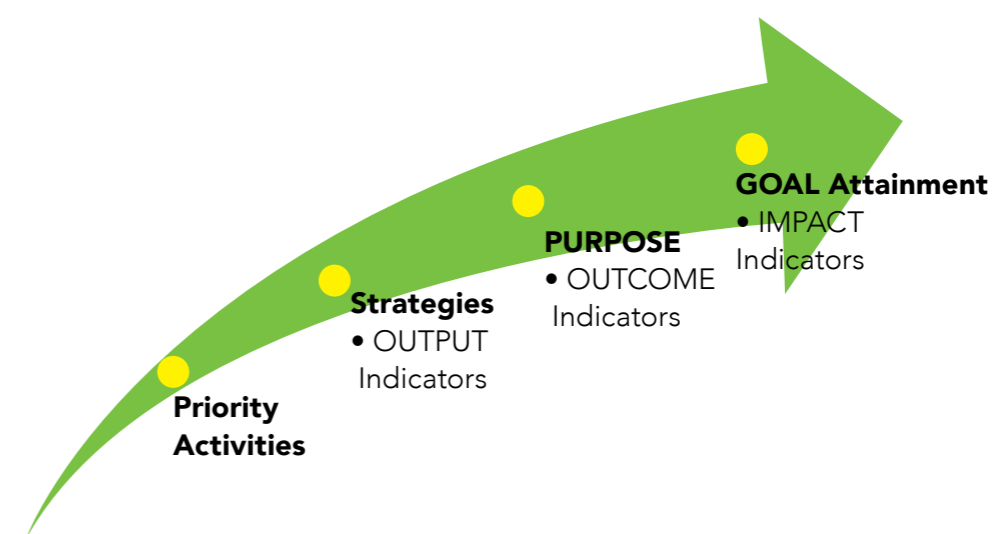


Figure 12. Health Sector Framework on HIV and STI

THE PURPOSE OF THE NATIONAL AIDS/STI PREVENTION AND CONTROL PROGRAM (NASPCP)

With the rising HIV epidemic primarily seen among key populations, the health sector response intend to focus in containing and preventing the further spread of HIV among key populations and to the general population with four (4) strategies that enable a strengthened delivery of services at the same time addressing barriers and system gaps and weaknesses.

THE STRATEGIES

The Health Sector Plan for HIV and STI has been built on the consultation process and consideration of the results of recent program reviews of its progress and the broad consultative process with key stakeholders, sector partners, and the target community. Based on the current need to scale up activities, four (4) broad strategies were identified to guide responses that will hopefully contribute to the over-all goal of halting and reversing the HIV epidemic of the country.

It is equally important to recognize that for operation of services/ interventions to be successful, there should be an active meaningful partnership between different agencies, institutions or organizations. Understandings one's roles and responsibilities not only ensure accountability but can also points to gaps and weakness that needs to be supported and strengthened. Table 6 depicts the continuum of care framework of the health sector response with responsible implementing agencies for specific basic services and intervention for each population to be targeted from well/ general and vulnerable population to at risk/ KP to those who are already infected with HIV. This continuum of care framework developed by the program stems from series of consultation/ workshops between key stakeholders and target community. This services as a guide for activities identification per strategy.

Table 6. HSP Continuum of Care Framework with implementing agencies/ facilities

Key Populations	Key Populations	Key Populations	PLHIV (Asymptomatic)		PLHIV (Symptomatic)	
Service Delivery Area	Health Promotion	Prevention	Diagnosis	Treatment & Care	Re-Integration	
Service Package	Education for 15-18 yr. old and other vulnerable population* thru Strategic Quad-Media; Community and school-based activities	Information and Education in different media, BCC and prevention commodities, Social, Legal and other psychosocial support services		Positive Prevention and Adherence Counseling, Nutritional support	Home – based Care	
		Primary health care services, Nutritional support, STI screening smear monthly for SW; Syphilis 2x/yr); Cervical cancer screening for FSW, Management of sexual violence, post abortion care, family planning services, Referral/ linkages for TG specific needs (eg HRT)	Baseline CD4, viral load; Vaccinations	Psycho-social counseling		
	Community Education: HIV integration in medical and allied health professional curriculum	HIV Counseling and Testing 2x/yr for KP, PICT on contact for pregnant women and TB patients (sites specific),		ART Eligibility determination and initiation	ART initiation	Spiritual counseling
	TB, drug/ alcohol and HIV screening and on site/ referral for treatment	Vaccination for STI (eg. HBV, HPV)	Early Infant Diagnosis	Treatment of co-infections: TB, CMV, PCP,		
TB, drug/ alcohol and HIV screening and on site/ referral for treatment		Partner-disclosure counseling				
Main Implementing Partners	LGU, PNAC, NGO, Education Sector, private-sector (media ads), DSWD	SHC, NGO, DSWD, DOH NCHP	Social Hygiene Clinics, RHU, TB DOTS, private labs, DOH	Satellite Treatment Hubs	Treatment Hubs	NGO, DSWD, FBO, Mental Health Providers
		Peer Facilitators / Counselors				

* 15-18 yr old YP; people in closed-settings (jails, prisons, rehabilitation center); children of key population

STRATEGY 1. CONTINUUM OF HIV/STI PREVENTION, DIAGNOSIS, TREATMENT AND CARE SERVICES TO KEY POPULATIONS

Objective: To improve coverage and linkage of services from prevention and diagnosis among KP to treatment and care for PLHIV through an intensified delivery of quality and evidence based services.

Key Populations. The key populations identified in the AMTP are the following:

1. Female Sex Workers (FSW), categorized into two as follows –
 - 1.1. High risk group or Group 1: Freelance FSW or street-based
 - 1.2. Low risk group or Group 2: FSW in Registered Entertainment Establishments
2. Men having sex with men (MSM)
3. Transgender women
4. Injecting Drug Users (IDU) or People Who Inject Drugs (PWID)
5. Young people (high risk)

It is also equally important for health sector to recognize that different key populations may have different levels of risk. As such KP at higher risk for HIV should be further identified and targeted. Efforts to find them and provide them with services should be exerted and these can be done through mapping, peer network, internet/SMS, partner notification, tracing and testing, in-depth exploration with dedicated peers and others.

As such, the delivery of HIV and STI interventions from prevention, diagnosis to treatment and care services to key populations needs to be strengthened. Any leaks to the cascade of services for the continuum of care must be addressed for responses to be effective as depicted in the diagram below (Figure 13).

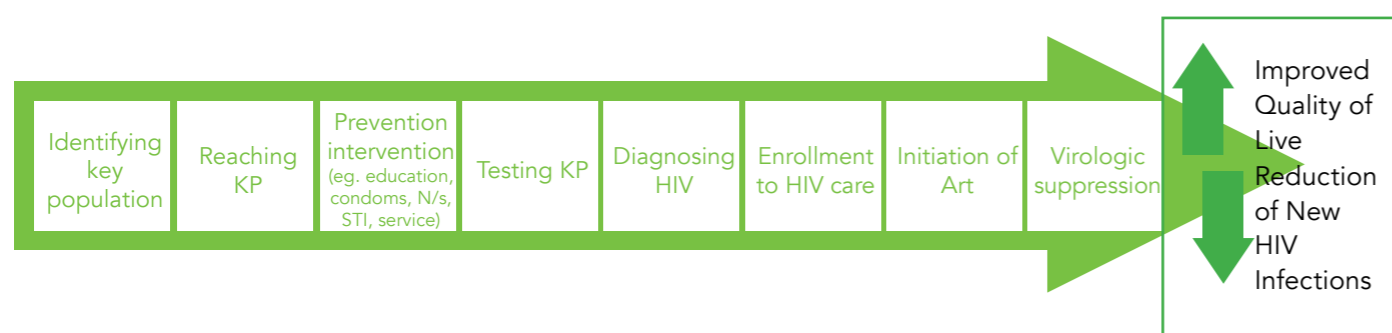


Figure 13. Implementation of Cascade for the Continuum of Care

Each component in the cascade of services for STI/ HIV is equally important, from identifying areas of convergence of key populations to reaching them with basic information and prevention services to ensuring they get access to HIV testing and counseling which is a very important gateway for more HIV prevention and TCS services. An HIV negative individual will learn ways on how to maintain their negative status and be regularly provided with preventive commodities. On other hand, an HIV positive person needs to be enrolled to HIV care where assessment of his needs and promotion of a positive living will be provided. Once a PLHIV needs ART, access for its timely provision and long term adherence should also be ensured. Addressing leaks to each phase in this cascade is crucial in the attainment of the health sector's goal towards reduction of new HIV infections at the same time improving the quality of life among PLHIV.

Key Interventions.

I. Prevention, Treatment & care

In boosting the prevention and control program, HIV-specific interventions needs to be strengthened and expanded. Equally crucial is for core programs to enhance the quality, effectiveness and coverage of HIV interventions and approaches, as well as to identify new HIV interventions on prevention, diagnosis, treatment and care.

Core programs for preventions are 1) Prevention of sexual transmission of HIV and includes condom availability and provision 2) Detecting and managing sexually transmitted infections 3) Elimination of congenital syphilis 4) Blood safety 5) Elimination of HIV transmission in health care settings and 6) Eliminating new HIV infections in children.

It is important to highlight HIV prevention for those who are already living with HIV. Early referral to ART services and measures to retain patients in care are indispensable in achieving good patient and program outcomes. Treatment access and adherence can be improved by involving the positive community in planning and management of treatment and care. Engagement of CBO in the maintenance of treatment, adherence and monitoring not only improve access and adherence but can also reduce the burden on health systems/ facilities.

Treatment and care program will include prophylaxis, diagnosis and treatment for common opportunistic infections and co-morbidities particularly in diagnosis and treatment for TB, pneumonia, diarrhea, viral hepatitis, malnutrition and other clinical conditions that are more serious for people living with HIV. As TB remains the main cause of mortality in people living with HIV including those who are on ART, collaborative HIV–TB activities will be enhanced to ensure that HIV-positive TB patients are identified and treated appropriately, and to prevent TB in HIV-positive patients.

For the needed services to be accessed, the cascade for continuum of care will be supported and enhanced from providing prevention intervention to actively ensuring that target population are linked, accessing and eventually retained in treatment and care services.

II. HIV Counseling and Testing (HCT)

The process of HCT is very important, as it is the gateway not just for prevention intervention but also for people to access treatment and care. Increasing the numbers of people who know their HIV status, especially among key populations is key to expanding access to HIV prevention, treatment and care.

The UNAIDS/WHO policy on HIV testing and counseling defines two main categories of HCT, which are the client-initiated HIV testing and counseling (CITC) and the provider-initiated HIV testing and counseling (PITC). Through these processes, those who found to be HIV-negative are taught how to remain negative and those found to be HIV-positive are taught how to prevent transmission to others and maintain their own good health.

Increasing the coverage for HCT should then be a priority intervention for the health sector as recent data have shown a very low HCT coverage among key populations. Among the estimated number of MSM in the country, only about 8% of them were tested and knew their HIV test results, 5% among TG, 6% among PWID, 39% among RFSW and 7% among FFSW (Figure 14).

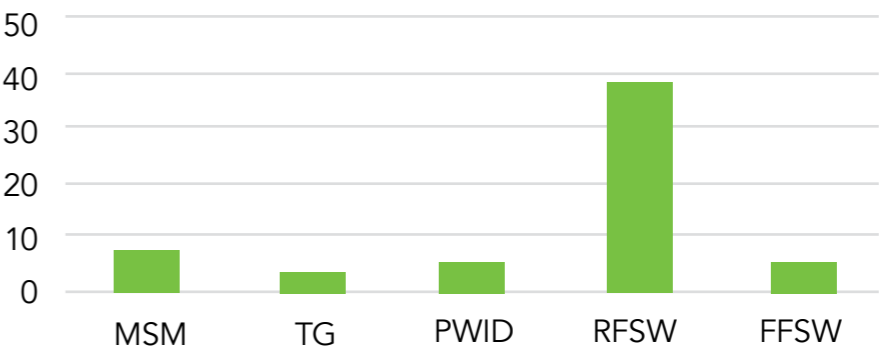


Figure 14. HCT Coverage (%) among Key Populations (tested and knew results)
(Source of Data: 2013 IHBSS for MSM, TG, PWID and FSW)

WHO recommendations on priority interventions in low-level or concentrated epidemics, is for PICT to be considered in a range of specific situations (where patients have come for STI services; where services are provided to most-at-risk/key populations; where people have come for antenatal, childbirth and postpartum services, or tuberculosis (TB) and hepatitis- related services). On the other hand, the programmatic focus on providing CICT should be on increasing access and uptake among most-at-risk populations. These recommendations are being considered in priority activities to be conducted in the immediate years of implementing the new HSP.

Cognizant to the importance of increasing uptake and coverage of HCT, the DOH will be expected to lead to 1.) Expand and diversify testing options and settings which can be facility- based (SHC, ANC, TB, other facilities which can be stand alone, drop in center, closed settings such as in prisons and rehabilitation centers) and community-based (peer led-testing); 2.) Simplify testing not only by health staff but also by CBO staff (peers) with use of rapid tests at point of services (pending results of study by National Reference Laboratory (SACCL); 3.) Support to regular repeat HCT among KP in combination with other tests such as syphilis; 4.) Support couple HCT/ disclosure to sexual partners of positives; 5.) Improve follow up for results and ensure active linkage to treatment and care services.

III. 'Essential' packages for specific KP

Essential health packages aim to concentrate scarce resources on interventions that provide the best 'value for money'. By doing this, essential health packages are often expected to achieve multiple goals: improved efficiency; equity; empowerment, accountability, and altogether more effective care. EHPs are intended to be a guaranteed minimum and exist, generally using the terms basic, minimum health care services or benefit package.¹⁹

The human skills, drugs, equipment and other resources required to deal with interventions within the package should be available. The Health Sector Plan identifies essential package of services for key population as those that directly prevent HIV and STI infections. Additional services that were identified and needed by KP (through consultation) for better health outcomes and to increase their access to health services comprise a Comprehensive Package. Given the limited resource, the health sector response may need to prioritize the essential package of services for funding but also encourage referral for other needs. Eventually, ways may need to be in place for a comprehensive package by building up the capacity of health facilities to provide

¹⁹ WHO. Essential Health Packages: What are they for? What do they change? WHO Service Delivery Seminar Series. Draft Technical Brief No. 2, 3 July 2008.

such services. Services for young people especially those who are practicing high-risk behavior will also be considered.

Essential and Comprehensive packages of services for KP considered the recommendations from WHO. However, the final package of essential and comprehensive package of services identified in this document stems from series of consultation meetings between the target communities and HIV TWG (Table 7).

Table 7. Essential and Comprehensive Packages of services for KP

Essential Package of Services	Additional services for a Comprehensive Package
<p>Sex Workers²⁰</p> <ol style="list-style-type: none"> 1. Comprehensive condom and lubricant promotion and provision (including female condom) 2. Periodic screening including serological testing for asymptomatic syphilis and treatment of common curable STI 3. Provider-initiated HIV Counseling and Testing 4. Provision of family planning and other SRH services 5. Prevention of Hepatitis including Hepatitis B vaccination 6. Peer-led risk reduction counseling (FFSW) 7. Referral and immediate linkages to TCS, and other health and social services. 	<ol style="list-style-type: none"> 1. Linkage to other health, social and legal services <ul style="list-style-type: none"> • Management of sexual violence • Cancer screening (cervical) • TB screening • Obstetric, pediatric and other primary health-care services • Drug and alcohol screening and treatment

²⁰ Adapted from: WHO. Prevention and Treatment of HIV and other STI for Sex workers in low and middle-income countries. Recommendations for public health approach. 2012. Geneva, Switzerland

²¹ Adapted from: WHO. Prevention and Treatment of HIV and STI among MSM and TG. Recommendations for Public Health Approach. 2011. Geneva, Switzerland

Essential Package of Services	Additional services for a Comprehensive Package
MSM and Transgender² <ol style="list-style-type: none"> 1. Condom and lubricant promotion and provision 2. Provider-initiated HIV Counseling and Testing 3. Screening and treatment of symptomatic STI including periodic serological testing for asymptomatic syphilis 4. Prevention of Hepatitis eg. catch-up HBV immunization 5. Access to information, counseling and support on transgender issues (for TG) 6. Referral and linkages to other health and psychosocial needs (eg. hormonal replacement therapy and concerns on gender surgery for TG) 7. Peer-led risk reduction counseling 8. Referral and linkages for treatment, care and support 	<ol style="list-style-type: none"> 1. Individual and community level behavioral interventions for the prevention of HIV and STIs among MSM and transgender people 2. Targeted internet-based information and sex venue-based outreach strategies to decrease risky sexual behaviors and increase uptake of HIV testing and counseling among MSM and transgender people 3. Using social marketing strategies to increase the uptake of HIV/STI testing and counseling and HIV services among MSM and transgender people

²¹ Adapted from: WHO. Prevention and Treatment of HIV and STI among MSM and TG. Recommendations for Public Health Approach. 2011. Geneva, Switzerland

Essential Package of Services	Additional services for a Comprehensive Package
PWID²² <ol style="list-style-type: none"> 1. Needle and Syringe Program 2. Provider-initiated HIV Counseling and Testing 3. Screening and treatment of symptomatic STI including periodic serological testing for asymptomatic syphilis 4. Condom program for PWID and their sexual partners 5. Viral hepatitis prevention, vaccination, diagnosis and referral for treatment 6. Skin infections/ abscess prevention and treatment 7. Peer-led risk reduction counseling 8. Psychosocial support services 9. Referral and linkages for TCS and voluntary rehabilitation 	<ol style="list-style-type: none"> 1. Targeted IEC 2. Nutritional support 3. Primary health care services 4. Social services including livelihood and sports/ recreation activities 5. Conduct of activities to support health such as personal hygiene and regular health check ups 6. TB prevention, diagnosis and treatment

²² Number 1-7 adapted from: WHO, UNODC, UNAIDS Technical Guide. For Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users. 2012 Revision

Essential Package of Services	Additional services for a Comprehensive Package
Young People <ol style="list-style-type: none"> 1. Information and counseling to help young people acquire the knowledge and skills to delay sexual initiation, limit the numbers of sexual partners, use condoms correctly and consistently, avoid substance use or, if injecting drugs, use sterile equipment 2. Condoms for sexually active young people; 3. Harm reduction for young people who are injecting drug users; 4. Diagnosis and treatment of sexually transmitted infections; 5. HIV counseling and testing 	<ol style="list-style-type: none"> 1. Provision of adolescent – friendly services 2. Primary Health Care 3. Consider HPV vaccination

In order for young people to benefit from HIV prevention, health services must take their unique concerns and needs into consideration. In terms of content, the basic package of interventions to prevent HIV is much the same for young people as it is for adults. Prevention services for adults can be modified so that they are also appropriate for young people, but there should also be youth-specific prevention in settings where young people are more likely to access them. These may include schools, universities, youth clubs, popular youth hangouts, and workplaces.

Major Activities

It is the aim of the Health Sector Plan to improve coverage and linkage to cascade of services prioritizing geographic sites and key populations through the conduct of the major activities in the immediate years of its operationalization (Table 8).

Table 8. Major Activities to be Conducted Under Strategy 1

Prevention and Diagnosis
<ol style="list-style-type: none"> 1. Roll-out of the 100% Condom Use Program in all Regions 2. Develop set of standards for HIV testing, including but not limited to test kits, procedures, release of test results, testing modalities, and timely provision of needed HIV treatment and care. 3. Support to conduct of mobile voluntary HIV counseling and testing 4. Integration of HIV in MCH, NCD, TB and DRRM (emergency settings) 5. Develop Manual of Operations for PWID 6. Develop guidelines for HIV services in closed settings 7. Review and update existing guidelines and policies (eg. PEP, PMTCT, STI screening and management in SHC) 8. Implement PMTCT program in NCR and Cebu City 9. Integrate PMTCT in the HIV service points (hubs, SHC, HIV testing facilities, NGO/CBO led services) 10. Provide essential and comprehensive package of services for KP (site specific) 11. Integrate PE approach in the healthcare delivery system 12. Expand Pilot sites for shorter HIV testing algorithm 13. Develop policy to establish sub-national laboratories for HIV diagnosis 14. Support the conduct CBO-organized STI and HCT activities (i.e community-based testing) 15. Implement and monitor Community-based Comprehensive Services for PWID in a key priority site 16. Integrate Psychosocial support services for PWID 17. Provide drug dependence counseling to PWID 18. Referral of PWID to Drug Treatment and Rehab Center

Treatment, Care and Support Services

19. Update and disseminate guidelines on management of Opportunistic Infections
20. Develop system to remind clients on the timely pick up of ARV
21. Expand or set up additional satellite treatment hub accessible in C-45 sites
22. Strengthening database management within treatment hubs (prompt identification of patient lost to follow up)
23. Establish/Strengthen local KP specific support group among PLHIV toward healthier positive living
24. Maximize Outpatient HIV/AIDS Treatment (OHAT) Package
25. Provision of Enablers fund to PLHIV for support to laboratory needs and home visits
26. Integrate and ensure provision of reproductive health services in HIV treatment centers
27. Integrate/Strengthen PLHIV peer approach in the provision of psychosocial services and support to adherence and partner disclosure in the treatment hub (GIPA - MIPA)
28. Strengthen linkage between treatment centers and social services for psycho social support of HIV infected and affected children
29. Expansion of satellite treatment hubs and treatment hubs in C-45 areas
30. Preventive commodities for augmentation (condoms and lubes, needles and syringe)

Procurement of affordable Drugs, Reagents, and supplies

31. Drugs for syphilis and other STIs
32. Anti-retroviral drugs
33. OI drugs other than for TB
34. INH for IPT (c/o TB program)
35. Laboratory reagents, supplies and equipment for syphilis and other STIs
36. HIV test kits for HIV testing
37. Supplies and reagents for Virological test on HIV for infants
38. CD4 machines and reagents
39. Equipment to powder ARV for pediatric use
40. Viral load reagents
41. Reagents for Drug resistance (ARV) study
42. Development of IEC materials on KP specific prevention messages, promotion of services and on positive living
43. Development of IEC materials specific for HIV positive women on PMTCT
44. Capability-building
45. HIV Counseling and Testing Training (Client-initiated HIV counseling and testing and Provider-initiated HIV counseling and testing)

46. PICT training in TB-DOTS and PMDT facilities in Category A and B priority sites
47. PICT training and PMTCT of HIV to all ANC staff in NCR and Cebu City
48. HIV proficiency training for medical technologist
49. PMTCT of HIV including provision of RH services in all HIV treatment centers/ hubs
50. ARV treatment guidelines (including management of pediatric HIV and AIDS), support and Adherence Counseling and palliative care
51. Training on OI management including OI screening in all HIV treatment centers/ hub
52. Infection control including use of PEP for Occupational exposures (facility based and community based HIV and STI services)
53. Conduct of treatment Hub Conference
54. Training on Psychosocial Support

Augmentation of Human Resources

55. Augment personnel in facilities catering to HIV and STI services (Physician, Medical technologist, and nurses, PSM staff/s, project aides) and DOH-NASPCP

STRATEGY 2. HEALTH PROMOTION AND COMMUNICATION ON HIV AND STI PREVENTION AND CARE SERVICES

Objectives:

1. To raise the awareness of key populations and the public on HIV and STI prevention and care services.
2. To increase demand and access to available HIV and STI services.

Access to a strengthened and quality prevention, treatment and care packages can be accelerated through demand generation from the community. Hence activities to create demand can be scaled up through intensified information and education on HIV and STI coupled with promotion of related services. Information, education and communication through peer outreach have been recognized as an important intervention to create demand and hence increase coverage in reaching target population.²³ As such, community-based outreach can be the most effective way of delivering HIV prevention, treatment and care to KP. The outreach approach can assist with the referral process for KP to be directed towards specific health services. (Annex 4 for detailed recommendations on PE for MSM and PWID.)

Further, accelerating appropriate community-based information and education to prevent and reduce risky practices should also sum up health sector response for the general and vulnerable population. Under this strategic direction, major activities will

²³ Casey, Dano, Onofre. Evaluation of HIV and STI Programs and Strategies for MSM, TG and PWID in the Philippines. 2014. DOH, Manila.

Table 9. Major Activities to be Conducted under Strategy 2

1. Implementation of National Communication Plan that strategizes demand generation for STI and HIV services, and executes in part the “One BCC Framework for KP”
 2. Assist LGUs and their respective partners in localizing National Communication Plan that strategizes demand generation for STI and HIV services
 3. Develop standards for peer education, peer counseling, and other community-led support services
 4. Develop and operate ICT-based BCC tools as supplementing channels for primary approaches of the “One BCC Framework for KP”
 5. Develop and produce BCC materials for primary approaches of, and for facility-based information services supporting the “One BCC Framework for KP”
 6. Launch publicity-generating national advocacy campaigns on ART, HIV testing and condom use, consistent with “HIV Stigma Management Strategy”
 7. Assist LGU and other community leaders in local advocacy campaigns, consistent with “HIV Stigma Management Strategy”
 8. Assist private sector and non-health sector partners for strategic participation in demand generation for STI and HIV services (including promotion of Treatment hubs & CBO services, and PMTCT of HIV programs to medical societies and private testing facility)
 9. Number of advocacy events conducted that help generate demand for STI and HIV services.

STRATEGY 3. ENHANCED STRATEGIC INFORMATION SYSTEMS

Objective: To provide timely evidence-based information for planning, monitoring, evaluation and quality assurance of HIV and STI program.

Systematic collection of strategic information on HIV and other STIs among KP can guide health policy, planning, resource allocation, program management, service delivery and accountability. It is essential for action at all levels of the health system. There is an increasing recognition of the need to invest in strate-

gic information to guide program planning and sustain national and international commitment and accountability.²⁴ Program planning that will include formative assessments to determine the needs and vulnerabilities of KP should also involve target community in its design and delivery.

HIV surveillance provides essential data to understand the magnitude and determinants of the country’s epidemic, assess the burden of disease, monitor trends over time, develop interventions and evaluate their impact. Mapping and developing reliable estimates of the size of populations at high risk for HIV is another important aspect of surveillance, to inform assessment of needs and development of appropriate policies and programs. On the other hand, STI surveillance is a useful early warning system for expansion of an HIV epidemic.

Appropriate responses to these information generated entails timely dissemination and utilization for national and local programming to be best responsive. Major activities to be conducted by the health sector under this strategy were reflected in Table 10.

Table 10. Major Activities to be Conducted under Strategy 3

1. 1. Implement surveillance activities.
 - Integrated HIV Behavioural and Serologic Surveillance (IHBSS) - AIDS Registry (Form A, B, D)
 - Sentinel STI Etiologic Surveillance System (SSESS)
 2. Implement activities related to estimates and projections.
 - Rapid Assessment of HIV Vulnerability (RAV) - Micro mapping
 - AEM, EPP Spectrum
 3. Implement HIV program monitoring
 - Unique Identifier Code (UIC)
 - Development of tracking system to monitor patient follow-up in treatment hubs
 - Opportunistic Infections and TB-HIV Reporting
 4. Implement special studies

24 WHO SEARO. Regional Health Sector Strategy 2011-2015. Provisional Agenda. 2011. India

- Bed Assay, STI and HIV Drug Resistance Study (Transmitted Resistance), TG &/or partners of PLHIV, Opioid substitution therapy for Nalbuphine, HIV Risk and Vulnerabilities in Closed-settings and among emerging sub groups KP (eg. Deaf mute), HIV related stigma, PLHIV mental health, etc.)
5. Implement data utilization activities in sites.
 - Local Dissemination forums
 - Develop LGU Data Utilization scorecards - Local strategic and operational planning
 6. Implement strategic and operational planning in sites
 7. Conduct monitoring, evaluation, and quality assurance of EB data systems.
 8. Conduct quality assurance and evaluation of HIV programs.
 - Program Implementation Review (PIR) - Prevention programs and STI services
 - HCT services
 - Treatment and care services
 9. Ensure timely release and utilization of data

STRATEGY 4. STRENGTHENED HEALTH SYSTEM PLATFORM FOR BROADER HEALTH OUTCOMES

Objective: *To intensify delivery of quality STI and HIV services through a strengthened support system by addressing barriers, improving linkages and ensuring availability of critical enablers.*

WHO defines a health system as “the sum total of all the organizations, people and actions whose primary intent is to promote, restore or maintain health”. A country’s health system embraces those who try to influence the determinants of health, as well as those who deliver health-improving services. The health system should also ensure that the expanded response to HIV will be effective, efficient and comprehensive in which HIV and other essential services are available, accessible and affordable. Effective scale-up and utilization of a comprehensive of HIV and STI services and products requires a well functioning health system. As such, the system should be able to respond to current and future emerging and re-emerging HIV and AIDS issues and it should be improved to

create broad synergies and better health outcomes and addresses barriers and gaps for the efficient delivery of services.

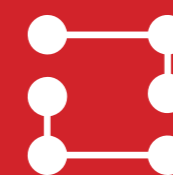
The DOH National Objectives for Health (2011-2016) states that the Philippine health sector should aim to (1) improve the health status of the population, (2) develop a health system that is more responsive to the health needs of the people, and (3) ensure equity in financing health care. To achieve these goals, the health sector must first strengthen its health system in terms of efficiency and effectiveness. Problems with infrastructure, health workers/ human resource, health commodities, logistics, and information technology must be addressed before the country can meet the health needs of its people. As such, critical enablers must be mobilized and enhanced not just to scale up provision and access to services but also to address impediments to its implementations.

For example, the health sector should promote and support legal and social frameworks that are rights-based and consistent with public health and HIV prevention goals, address critical obstacles to provision and uptake of interventions by reducing stigma and discrimination through strong leadership and concrete strategic measures, and support community outreach to young people by providing guidance and linkages between services in the health sector and other sectors. Some adolescents and young people belonging to most-at-risk groups and may not access the services due to legal constraints related to their age. Therefore, policy issues related to age constraints should be addressed. Services targeting adolescents and young people should also be designed or modified to be youth-friendly. Major priority activities will then be conducted to strengthen the health system platform as itemized in Table 11.

Hence, a strengthened health system platform for broader health outcomes tackles concerns related to Leadership/ Governance, Health Financing, Human Resource, Medical Products and Technologies, Information Systems, Service Delivery. The service delivery and information system have been addressed in strategy 1 and 3, respectively.

Table 11. Major Activities to be Conducted under Strategy 4

Leadership/ Governance	<ol style="list-style-type: none"> 1. Strengthen regulation/guidelines for HIV and AIDS Core Teams in hospitals 2. Establishment of psycho social sup through partnership with professional organizations like the Psychological Association of the Philippines 3. Establish and maintain public-private partnership in the delivery of STI and HIV services for key population 4. Strengthen coordination and linkages with TB, MCH program at national and regional level ensuring guidelines are disseminated and implemented by local implementers. 5. Strengthening of Procurement Supply Management Chain from National to Treatment Hub <p><i>LGU-related</i></p> <ol style="list-style-type: none"> 6. Develop policy to establish sub-national laboratories for HIV diagnosis 7. Organization and conduct of HIV and STI advocacy and stigma reduction activities 8. Expand sites implementing 100% Condom Use Program (CUP) 9. Organization and Strengthening of Local AIDS Council (LAC) which includes a local community organization as an active member through an ordinance 10. Establish performance -based financial grant mechanism to LGU and/or NGO financing HIV and STI services
Human Resources/ Manpower	<p><i>Capability building among key stakeholders in the LGU on</i></p> <ol style="list-style-type: none"> 11. 100% CUP (Condom Use Program) 12. SOGIE (Sexuality, Orientation, Gender Identity and Expression) 13. PWID interventions 14. Capacity building of LAC members to respond to HIV-



IMPLEMENTATION FRAMEWORK

STRATEGY IMPLEMENTATION

The Department of Health through its Disease Prevention and Control Bureau (DPCB) is responsible in coordinating the overall health sector response. It will not just coordinate but also facilitate provision of technical support to the local health department through its DOH-regional offices. Enhancement of health sector program structure and operations will be through boosting of collaborations across other health program areas and with other partners.

The DOH shall ensure linking of HIV with a range of other related high-priority areas within DOH such as health-information systems, FHO/MCH, TB program and other infectious diseases, blood volunteer services program, non-communicable diseases, mental health and access to essential medicines. Priority will be given to strengthening integration of HIV into the core work of these other program areas. Mechanisms for joint planning and coordination across program will need to be enhanced such as support to the Elimination of New HIV Infections in Children (PMTCT of HIV) initiative will be coordinated across units responsible for HIV, maternal and child health, and family planning services, adolescent reproductive health programs and contribution to treatment outcomes will be coordinated across units responsible for HIV, tuberculosis, other infectious diseases and bureau responsible for procurement of essential medicines and diagnostics.

On the other hand, civil society partners shall be tapped to provide technical and programming support for national and local health departments, including advocacy and implementation of policies, tools and guidelines. As such, DOH will also work closely with partners at all levels particularly with major donor and development agencies, and implementing partners particularly NGO/ CBO with aim to strengthen national institutions, structures and systems for a sustainable response. DOH collaboration with civil society is particularly important in ensuring that important services are being provided to populations not reached by government health services and advocating for evidence-based guidelines/policies, provision of adequate resources and greater accountability and human rights protections for key populations. National, regional and local health department can help strengthen the capacity of these NGO/ CBO to deliver quality and efficacious services by not just providing technical directions/ guidelines but also in capacity building of skills through training and supportive supervision. It is recommended for future references that a National Peer Education program will be in order where there will be central guidance for planning, implementing, monitoring and evaluation, and

supportive supervision for all partner NGO/ CBO with goal of standardizing efforts, messages and scale ups. This could be under PNAC or under the technical guidance of DOH.

The Health Sector Plan will guide the development of outputs and main activities to be carried out. The work plan can be monitored through a medium-term review and progress towards achievement of the expected results as reported at the end of each biennium. The midterm assessment will not only focus on progress made in plan implementation and but will also assess the appropriateness of the overall strategic direction. It will therefore be designed to inform the remaining period of the plan and recommend adjustments where needed.

COSTING scenarios in HSP

Given the country's limited resources and the known huge financial gaps in the implementation of the national strategic plan (AMTP), the health sector shall prioritize funding specific services among target population in priority high burden sites that can give a significant impact in achieving its goal. With recent epidemiological and surveillance findings, priority sites were re categorized acknowledging different epidemic scenario and peculiarities among these sites. Crucial differences noted were the characteristic site-specific upsurge of cases (slow vs. rapid) and the presence of affected key populations such that some sites may have a concentrated epidemic among MSM only, some among FSW and in some sites in one or more KP are noted.

Re-Classifying Problematic HIV Areas for Prioritization. Recent data in HIV/AIDS registry as of April 2014, showed that 82% of new HIV cases came from NCR (40%), Region 7 (15%), Region 4A (13%), Region 3(8%) and Region 11 (6%). And just recently, DOH EB has identified top 10 cities with high number of HIV (see Figure 15) and cities with highest HIV prevalence among MSM (see Figure 16 next page).

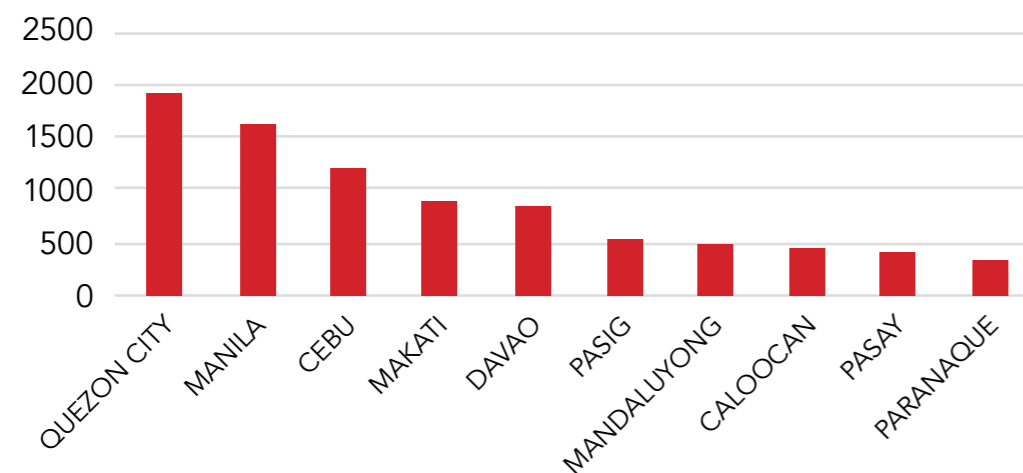


Figure 15. Top 10 Cities with high number of reported HIV cases Registry

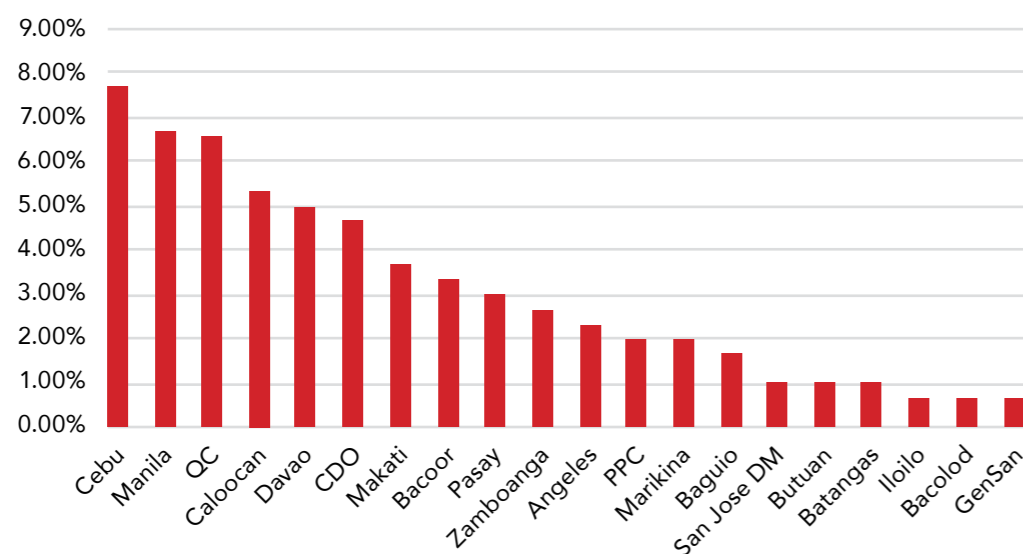


Figure 16. Cities with high HIV prevalence among MSM (IHBSS 2013)

The focus of interventions will be in these categorized sites. The recent findings on key populations identified to be highly affected by HIV, their characteristics and presence in these specific geographic areas where they are located highlights the need to scrutinize and consider re classifying priority areas for a targeted and calibrated interventions. The geographic areas with the most number of reported cases include three highly urbanized areas: Greater Metro Manila Area (which includes the provinces adjacent to Metro Manila like Rizal, Cavite, Laguna and Bulacan), Metro Cebu, and Davao City. These three areas plus Angeles City and Danao City are now being considered as the highest priority areas for HIV intervention.

With this new progress, the DPCB and HIV TWG together with key partners re-classified the priority sites:

Table 12. Categorization of New Priority Sites for HIV and STI Interventions

A. Priority Areas for HIV Intervention (PAHI) 2012

Category A (22)	Category B (18)	Category C (30)
Paranaque City • Muntinlupa City • Pasay City • Makati City • Marikina City • Quezon City • Caloocan City • Navotas City • Las Pinas City • Manila City • Pasig City • San Juan City • Malabon City • Valenzuela City • Pateros • Angeles City • Davao City • Cebu City • Mandaue City • Danao City	Olongapo City • Antipolo City, Rizal • Bacoor, Cavite • Dasnarinas City, Cavite • Batangas City, Batangas • Cainta, Rizal • Imus, Cavite • Lipa City, Batangas • Puerto Princesa City, Palawan • Iloilo City • Bacolod City, Negros Occidental • Lapu-Lapu City, Cebu • Talisay, Cebu • Zamboanga City • Cagayan de Oro City • General Santos City • Baguio City • Butuan City	Dagupan City, Pangasinan • San Fernando, La Union • Tuguegarao City, Cagayan • Tarlac City • San Fernando, Pampanga • Mabalacat, Pampanga • Marilao, Bulacan • Malolos, Bulacan • San Jose Del Monte, Bulacan • Sta. Maria, Bulacan • San Pedro, Laguna • Sta. Rosa, Laguna • San Pablo, Laguna • Calamba, Laguna • Cavite City, Cavite • Lucena City • San Mateo, Rizal • Taytay, Rizal • Puerto Gallera, Mindoro Oriental • Legazpi City, Albay • Naga City • Camarines Sur • Malay, Aklan • Toledo, Cebu • Tagbilaran City, Bohol • Tagbilaran City, Bohol, Tacloban City • Ilagan City • Tagum, Davao del Norte • Panabo, Davao del Norte • Cotabato City

Category of Priority Sites (HSP, 2014)

C45 Priority Sites

Category A+ (26)	Category B+(19)
Paranaque City • Muntinlupa City • Taguig City • Pasay City • Makati City • Mandaluyong City • Marikina City • Quezon City • Caloocan City • Navotas City • Las Pinas City • Manila City • Pasig City • San Juan City • Malabon City • Valenzuela City • Pateros • Angeles City • Davao City • Cebu City • Mandaue City • Bacoor, Cavite • Puerto Prinsesa City • Palawan • Zamboanga City • Cagayan de Oro City • Baguio City	Danao City, Cebu • Olongapo City • Antipolo City, Rizal • Dasmariñas City, Cavite • Batangas City • Batangas • Cainta, Rizal • Imus, Cavite • Lipa City, Batangas • Iloilo City • Bacolod City, Negros Occidental • Lapu-Lapu City, Cebu • Talisay, Cebu • General Santos City • Butuan City • San Fernando, Pampanga • Mabalacat, Pampanga • San Jose del Monte, Bulacan • Meycauayan, Bulacan • Sta. Rosa, Laguna
Rest of the Country (ROTC)	

Former Category C Sites and others

Building on the PAHI 2012 and the most recent results of the Philippine HIV and AIDS Registry and the IHBSS 2013, the HIV/STI HSP re-clustered the categories of priority sites for intervention as shown in Table 12A. This table shows the original clustering; the colored texts indicate the movement of sites as a result of the re-clustering. Sites in red fonts which has more than two percent of HIV prevalence have been moved to Category A, while sites in blue fonts which reported less than two percent of HIV prevalence have been moved to Category B.

In the re-classification of priority sites, Category A sites of Table 12B are those to be highly prioritized in the next 3 years with maximum target of interventions expected for KP in these sites. They are composed of 26 sites from previous Category A and B sites and will be targeted for at least 80% reach for prevention intervention. These sites are Paranaque City, Muntinlupa City, Taguig City, Pasay City, Makati City, Mandaluyong City, Marikina City, Quezon City, Caloocan City, Navotas City, Las Pinas City, Manila City, Pasig City, San Juan City, Malabon City, Valenzuela City, Pateros, Angeles City, Davao City, Cebu City, Mandaue City.

The new category B sites (Table 12B) are composed of a total of 19 sites from Olongapo city, Antipolo city, Dasmariñas city, Batangas city, Cainta Rizal, Imus Cavite, Lipa city Batangas, Ili-ilo city, Bacolod city Negros Occidental, Lapu-lapu city Cebu, Talisay Cebu, General Santos city, Butuan city, Danao city, San Fernando Pampanga, Mabalacat Pampanga, San Jose del Monte Bulacan, Sta. Rosa Laguna. The rest of the sites (formerly Category C and other sites) are classified under the Rest of the Country (ROTC).

It should be emphasized that re-classification/re-categorization may occur as new evidence-based data are generated.

Utilizing the Projection of Impact of the Philippines AIDS Epidemic Model (AEM). The Philippine AIDS Epidemic Model (AEM) was developed in 2012. A team was created composed of representatives from the Epidemiology Bureau of the Department of Health (DOH-EB), Philippine National AIDS Council (PNAC), National AIDS/STI Prevention and Control Program (NASPCP), Health Action Information Network (NGO PNAC Member), UNAIDS Country Office, the National Economic and Development Authority (NEDA). DOH EB spearheads the process in collaboration with PNAC²⁵. AEM is a semi-empirical process model and an epidemiological tool that can also be utilized for management planning and advocacy as it can provide information for strategic decisions. It is also a tool enabling strategic investment analysis and estimation of infections averted and lives saved. Key populations included were registered and freelance female sex workers (FSW), males having sex with males (MSM), and people who inject drugs (PWID). Data from the IHBSS and Philippine HIV and AIDS Registry were used as inputs to AEM. For the costing, the AEM team referred to the 5th AIDS Medium Term Plan (AMTP) and UNAIDS costing analysis.

25 DOH NEC, PNAC, DOH NASPCP, NEDA, GFATM, UNAIDS, HAIN, EWC. AIDS Epidemic Model Impact Modeling and Analysis. Philippines Case Study 2014.

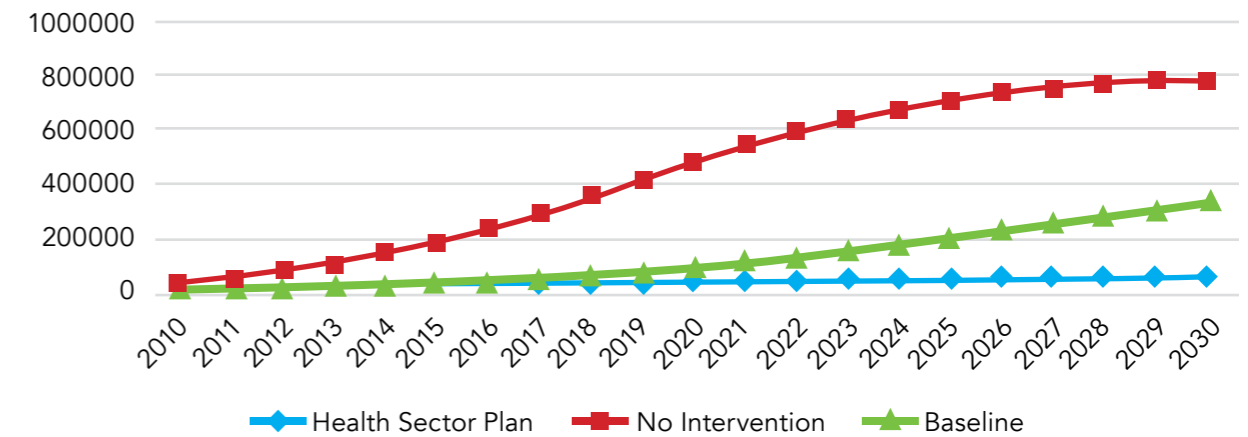
Table 13. Target Coverage per Category and MARP

Category	KPs	Target
A	MSM	80%
	IDU	80%
	FFSW	60%
	RFSW	60%
	PLHIV on ART (CD4 500)	90%
B	MSM	60%
	IDU	40%
	FFSW	60%
	RFSW	60%
	PLHIV on ART (CD4 500)	90%
C and ROTC	MSM	MSM
	IDU	IDU
	FFSW	FFSW
	RFSW	RFSW
	PLHIV on ART (CD4 500)	PLHIV on ART (CD4 500)

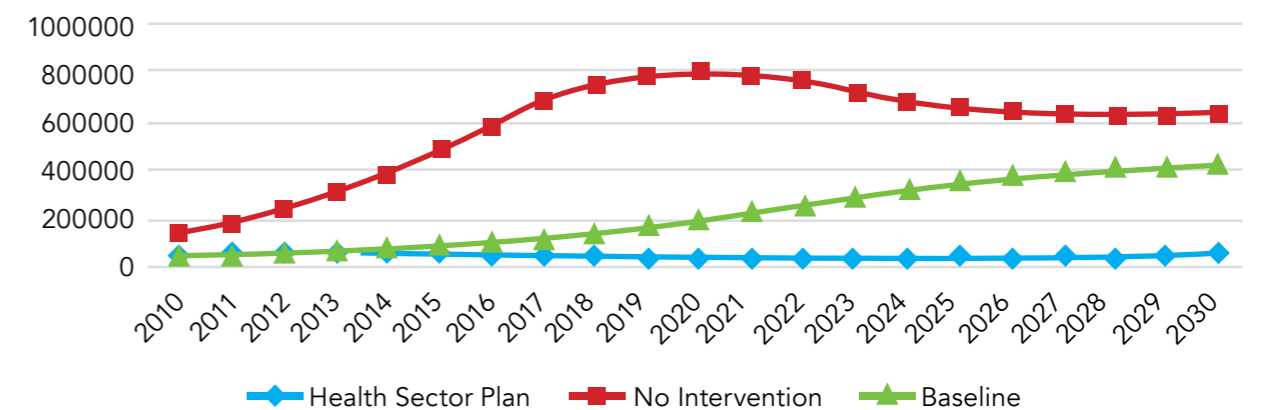
Table 13 shows the targets that were adopted by the Health Sector Plan. Baseline results of the AEM showed that majority of new HIV infections would come from Greater Metro Manila, Cebu Province, Pampanga Cities, and Davao City combined. Thus, highest prioritization was given to these models (Category A). Category B was given the next level of prioritization due to its significant share of HIV infections, with scaled down targets while Category C and the rest of the country (ROTC) will be included in the HSP but would be given the least priority in terms of HIV interventions.

The AEM team developed a policy scenario adopting these targets. Results showed that a significant number of HIV infections will be averted – a total of 17,718 infections will be averted within the HSP period of 2015 to 2017 with corresponding resource needs of \$32 million in 2015, \$43 million in 2016, and \$53 million in 2017.

Figure 17 shows that if we continue the current intervention program where targets and coverage are very low, the total number of current infections will exponentially rise by 2030. Implementation of the HSP 2015-2017, which scales up targets and coverage, will result to a decrease in the number of current infections among adults from 2010 to 2030.

**Figure 17.** Total number of current infections among adult with HSP vs. No intervention & Baseline.

Scaling up interventions will reduce the total number of new infections among adults from 2010 to 2030 (Figure 18).

**Figure 18.** Total number of new infections among adult with HSP vs. No intervention & Baseline, 2010-2030

Monitoring, Evaluation and Reporting

An efficient monitoring and evaluation system is the cornerstone for measuring a country's progress in providing universal access to prevention, care and treatment services and achieving the Millennium Development Goals particularly to MDG 6 which is to "halt and reverse the spread of HIV" by 2015.

Monitoring is to know whether implementation is moving ahead as planned and whether interventions are having the desired effect of slowing STI and halting HIV transmission. Mechanisms shall be set up to ensure that policies and programs are based on best available evidence. Monitoring and evaluation across all administrative levels shall be done to ensure that activities contribute to over-all objectives and priorities of the HSP and subsequently to the over-all country goal. (See Annex 7)

In the process of implementing HIV/STI HSP, there may be inadvertent consequences that require corrective action. For example, scaling up of activities and services may improve, but quality may deteriorate such that a strong and vigilant oversight is essential in any expansion of package of HIV and STI services. Information from routine service statistics and periodic surveys should be used to strengthen intervention and coordinate an effective response.

The National Epidemiology Center together with support from related programs of DOH will be responsible for the development of monitoring and evaluation of system, documented output and outcomes of the health sector interventions and will also be responsible in providing country data for submission to the global community through PNAC (Figure 19). It is understood that not all SHC may have peer educators/ partner CBO, on the other hand some treatment hubs have a robust partnership with CBO. Equally important in the monitoring and evaluation process, is the timely utilization of data not just for national programming but also for the implementer to help them best improve their services. Best practices will also be identified and strategies will be developed to improve weaknesses. The identified best practice will be documented and shared with other stakeholders to improve practices across the sector.

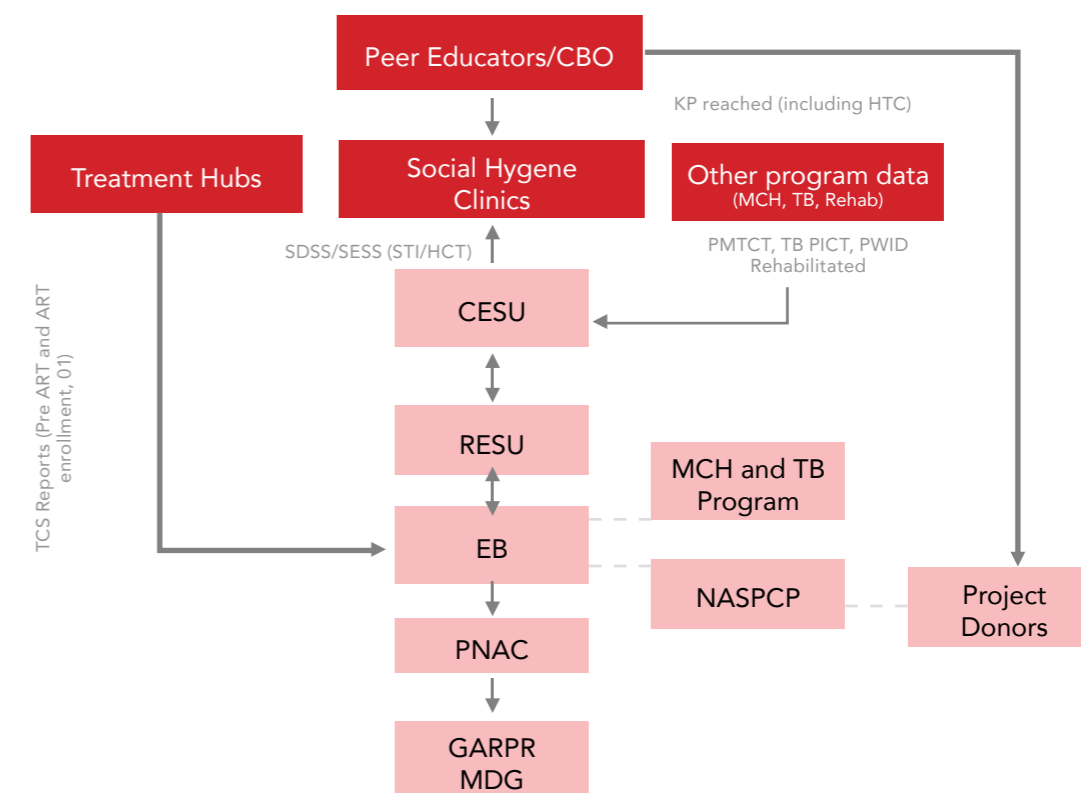


Figure 19. Reporting Flow for HIV and STI Program Data Program indicators will be employed from expected output of activities to the expected outcome under each identified strategies. These outcome indicators are expected to eventually contribute to the attainment of impact indicators.

The final indicators utilized in HSP are product of several consultation meetings organized by NASPCP and HIV TWG. The logical framework utilized stems from the recommendations of midterm review of 5th AMTP health sector component on addressing leaks in the cascade of care to achieve the goal of Universal Access (UA) to prevention, treatment and care from improving access to Social Hygiene Clinics and other service delivery points, making HCT and TCS available and more accessible, strengthening partnership with community-based organizations and other stakeholders, improving planning and management capacity of HIV program to enhancing strategic information system.

The following recommended outcome and impact evaluation components from midterm review of 5th AMTP were considered in HSP:

1. HIV prevalence trends in key populations (registered and unregistered female and male sex workers, MSM and PWID, transgender and transsexual people; STI patients; and tuberculosis patients);
2. HIV incidence using newly available assays;
3. Mean CD4 count in newly diagnosed PLHIV;
4. Incidence and prevalence of STIs as proxies for assessing changing preventive and care-seeking behaviors.
5. Other measures of outcome and impacts should consider behavioral trends (e.g.; use of condoms and other safe sexual practices; use of sterile needles and other harm-reduction practices, such as drug substitution and treatment)
6. Trends in the ability of key populations and PLHIV to be freed of stigma and discrimination, resume productivity, increase their autonomy and participation in public affairs, and improve their quality of life.

INDICATORS, SOURCES AND TARGETS

VISION: Zero New Infections, Zero AIDS Related Deaths, Zero Discrimination

GOAL

By 2017, the country will have maintained a prevalence of less than 1% of the total population by preventing the further spread of HIV infection and reducing the impact of the disease on individuals, families, sectors and communities

IMPACT INDICATORS	Source of Data	TARGETS		
		2015	2016	2017
1. Media Prevalence on STI and HIV information and services				
2. HIV incidence (within the past 6 months) among MSM is reduced	SACCL Bed Assay	<50%	<50%	<50%
3. HIV Prevalence among young (<20yo) childbearing women in NCR cities and Cebu city is maintained from 2014 baseline	PMTCT data (ANC files), CHD program data	<1%	<1%	<1%
4. HIV prevalence among other KP (PWID, FSW, etc) is reduced	IHBSS	<50%	<50%	<50%
4. Percent (%) of KP with STI infection is reduced	SSESS			
5. Percentage of KP with syphilis is reduced	IHBSS	<1.5%	<1.5%	<1.5%
6. HIV-related deaths is reduced from 2014 baseline	NEC form A; Mortality Data		<60%	<80%
7. TB-related deaths is reduced from 2014 baseline	NEC form A; Mortality Data	<1%	<1%	<1%

PURPOSE OUTCOME

The further spread of HIV in key populations is prevented through strengthened delivery of essential prevention, treatment and care interventions

IMPACT INDICATORS	Source of Data	TARGETS		
		2015	2016	2017
1. Percent (%) of key populations (KP) who demonstrate comprehensive knowledge of HIV prevention and transmission	IHBSS	50%	60%	70%
2. Proportion of females and males, 15-24 y.o who correctly identify ways to prevent sexual and drug related transmission of HIV, and reject major myths and misconceptions about HIV transmission	NDHS, SWS	70%	70%	80%
2. Percent (%) of KP who report using condom the last time they had sexual intercourse	IHBSS	80%	80%	80%
3. Percentage of PWID who reported non-sharing of injecting equipment the last time they injected	IHBSS	40%	50%	60%
4. Percent (%) of PWID who report utilization of a drug treatment and rehabilitation service in the past year.	Rehab program data	40%	50%	60%
5. Percent (%) of KP who are diagnosed with STI who received treatment – SSESS				
6. Percent (%) of KP who are diagnosed with syphilis and who also report having received treatment	SSESS	80%	80%	80%

HSP Costed Plan

An operational plan for the implementation of strategies contained within the HSP can facilitate the co- ordination of required resources (e.g. human, financial and structural) so that its goals and objectives can be achieved. This costing was developed for its 1st 3 years of implementation that will formulate specific and detailed activities and budget of every single strategy contained in HIV/STI HSP, its possible funding source as well as to provide personnel/ institutions/ agencies clear picture of their tasks and responsibilities as stipulated in HSP.

The Operational Plan made use of population estimates among key population and PLHIV utilizing the more recent Philippine AIDS Epidemic Model (AEM) and break it down accordingly by sub groups of KP per priority sites.

Based on the detailed operational plan (See Annex 6: Detailed Operational Planning Matrix of the Health Sector Plan for 2015-2017), the total cost of the Health Sector Plan on HIV and STI for 2015 to 2017 is Php 9,201,110,896.92 (USD 204,469,131.04). The cost per strategy is shown in the table below:

Table 14. Cost per Strategy of the Health Sector Plan from 2015-2017

STRATEGIES	2015	2016	2017
1) Continuum of HIV / STI prevention, diagnosis, treatment and care service to KP	Php2,473,613,818.31	Php2,943,053,430.03	Php3,193,534,219.87
2) Health Promotion and Communication on HIV and STI prevention and care services	Php77,196,646.11	Php23,035,334.72	Php20,267,291.02
3) Enhanced Strategic Information Systems	Php78,384,924.00	Php52,245,984.00	Php67,341,124.00
4) Strengthened Health System Platform for Broader Health Outcomes	Php112,811,675.25	Php108,522,824.80	Php51,103,624.80

Table 15. Breakdown per Cost Category

COST CATEGORY	2015 (Php)	2016 (Php)	2017 (Php)
Advocacy, Communication and Social Mobilization	191,162,154.70	132,740,292.85	72,553,049.16
Health Equipment	12,780,000.00	20,000,000.00	72,553,049.16
Health Products- Prophylactic	116,044,510.02	152,361,659.35	187,615,258.89
Health Products- Reagents	351,141,186.10	402,854,477.70	451,233,282.70
Health Products- Screening & DiagnosticTests	173,982,912.34	158,693,628.62	179,699,462.08
Human Resources	1,351,644,232.83	1,380,336,013.65	1,409,979,309.54
Infrastructure	58,100,000.00	52,600,000.00	22,600,000.00

COST CATEGORY	2015 (Php)	2016 (Php)	2017 (Php)
Living Support to Clients/ Target Population / Human Resources	14,055,000.00	11,134,000.00	13,004,500.00
Monitoring and Evaluation	29,081,180.00	16,870,040.00	18,037,380.00
Pharmaceutical Products (ARV Drugs/Medicines)	189,868,664.62	542,940,056.25	688,901,200.15
Pharmaceutical Products (STI Drugs/Medicines)	25,258,620.31	30,733,322.99	35,218,549.87
Pharmaceutical Products (OI Drugs/Medicines)	125,356,454.00	136,559,750.00	148,546,835.00
Pharmaceutical Products (Vaccines)	17,083,646.40	17,303,690.40	19,373,203.80
Planning and Administration	12,334,092.49	12,224,305.20	12,939,118.64
Research and Surveillance	49,752,784.00	35,824,984.00	49,752,784.00
Technical Assistance	9,895,612.00	9,673,112.00	9,673,112.00
Training	14,466,013.87	14,008,240.53	13,119,213.87

Funding Gap Analysis

Based on the National AIDS Spending Assessment (NASA), total government AIDS spending of 2011 (USD 4.181 million) increased by 8.53% in 2012 (USD 4.656 million) while a minimal decrease of 2.33% was registered in 2013 (USD 4.523 million). The government percent share in the overall AIDS spending from 2011-2013 ranged from a low 33.06% (2011) to a high of 48.27% (2013). Private sector domestic contributions were below 1%. Biggest contributors were the external sources at 30.62% (2011), 51.49% (2012) and 56% (2013). Among the external sources is the Global Fund which shared the most at 15.46% in 2011 (USD 1.955 million) at 45.03% in 2012 (USD 4.343 million) and at 30.82% in 2013 (USD 3.181 million). The table below is the breakdown (in Philippine Peso) per NASA Cost Category of the operational planning matrix of the Health Sector Plan:

Table 15: Costed Plan per NASA Category

	2015 (Php)	2016 (Php)	2017 (Php)	
Prevention	1,703,809,163.86	1,703,809,163.86	1,817,004,121.55	5,276,603,037.76
Care and Treatment	830,047,450.41	830,047,450.41	1,376,486,138.32	3,393,753,306.41
Advocacy, Communication and Social Mobilization	191,162,154.70	191,162,154.70	72,553,049.16	396,455,496.71
Health Systems	-12,092,885.29	-12,092,885.29	48,165,570.66	70,310,456.04
M&E	29,081,180.00	29,081,180.00	18,037,380.00	63,988,600.00
Grand Total Indicative Budget	2,742,007,063.68	3,126,857,573.54	3,332,246,259.69	9,201,110,896.92

Table 16 reflects the related costs items to the programs areas. Overall, the detailed costed plan's identified funders are: Local Government Units (LGUs) will be the biggest fund provider at 40.5% followed by DOH Central Office at 34.6%. Philhealth share will be 11.2% and DOH Regional Office will be at 1.22%. Global fund under the TB program for TB-HIV will be at 0.08% while development partners will shell out 0.77%. Out-of-Pocket will be at 0.25% and Unfunded or not yet identified source will be 11.35%. The Global fund New Funding Model proposal will shoulder activities that are as yet unfunded.

For the costs items, Human Resource is the biggest costs at 43.44% and this will be funded mostly by the LGUs at 89.30% considering the current SHC staffing. Health Products and Pharmaceutical Products are next larger costs at 23.3% and 20.74% and both cost items will be funded by mainly by DOH-Central Office. Philhealth will also shoulder Health Products at 44.20%. Health Equipment will also be funded mainly by DOH-CO at 61.37% and the other 33.55% will be to be funded by developmental partners. Majority of still unfunded cost items consist of Planning and Administration (64.67%), Advocacy, Communications and Social Mobilization (35.1%), Living Support to Clients/Target population/Human Resources (85.47%) and Training (8.44%),

Table 16: Operational Costs 2015-2017 as to Fund Source

COST CATEGORY		FUND SCORE		
Cost Items	Amount (Php)	% of total costs	Identified Possible Source	% Participation
Human Resources	4,141,959,556.02	45%	LGU	89.30%
			Unfunded	9.45%
			Dev't Partners	0.79%
			DOH CO	0.40%
			GF TB-HIV	0.57%
Pharmaceutical Products	1,977,810,012.12	21.5%	DOH CO	84.93%
			LGU	0.21%
			OOP	1.10%
			PHIC	3.45%
			Unfunded	10.31%
Health Products	2,173,626,377.80	23.6%	DOH CO	51.50%
			LGU	1.14%
			OOP	0.25%
			PHIC	44.20%
			Unfunded	2.92%
Health Equipments	32,780,000.00	0.36%	DOH CO	61.38%
			Dev't Partners	33.56%
			Unfunded	5.06%
Advocacy, Communication and Social Mobilization	396,455,496.71	4.31%	LGU	0.14%
			DOH CO	11.65%
			DOH RO	0.03%
			Dev't Partners	1.44%
			Unfunded	86.73%
Training	41,593,468.27	0.45%	DOH CO	15.84%
			Dev't Partners	16.42%
			DOH RO	45.27%
			LGU	2.15%
			GF TB-HIV	11.88%
Planning & Administration	37,497,516.33	0.42%	Unfunded	8.43%
			LGU	15.47%
			DOH RO	12.77%
			Dev't Partners	5.42%
			DOH CO	1.47%
			GF TB-HIV	0.18%
			Unfunded	64.68%

COST CATEGORY		FUND SCORE		
Cost Items	Amount (Php)	%of total cost	Identified Possible Source	% Participation
Monitoring & Evaluation	199,319,152	2.17%	DOH CO	95.51%
			Dev't Partners	4.37%
			LGU	0.06%
			Unfunded	0.06%
Research & Surveillance Infrastructure	133,300,000.00	1.45%	DOH RO	67.52%
			DOH HFEP	28.88%
			Unfunded	3.60%
Technical Assistance	29,241,836.00	0.32%	DOH CO	97.26%
			Unfunded	2.74%
Living Support to Clients/ Target population/ Human Resources	38,193,500.00	0.42%	Dev't Partners	14.52%
			Unfunded	85.47%
Total Operations Cost	9,201,110,896.92	100%		



ANNEX

ANNEX 1

Summary of Processes and Activities conducted in the development of HSP

- I. *Dissemination of 5th AMTP midterm review findings and recommendation (October 2013)*
The dissemination meeting was attended by various key stakeholders, department heads of DOH, program managers, representatives of LGU/ SHC managers and CSO/NGO from the positive community and those that represent the KP such as MSM, developmental partners and other government agencies. The evaluating team themselves discussed the key findings and recommendations which was also presented to the PNAC Executive Committee.
- II. *Consultation meeting with HIV TWG (March-April 2014)*
After internal deliberation of 5th AMTP midterm review, the DOH led by NASPCP convenes the national HIV TWG to discuss the findings and recommendation. It was agreed that there's an urgent need to revise and update the National Strategic Plan (AMTP) to better respond to the current epidemic scenario. After several meetings, it was also agreed that the group will have to focus on revising the Health sector strategy 1st as it is the main driver of the country's overall response. Taking on the recommendations of 5th AMTP review focusing on the Health sector component, strategic objectives were formulated in a logical process utilizing the logical framework on what the health sector would like to achieve highly considering the continuum of care or cascade of services for target population from access to prevention intervention to diagnosis, treatment, care and support services. The logical framework and tools will ensure that targets/ goals/purpose/key results areas are logically connected to the activities to be conducted. The process of formulating the logical framework took several consultation meetings with HIV TWG.
- III. *Consultation workshops with target population (March-April 2014)* For the development of Health sector strategy to be a 'bottom up' approach with greater involvement of target population, consultation workshops were also conducted with the community to better understand their needs and ensuring its assimilation into the updated Health Sector Strategy. PLHIV – March 18, 2014 MSM- March 27, 2014 TG – April 10, 2014 PWID – April 10, 2014 SW – April 15, 2014
- IV. *National Stakeholders Meeting (April 24, 2014)*
The national stakeholders meeting was attended by 75 participants from 40 organizations from private sectors, academe, allied medical society (PNA), to CSO/ NGO working for target population, faith-based organizations, government agencies, PNAC members, developmental partners, LGU/ SHC and representatives from the community including peer educators of MSM, TG, PWID and PLHIV. The meeting aimed to consult key partners and target population on the needed revisions to National HIV strategy focusing on the Health sector component and also provided a venue for informed dialogue on findings of 5th AMTP midterm review. Results of consultation workshops with key populations were also presented for validation with peers. The meeting also aims to seek the opinions of attendees to the proposed key interventions for the health sector strategy for the next 3-6 years.
- V. *Consultation meetings with representatives of HIV TWG, PNAC secretariat and other DOH bureau on the costing of Health sector plan utilizing the AIDS Epidemic model (AEM) developed primarily by DOH EB and UNAIDS. (May 28, 2014)*

The AIDS Epidemic Model was developed two years ago spearheaded by DOH EB together with team members who were representatives from Philippine National AIDS Council (PNAC), National AIDS/STD Prevention and Control Program (NASPCP), Health Action Information Network (NGO PNAC Member), UNAIDS Country Office, the National Economic and Development Authority (NEDA). The AEM as an epidemiological tool was crafted for impact modeling and analysis of the country's current HIV epidemic scenario. This hopes to guide program planners in projecting HIV cases and predict effects of different investment scenario to the halting/ reducing the rise of HIV epidemic based on unit cost for important interventions and services for KP.

The meeting looks closely, deliberated and refined specific interventions for KP and corresponding unit cost and tried to extrapolate how much it will cost the country for these interventions. The output to this meeting was presented in the succeeding Validation write shop.

Attendees to the meeting were representatives from HIV TWG members, DOH EB and NASPCP, UPecon HPDPB, BHIC/ GF-TFM, Consultant Save the Children, Consultant (local) WHO for HSP.

- VI. *Validation write shop on the Updated Health Sector Strategy for HIV and STI (June 3-5, 2014)*
This is another exercise attended by different key stakeholders to validate through detailed discussion and analysis of the core components of initial draft to the Updated Health Sector Plan (2015-2020). Attendees commented and suggested revisions to the log frame of activities and indicators of HSP. Outputs to this writeshop were considered and most were incorporated into the document.

Attendees to the workshop were DOH NASPCP, DOH EB, representatives from PNAC Secretariat, BHIC/ GF-TFM, DOH Regional Office rep (CHD 8), TWG (RITM, SACCL, WHO, UNAIDS), Local government unit (Manila, Quezon City, Marikina, Makati, Davao City), FPOP, USAID FHI 360, PNGOC/ PSI, and NGO/ CBO from the target community, PLHIV and faith-based organizations (Save the Children, The Red Ribbon Project, Take the Test, TLF SHARE, PAFPIPinoy Plus, Babae Plus, Redx, ACHIEVE, AIDS Society of the Philippines (ASP), CBCP- St. Camillus)

- VII. *Consultation Meeting with HIV TWG and other key stakeholders (July 4, 2014)*
The initial draft of HSP was reviewed during this meeting followed by presentations of relevant studies/ evaluation that can also set directions for the HSP such the Evaluation Study of MSM, TG and PWID Strategies (focused on Peer Education and Peer-led interventions) and output and agreements to the 1st Country Dialogue with CCM members and other stakeholders including planning for the costed operational plan of HSP.

Attendees to this meeting were from DOH NASPCP, DOH EB, representatives from PNAC Secretariat, BHIC- GF-TFM and BHIC- CCM, TWG (RITM, SACCL, WHO, UNAIDS), PNGOC, and NGO/ CBO from the target community, and PLHIV (Save the Children, The Red Ribbon Project, TLF SHARE, Pinoy Plus, Babae Plus, ACHIEVE, AIDS Society of the Philippines (ASP), WHO local consultant for HSP.

- VIII. *Operational Planning workshop (July 15-17, 2014) and Costing of Operational Plan (July 31- August 1, 2014)*
A series of workshops for the Operational Plan of HSP were conducted. The operational plan show the detailed activities to operationalize priorities of the Health Sector Plan (See Annex 5). The workshop were attended by DOH NASPCP, DOH EB, representatives from, PNAC Secretariat, BHIC- GF-TFM, TWG (RITM, SACCL, WHO, UNAIDS), selected DOH RO, PNGOC, selected LGU (Manila, Marikina, Makati), selected treatment hubs and NGO/ CBO from the target community, and PLHIV (Save the Children, The Redx, Take the test, Pinoy Plus, Babae Plus, ACHIEVE, WHO local consultant for HSP.

- IX. *HIV TWG meeting*
The HIV Technical Working Group did a series of regular meetings convened by the National AIDS/STI Prevention and Control Program to develop the updated Health Sector Plan in terms of conceptualizing the logical frame of indicators, formulating the strategic framework and prioritizing activities based on the consultations with the key affected populations and other stakeholders.

- X. *Validation Workshop of HSP Major Activities (September 1, 2014).* Attended by key stakeholders from CHD, LGU/ SHC, Treatment Hubs, CBO/ NGO, GF TFM staffs.

- XI. *Consultation Meetings on ARV Implementation Plan for 2015-2017 (March 4, 2015 and March 19, 2015)*

Attendees of the said meetings were representatives from the HIV TWG members such as DOH NASPCP, DOH EB, Pinoy Plus, Babae Plus, PNAC Secretariat, WHO, UNICEF, UNAIDS, San Lázaro Hospital, and RITM. Other stakeholders such as DILG-LGA, FHI 360 and Save the Children were also able to attend.

This ARV Implementation plan attempts to outline the standards for the ART programme in the Philippines. This document provides direction as a reference guide for stakeholders and health service providers and supports the planning and implementation of a safe and effective ART program. Further consultations will be undertaken in the succeeding months, particularly with frontline health service providers at the treatment hubs and satellite treatment hubs and the community of PLHIV to further improve this plan.

ANNEX 2

List of Different GF – ATM Rounds Activities and Budget Support for the HIV and STI Health Sector Response in the Philippines

Summary of Activities and Budget from Global Fund ATM for the HIV and STI Health Sector Response Philippines per Round										
2004	2005	2006	2007	2009	2010	2011	2012 2	013	2014 2	015
<p>Round 3 “Accelerating STI and HIV/AIDS Prevention and Care through Intensified Delivery of Services to Vulnerable Groups and People Living with HIV/AIDS in Strategic Areas in the Philippines”</p> <p>Implementation Period: 2004 – 2009</p> <p>Principal Recipient: Tropical Disease Foundation, Inc.</p> <p>Grant Budget: USD 5,528,825.00</p> <p>Goal: contribute to the national goal of preventing the further spread of HIV/AIDS and reduce its impact on those already infected and affected.</p> <p>Objectives:</p> <p>1) improve behaviour change communication and STI management among vulnerable and poor population such as: people in prostitution, (PIPs), men having sex with men (MSM), migrant workers in 11 sites, IDU for 1 site (Cebu City)</p> <p>Activities supported: social mobilization and advocacy campaign to key stakeholders, outreach and education activities including condom promotion, needles/syringe programme, capacity building of service providers and vulnerable groups, improve STI management, strengthening monitoring and evaluation</p> <p>2) To scale up voluntary counseling and testing (VCT), support, care and treatment for people living with HIV/AIDS (PHAS) and their families in four geographic areas (Manila, La Union, Cebu and Davao).</p> <p>Activities supported: expansion of VCT, development of partnership mechanisms involving service providers, PHA and key stakeholders, improvement and expansion of clinical services including ARV, establishment of home and community care.</p>										
1,818,456 1	,678,409	875,320	594,320	562,320 -	-	-	-	-	-	-

<p>Round 5 "Upscaling the National Response to HIV/AIDS Through the Delivery of Services and Information to Populations At Risk and PWLHAs"</p> <p>Implementation Period: 2006 – 2011</p> <p>Principal Recipient: Tropical Disease Foundation, Inc. to DOH</p> <p>Grant Budget: USD 6,748,062.00</p> <p>Goal 1. "To prevent the further spread HIV/AIDS infection by maintaining an HIV/AIDS prevalence rate of less than 1% among vulnerable groups."</p> <p>Target groups and strategies supported: prevention interventions (people in prostitution, IDU, MSM and migrant workers) in 8 identified contiguous areas to the Round 3 GFATM AIDS Project, Behavior change communication, Promotion of condom use, STI Management and Voluntary Counseling and Testing</p> <p>Goal 2. "Reduce the impact of HIV/AIDS on individuals, families and communities."</p> <p>TCS interventions/ strategies supported: Prophylaxis, treatment of opportunistic infections: ARV support, Care and support of infected and affected persons, Home-based care will be provided to 200 adult and 60 children with HIV/AIDS, Expansion of Treatment Hubs from 5 to 11, Coordination and partnership development from local (organize Local AIDS Councils in 19 municipalities/cities) to national levels, Strengthen M and E System, Efficient procurement and supply system, Operations research (out-of-school youths, street children, and the informal workforce to assess their level of risks and vulnerabilities</p>										
-	-	1,319,769	1,692,151	1,369,651	1,043,279	1,053,212	-	-	-	-
2004	2005	2006	2007	2009	2010	2011	2012	2013	2014	2015
<p>Round 6 : "Scaling Up HIV Prevention, Treatment, Care and Support Through Enhanced Voluntary Counseling and Testing And Improved Blood Safety Strategies"</p> <p>Implementation Period: 2007 – 2012</p> <p>Principal Recipient: Department of Health</p> <p>Grant Budget: USD 17,978,910.00</p> <p>Goal 1: Maintain a less than 1% HIV prevalence by scaling up Voluntary Counseling and Testing (VCT) and ensuring safe blood supply</p> <p>Goal 2: Reducing the impact of HIV/AIDS among the PLHIVs, their families and significant others by scaling up treatment, care and support and strengthening health system to provide HIV/AIDS services.</p> <p>Target groups: Clients of Social Hygiene Clinics (SHC) and private STI clinics, migrant workers, pregnant HIV positive women, blood donors</p> <p>Strategies: Behavior Change Communication (BCC), STI diagnosis and treatment, VCT, Migrant workers and families trained for advocacy, Voluntary, non-remunerative blood donations, Safe blood supply, Mass media and public education focusing on healthy lifestyle and HIV/AIDS prevention, Strengthening surveillance and information system will be strengthened, Capacity-building of providers, ART and OI, and vaccines for OIs, Community based forums to reduce stigma, Microentrepreneurial activities for sustainable financial independence, Enrolment to the national health insurance program</p>										
-	-	-	4,418,668.46	2,876,222.28	3,609,647.46	3,367,733.40	3,706,638.40	-	-	-

<p>TFM</p> <p>Aims to contribute to the country's goal of maintaining a prevalence of less than 66 HIV cases per 100,000 population, and reducing the impact of the disease on individuals, families, sectors and communities by 2016.</p> <p>Specifically, the Philippine HIV and AIDS Transitional Funding Mechanism request has two objectives :</p> <p>-To sustain the gains and improve the quality of prevention programs for persons most-at-risk for, and living with HIV by mainstreaming the current prevalence of HIV/AIDS among MARPs in the select sites. Prevention Activities: Behavior Change Communication – Community Outreach, Counseling and Testing</p> <p>-To sustain the gains and improve the quality of treatment, care and support programs for people living with HIV (including those who remain at risk) and their families. Treatment and Care Activities: Focuses on treatment and care activities. Key components in providing treatment include ensuring quality of drugs, and continuous availability and supply of drugs and testing kits, Anti-retroviral Treatment, Care and Support for the Chronically Ill</p> <p>-Program Management and Coordination Activities: Focuses on program management activities.</p>										
-	-	-	-	-	-	-	-	3,836,276.05	1,074,260.65	-
TFM-IRR										
-	-	-	-	-	-	-	-	1,906,349.57	1,109,188.66	00,569.83
Total Budget per year										
19,903,476.01	19,763,429.01	19,404,789.01	4,520,750.46	2,978,304.28	3,711,729.46	3,469,815.4	3,808,720.4	1,906,349.57	1,109,188.66	00,569.83

ANNEX 3

Summary of Recommendations from 2013 External Evaluation of the Health Sector's Response to HIV in the Philippines, October 2013 (The recommendation numbers refer to the section of the Evaluation Report under which these issues were discussed)

Use data more efficiently

Recommendation 1.1.2 NEC should make widely available complete technical reports from IHBSS surveillance rounds accompanied by actionable fact sheets, within six to 12 months after the completion of each surveillance round, through online publication, local briefings and distribution of hard copies. A thorough description of the methods applied, samples obtained, analytic techniques and confidence intervals should be included in all materials. The current IHBSS Technical Working Group has not provided effective oversight regarding dissemination to date. Thus, scientific oversight should be carried out jointly by the leadership of NEC and/or the Office of the Secretary of the Department of Health (DOH), which oversees NEC, with an expert panel, feeding early results to DOH, local governments and the PNAC Executive Committee, given the importance of IHBSS data to HIV programming.

Recommendation 1.1.3 Ahead of IHBSS surveillance rounds, NEC should enter into a formal agreement (e.g., via a memorandum of understanding) with local governments selected to participate, stating that national and local findings will be made publicly available through technical reports, fact sheets and other media, and made available online, regardless of what the results show. Civil society should be made a part of this process via national and local AIDS councils so that their voices may be heard.

Map and estimate the size of key populations

Recommendation 1.1.4 Building on the Rapid Assessment of Vulnerability (RAV), regular assessments to identify the presence of significant PWID populations should be conducted in urban areas that meet objective criteria, such as all Category A sites, nationally. Additional criteria should be established to determine under what circumstances findings from these PWID vulnerability assessments should lead to establishing a new IHBSS site for PWID. The NEC's RAV guidelines should be enhanced to ensure that the assessments systematically gather and triangulate data from hospital emergency departments, substance abuse rehabilitation centres, police and local nongovernmental organizations working with drug users in order to identify evidence of injection drug use.

Recommendation 1.1.5 In order to guide more effective targeting of prevention efforts, data from IHBSS should be used to generate local maps that identify those locations (establishments and streets) with the highest concentration of highest-risk behaviours, including patterns of low condom use, a high number of partners, frequent needle sharing and overlapping risks (MSM–PWID, FSW–PWID). Organizations carrying out outreach, including social hygiene clinics (SHCs) and needle-syringe programmes, should be trained on how to use this information to target individuals at highest risk for HIV infection and transmission.

Recommendation 1.1.6 HIV sero-surveillance in antenatal women in cities where high levels of HIV infection in any of the most-at-risk populations (e.g., at least 10%) should be incorporated into local and national surveillance systems by either: (1) strengthening routine screening among pregnant women in these areas to bring HIV testing coverage to at least 90%; or (2) conducting periodic antenatal surveillance studies at selected sites in these areas every one to two years.

Recommendation 1.1.7 Formative research to characterize MSM and injecting drug use risk behaviours in prison populations should be carried out to determine the need for biological and/or behavioural surveillance. Criteria for selecting sites for the formative assessment should be established and should include consideration of: (1) the number of inmates; and (2) the geographic proximity to Category A areas. These data should be used to design, implement

and monitor HIV and TB prevention, care and treatment in prisons.

Recommendation 1.1.8a Dissemination of population size estimates for most-at-risk populations in Category A (and potentially Category B) areas should be improved by: (1) documenting the specific methods employed and findings (including the uncertainty ranges of the estimates) from size-estimation exercises in technical reports within six months of completion; and (2) providing technical support and capacity-building for programme implementers and service providers in Category A and B areas to improve their understanding and use of size estimates in prevention activities.

Recommendation 1.1.8b Size estimation using the multiplier method should be integrated into all future IHBSS surveillance rounds for MSM, freelance and registered FSWs, and PWID, using services and/or unique-object multipliers. Given the wide confidence intervals typically associated with these estimates, multiple multipliers should be used for each population as possible. Methods and findings from multiplier estimates should be documented as in the preceding recommendation.

Assess outcome and impacts

Recommendation 1.2.1 Three decades into the HIV epidemic, the HIV programme in the Philippines should not only remain accountable on the delivery of quality services and goods and the use of resources, but also should acquire the capacity to provide evidence of the outcome and impacts of the health sector's response to HIV. This implies the strengthening of epidemiological surveillance, the application of new laboratory technologies along with greater dispersion of existing technologies (e.g., rapid tests for HIV and STIs, CD4 count and viral load), stronger data linkages from individual entry into active prevention programmes, HIV testing and counselling, and enrolment in the care and treatment continuum (and eventually through the end of life), as well as improvements in social, behavioural and economic determinants of health and well-being.

Recommendation 1.2.2 The national surveillance system should incorporate measures of HIV incidence that include two strategies. First, incidence assays should be applied to specimens from IHBSS studies to estimate incidence among key populations, potentially pooling samples across nearby cities to obtain sufficient sample size.²⁶ Second, trends in HIV prevalence should be analysed among young childbearing women (ideally younger than 20 years old, in whom infection is most likely to be recent) from antenatal facilities in the geographic areas recommended under Recommendation 1.1.6.

Recommendation 1.2.3 NEC should develop methods to regularly (every one to two years) cross-check the HIV/AIDS registry with the national civil deaths registry in order to: (1) capture deaths among people with HIV due to any cause; and (2) capture deaths attributable to HIV. Analysis based on these combined data should be developed to improve understanding of patterns in mortality (demographic and risk characteristics, relation to late diagnosis and treatment characteristics) at the national and local levels, with the aim of improving the effectiveness of care and treatment.

Recommendation 1.2.4 AIDS registry reports should summarize rates, opportunistic infections and characteristics of PLHIV who have opportunistic infections (OIs). Summaries of trends in the rate of OIs should be made available to treatment hubs with support in using these trends to improve treatment effectiveness.

Recommendation 1.2.5 Analyses presented in the SSES reports should be expanded to include breakdowns by age, sex and type of facility. The analyses should be made more accessible and actionable by including figures illustrating trends, characterizing STI risks and vulnerability, and making the reports available to health practitioners and researchers online.

Monitor the continuum of prevention, care and treatment and the cascade of services

Recommendation 1.3.1 Standardized mechanisms for referral (see Section 1.3) should be accompanied by standardized mechanisms to routinely monitor that referrals have actually resulted in linkage between services (such as programme registers and summary reports), using a unique identifier, such as the STD AIDS Cooperative Center Laboratory (SACCL) code. Procedures for tracking referrals should be incorporated into existing standard operating procedures (SOPs), and training and supportive supervision should ensure their use. Data on trends over time in the percentage of referrals that are realized – from outreach to testing, testing to care, and care to treatment – should be made available to SHCs, treatment hubs, and TB treatment centres and directly observed treatment (DOT) facilities. Procedures for personnel to meet periodically (e.g., quarterly) to review these data and collaboratively identify measures to improve referrals should also be established. A data field for “source of referral into testing” should be added to the HIV and AIDS registry form in order to capture referrals from TB patients, antenatal care and private testing facilities.

Recommendation 1.3.2 Linkage to and retention in care should be monitored either through routine reporting using the new Form B, or by establishing facility-level registers that capture sufficient data on enrolment and follow-up (including SACCL code) to allow tracking of individuals over time. Additionally, standard care and treatment reports at the facility and national levels should include summaries of patients who are awaiting eligibility screening, those in pre-ART and those in ART. Cohort-based measures of retention in both care and treatment should be developed and procedures established for data review and decision-making to ensure the data are used regularly (e.g., monthly) for programme improvement.

Recommendation 1.3.3 At national and facility levels, trends in retention and loss to follow-up for MSM, FSWs (registered and freelance) and PWID should be routinely monitored through standard reports (ideally the same reports developed under Recommendation 1.3.2) with procedures for regular review and decision-making based on findings. Analyses to generate these trends would be most easily generated at the national level, given that national-level databases would allow the analyses to account for transfers between facilities.

Recommendation 1.3.4 The level of training and supportive supervision to help HIV testing and treatment facilities adhere to services protocols should be strengthened through inception training and periodic in-service refresher training activities centred around existing SOPs.

Recommendation 1.3.5 A single report should be developed for use at the local government unit (LGU) level that provides data and trends in indicators of programme quality and effectiveness, such as referrals into care and treatment, retention in care and treatment, and morbidity. A standard procedure should be developed to ensure regular review (e.g., quarterly) of the quality measures by individual health facilities (SHCs, treatment hubs and TB facilities) and local collaborative HIV teams in order to facilitate early detection of problems and collaborative solutions. The national level (NEC and PNAC) can support these efforts by providing guidance, training and supportive supervision for the review and interpretation of the quality indicators and problem-solving process.

Recommendation 1.3.6. The bulk of this work would be better accomplished by computer programmes, with manual review reserved for following up on those inconsistencies that are automatically detected. Such validation checks could be automated at low cost. Optical character recognition (OCR) technology should be introduced to automate the data entry process and reduce data entry error. This would require an initial investment, but would appear quite justified given the high volume of work involved.

Offer minimum prevention packages to key populations

Recommendation 2.1.1a The overarching principle is respect for and protection of human rights, ensuring health services are delivered in a stigma-free and friendly manner to key populations in health-care settings. Specific efforts should be made to address the bottleneck prohibiting the full implementation of the national guidelines at local level. The comprehensive packages for key populations should be reassessed, and a minimal package of prevention interventions should be defined and accompanied with a concrete quality-assurance mechanism.

Recommendation 2.1.1b The development of a master health sector plan should be considered, maximizing the utilization of the existing health infrastructure, SHCs in particular, to mainstream evidence-informed and rights-based prevention services to key populations. In addition, building staff capacity at SHCs to expand its scope of services in order to cover all key populations and establish a stronger partnership with nongovernmental organizations and community-based organizations (CBOs) working with key populations. Local innovation of service delivery models should also be encouraged and best practices documented for sharing and replication.

Recommendation 2.1.2a National surveillance for PWID should be strengthened by covering more of the National Capital Region (NCR) sites (Manila and Quezon City in particular) to detect epidemics early, while continuing to monitor the high level of needle and syringe sharing behaviour. Given the high HIV prevalence already detected in Cebu and Mandaue, it is urgent to initiate community-based pilot needle and syringe exchange programmes, in line with the instruction of the DDB in collaboration with DOH, WHO, other key partners and all local stakeholders in selected cities.

Recommendation 2.1.2b MSM must be engaged more actively in delivering services and peer outreach. Prevention activities must be adapted to the diversity of MSM sub-populations, including those living with HIV, and must address sexual health needs through a variety of approaches and combinations of interventions best suited to the specific needs, demands and capacities of these sub-populations. Innovative use of mass and targeted media, including the Internet and cell phones, should be integrated components in the delivery of prevention messages, health promotion and social support services. Commodities, such as condoms and lubricants, should be readily available and widely promoted. Prevention activities should be strengthened using a variety of channels and there should be encouragement of local innovations, including structural interventions, in locations where high-risk behaviour may occur. These should be included in a minimal package of preventive services, with strong linkages with HIV testing and counselling (HTC) and ARV. A minimal package for HIV prevention among MSM should consist of essential elements in line with recommendations of WHO, the United Nations Development Programme (UNDP) and UNAIDS recommendations.²⁷

Recommendation 2.1.2c Prevention interventions for sex workers should be adapted based on local sex work patterns, local STI prevalence and the policy environment. SHCs should be better used to improve the services for registered sex workers, building

²⁷ WHO/UNDP/UNAIDS (2010): Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach

partnership with sex work nongovernmental organizations and CBOs to extend the scope of quality services to freelance FSWs, MSWs and transgender people. Interventions should incorporate input from sex workers and their community into how to make services user-friendly.

Recommendations 2.1.2d A transgender-specific programme, informed by the forthcoming findings of a study being conducted in Cebu, should be created in consultation with transgender community representatives. Other project areas should also be more active in identifying transgender peer leaders as peer educators to initiate partnerships between health services and transgender community. Health providers should receive orientation and sensitization on transgender issues and on how to stimulate the participation of transgender people in peer outreach and in the delivery of services.

Recommendation 2.1.3 A national condom strategy should be developed. Policies on correct and consistent condom use in sex work settings should be in place and the policies should be supportive of community empowerment for the work norm of “no condom, no sex”. Condoms should be made available through a variety of channels: free-of-charge distribution, a condom social marketing approach and private sector promotion. Condoms should be easily available and accessible for registered sex workers based in sex venues. Outreach activities should be scaled up to offer free distribution of condoms and water-based lubricants to freelance FSWs and MSWs, MSM, PWID and transgender people.

Recommendation 2.1.4 Particular efforts should be made to improve the quality of STI screening among key populations. To this end, more systematic and optimal standards of clinical and biomedical diagnostic procedures should be enforced by periodically trained and retrained staff.

Recommendations 2.1.5a Greater investment in peer education and other service delivery models apart from SHCs should be considered. Skills of peer educators should further be enhanced through regular training and supportive supervision from site implementation officers. Appropriate peer educators should be recruited, including adequate number of peer educators. Eligibility criteria should be developed for recruitment and should set the optimal ratio of peer educators over the number of key populations (e.g., one peer educator for every 50 members of a key population). Peer educators should perform microplanning to ensure systematic approaches for reaching key populations. They should have appropriate monitoring tools to track the number of key population members reached and repeat visits, services provided and required follow-up. Training modules and job aids for peer educators should be developed and standardized.

Recommendation 2.1.5b In order to ensure availability of essential HIV prevention commodities, there is a need for a designated person at the national level to track stock-outs of essential HIV prevention commodities. Guidelines on tracking stock-outs could be provided by the Global Fund procurement focal point at the national level.

Recommendation 2.1.5c It is essential to maintain or improve coordination between SHCs and nongovernmental organization peer educators. Regular meetings should be held to discuss targets and issues concerning the quality of services. The needs of MSM and PWID and the acceptability of current services should be assessed, seeking suggestions on the best way to increase access and the acceptability of services. The conduct of exit interviews of key populations using services and the conduct of focus-group discussions among key populations not using these services should result in the design of new service delivery models aimed at increasing access and the use of services by MSM. Minimum standards of quality of service should be formulated along with monitoring indicators. The physical infrastructure of venues where services are provided (SHCs and others) must urgently be improved.

Recommendations 2.1.6 The following SRH services should be provided on-site or by establishing functional referral mechanisms: family planning and contraceptive counselling, promoting dual protection for pregnancy, STIs and HIV; availability of condoms and if possible contraceptives at service delivery points for sex workers and PLHIV; orientation of women to reproductive choices, safe pregnancy, abortion and post-abortion care and reproductive tract cancer screening (e.g., cervical, ano-rectal and prostatic cancers); and counselling on hormone use and referral to other gender enhancement practices for transgender people.

Recommendation 2.1.7a It is recommended that a formal agreement between the prison administration and DOH be approved in the form of a joint policy, accompanied by SOPs for the management of HIV within prisons and after transfer between prisons, addressing as well best practices in HIV/STI prevention and care and related supplies of medicines and commodities in detention facilities. It is further recommended that such procedures also cover the referral of inmates treated for HIV upon their release from prison so as to ascertain the continuum of care and prevention once they return to their communities. Civil society organizations and more generally nongovernmental organizations should be prompted and supported to play a key role in enhancing continuity of prevention, care and treatment for people in and out of jail.

Recommendation 2.1.7b There is a need to document current practices in rehabilitation centres where STI and HIV intervention activities have been initiated. Such evidence could inform future policy and practices that could be generalized to all rehabilitation centres, both private and government.

Recommendation 2.1.7c The ongoing STI and HIV-related interventions in some rehabilitation centres need to be coupled with capacity-building among staff, in particular on the handling of residents diagnosed with these conditions.

Recommendation 2.1.7d Given the large and growing number of drug-dependent residents, outreach and open rehabilitation services providing psychosocial support should be explored and enhanced. The high relapse rate after discharge from rehabilitation centres should be taken into consideration in the evaluation of the design, implementation and effectiveness of the interventions and support services.
HIV testing and counselling

Recommendation 2.2.1 Peer educators require standardized training with skills rehearsal that enables them to ask if people have had a test, to explore reasons for not having had a test, and to be able to challenge the client's thinking and encourage them to take a test. Similarly, this training needs to ensure peer educators also learn to ask in a sensitive manner whether or not people have collected their HIV test results and – without requesting to know the result – explore and challenge the reasons for not returning for results.

Recommendation 2.2.2 Expanding the available range and type of HTC models is key to improving coverage, access and entry into care. Innovative service models should be field-tested. These models include private-public partnerships with shared resources, such as counsellors provided by nongovernmental organizations, or government funding of private service providers that are favoured by key populations. Additionally, the expansion of service hours and the employment of different models of pre-test counselling that require less time should be considered to alleviate congestion and to meet future increased demand for HTC and to improve the quality of HTC in SHCs. Innovative service implementation should continue, for example referral to treatment hubs and the enrolment of MSM who are community VCT clients after they have had a provisional diagnosis following the receipt of two reactive results from two different tests. Such approaches should be applied and replicated where these services can be monitored for compliance with DOH service standards. In order to improve access to necessary health care for minors it is imperative that there is immediate, strengthened advocacy for the revision of RA8504, the Philippines AIDS Prevention and Control Act of 1998, with respect to the testing of minors.

Recommendation 2.2.3 There is a need for DOH to develop a quality monitoring and management system for HTC and assume a strengthened regulatory role. The HTC quality management programme would assume responsibility for standardizing pre- and post- test counselling training courses, ensure SOPs are available for different types of service models (e.g., mobile or community-based VCT), and ensure standard medical record documentation occurs across government, nongovernmental and private HTC services. It is further recommended that in order to ensure appropriate, explicit and consistent health messages are delivered by counsellors, counselling tools should be developed that are specifically oriented to the needs of specific key populations. There is an urgent need to send out a circular or memorandum to all HTC service providers alerting them to their legal and ethical duty to check results before provision to clients to ensure that the correct result has been provided to the client. Additionally, it is essential that HTC providers realize that they need to check a client's understanding of the results and implications for transmission prevention and to facilitate linkages to treatment and care. There is also a duty to assess a client's ability to cope with an HIV positive result and, as necessary, address threat of risk of harm to one's self and others.

Recommendation 2.2.4 Depression not only reduces the quality of life of infected women but can contribute to poor treatment adherence and to an inability to bond with and care for their newborn baby. It is imperative that counsellors are trained to be aware of common signs and symptoms of depression and the phenomena of post- partum depression and understand the importance of referring to appropriate mental health professionals. It is further recognized that it is important to increase the male partner's involvement in antenatal and postnatal care. Partners should be invited to consultations, as appropriate and feasible. Counsellors require training that enables them to offer family or relationship support.

Recommendation 2.2.5 Counsellors and ancillary support workers working with parents and children require specific training to address issues of disclosure, the preparation of children for clinic and hospital visits, and the provision of age-appropriate counselling for HIV positive children and adolescents and their siblings. Parents may also need additional support in managing treatment adherence in children.

Laboratory support

Recommendations 2.3.2a In order to accelerate the availability of confirmed results and reduce the number of those clients not returning for test results, it is critical that the planned serial rapid test validation study proceeds as soon as possible. It is also critical to assess available quality systems to support the implementation of a three rapid-test algorithm for screening and confirmatory screening – with immediate results in non- laboratory facilities, such as SHCs and community-based HIV testing and counselling centres as soon as possible. As an interim measure until the serial rapid test algorithm can be implemented, delays in the provision of results should be shortened by extending the model of service currently employed by community-based services whereby the referral to treatment hubs and enrolment of MSM who are community VCT clients occurs after provisional diagnosis with receipt of two reactive results from two different tests. This approach should be replicated only where these services can be fully monitored for compliance with DOH in order to support quality testing. There is an urgent need to address the gaps in quality assurance of HIV testing. To this end, the licensing, regulation of test kits, participation in EQAS and training should be considered. There is also a need to develop national training elements around the management and procurement of test kits and reagents. It is further recommended that the NRL extend EQAS

schemes from one round of distribution of samples to be tested for HIV by laboratories participating in the scheme to two annual rounds.

Recommendation 2.3.2b A three rapid-test algorithm for screening and confirmatory testing with immediate results should be considered during the validation of the new HIV testing algorithm. The availability of quality systems to support the implementation of a three rapid-test algorithm for screening and confirmatory test with immediate results in non-laboratory facilities, such as SHCs and HIV testing and counselling centres should be explored.

Recommendation 2.3.2c CD4 count technology and operating skills should be scaled up to match the expected increase in HIV testing demands, particularly as the criteria for enrolment in care change.

Recommendation 2.3.3 It is recommended that the policy of not providing results should be made clear to donors. For example, signage indicating that HIV test results will not be given to blood donors should be clearly posted in the BSF. Leaflets providing contact details for VCT services should be available to donors who request knowledge of their HIV status. Donors who volunteer that they have engaged in a recent exposure risk should be referred to an appropriate VCT service. Additionally, in light of the reported incidence of MSM presenting at BSF services in order to learn their HIV status, it is important that MSM outreach programmes address this issue in their peer education programmes.

Recommendation 2.3.4 It is recommended to review the orders that require NVBSP-NRL and SACCL to conduct parallel and duplicate activities for confirmatory testing and EQAS. This duplication in activities undermines the efficiency and quality of the testing.

Recommendation 2.3.5 SACCL and clinicians should review current operating procedures to determine the most appropriate HIV testing algorithm for children less than 18 months of age, in particular whether PCR testing should be centralized at SACCL only for the purpose of diagnosing HIV among infants and young children and if two positive PCRs should be sufficient to decide on enrolment in paediatric ART.

Recommendation 2.3.8 HIV testing facilities should be supported to implement quality management systems (QMS); address the gaps in the national systems that support quality assurance in HIV testing; and consider allowing the use of test kits only if they are licensed for use in the Philippines by the National regulatory Authority, and accompanied by participation in EQAS and training. .

Recommendation 2.3.9 The National AIDS and STI Prevention and Control Program (NASPCP) should develop national training elements around the management and procurement of test kits and reagents. CD4 and viral load testing need be considerably expanded in an effort to remove the current bottleneck to increased enrolment of PLHIV in the treatment cascade. Availability, coverage, uptake and costs should be considered. Programmes need to be developed to minimize stock-outs; each facility should have an individual responsible for managing test kits and reagent stocks.

Recommendation 2.3.10a It is recommended that the policy of not providing results should be made clear to donors. For example, signage indicating that HIV test results will not be given to blood donors should be clearly posted in the BSF. Paid blood donation schemes should be phased out and eliminated as soon as possible.

Recommendations 2.3.10b Scale up access to VCT and provider-initiated counselling and testing (PICT) and promote the use of these services among blood donors. Discourage the use of blood donor screening as a de-facto testing service by clearly indicating to prospective donors that they will not be informed of their results. Donors

who indicate that they have been exposed or who have potential ongoing exposure should be referred for a detailed assessment at a VCT service and declined as donors. Donors who are declined as regular donors should be informed that they require further health assessment and that they should refrain from donating blood as they may have an infection and that one of the possible infections may be HIV.

Infection control and occupational exposure

Recommendation 2.4a As with other issuances from DOH, guidelines and policies on pre- and post-exposure management (PEM) should be disseminated to health-care facilities and a system should be in place so that this is coupled with training/orientation of protocols and supportive supervision from clinic managers to local and regional health departments. It is further recommended that a simple flow chart that summarizes the steps in PEM be required to be displayed on walls in exposure-prone health service areas, such as outpatient departments, emergency wards, laboratories, surgery facilities and service areas for the HIV/AIDS core team (HACT). The wall chart should also have after-hours contact numbers of staff designated to support exposed workers.

Recommendation 2.4b A written policy that includes prompt reporting of incidents and referral should be in place within the health-care facility and be visible and readily accessible by health-care workers. For compliance, this requirement should be included in the general infection control checklist of the health facility assessment or in a quality assurance checklist from a regulatory body from DOH.

Recommendation 2.4c Strengthen collaboration and establish a robust referral system from different health facilities to HACT of nearest treatment hub or satellite hubs so there can be timely access to PEP for exposed health-care workers. To prevent delay, somebody should be delegated by HACT to be available during regular non-working hours to attend to and provide PEP to exposed health-care workers.

Recommendation 2.4d DOH and the health departments of local government units (LGUs) may need to revisit the structural set-up in these facilities and support facility enhancement and compliance to environmental control as part of infection control measures. It is important and beneficial for health-care personnel to have a safe working space place as they attend to the various medical needs of patients in one facility. Mechanisms should also be in place for their health care, such as regular medical and laboratory evaluation and vaccinations.

Recommendation 2.4e DOH may consider revising its policy on post-exposure management (PEM) for health-care personnel to expand coverage for victims of sexual assault. Any policy changes should be disseminated and formal links should be established between units tasked with protecting women and children and the HIV treatment hub so access to PEP for victims of sexual assault, especially women and children, is facilitated in timely fashion.

Referral and access to care, treatment and support services

Recommendation 2.5a The laboratory services system for confirmatory HIV tests should be reformed. Services urgently need to be decentralized in consideration of the demographic coverage of screening test sites. The long turnaround time of confirmatory HIV testing can be a big barrier for key populations being referred and access to treatment, care and support (TCS) services.

Recommendation 2.5b A formal referral system from HIV testing sites to treatment hubs, including a client tracking system, urgently needs to be established. The system should allow easy linkage of client information across sites and locations so the system can

assess whether people receiving needed services at the most proximal site suggested, or anywhere else in the treatment, care and support (TSC) system. NEC should provide the methods and tools to ensure close monitoring of the treatment, care and support continuum and provide early warnings when the tracking system fails to perform.

Recommendation 2.5c Clinical assessments, especially CD4 tests, needed to determine ART eligibility should be conducted immediately after clients are referred to TCS services in order to provide early treatment, if indicated. Blood drawn for the confirmatory HIV test could be used for baseline clinical assessments. It could cut the time needed to begin treatment.

Pre-antiretroviral therapy

Recommendation 2.6.1a Through post-test and/or pre-treatment counselling, health-care workers should provide information and education to PLHIV in pre-ART on the importance of clinical monitoring.

Recommendation 2.6.1b A formal follow-up system for pre-ART clients should be established urgently. Otherwise, clients will miss timely ART initiation, which could lead to poor outcomes and allow further transmission of HIV in the community. Cohort analysis may be a useful way to monitor clients' retention rate and the rate of loss to follow-up.

Recommendation 2.6.2a NASPCP should produce national guidelines on treatment for opportunistic infections and response monitoring, including guidance on dealing with immune reconstitution inflammatory syndrome (IRIS). Currently available guidelines do not provide details of diagnosis and treatment in varying clinical scenarios. At present, a technical working group is preparing guidelines on the treatment of opportunistic infections in PLHIV. These guidelines, intended for physicians who are non-specialists, must be released soonest to aid the timely and accurate diagnosis and treatment of opportunistic infections in PLHIV.

Recommendation 2.6.2b Reinforced linkages between HIV and TB, which is the most frequent co-infection among PLHIV, will enhance an efficient continuum of services. The HIV testing rate among TB patients has been increasing dramatically through an effort by DOH to promote the implementation of a new policy of universal testing for TB patients. TB screening among PLHIV is also routinely conducted at HIV clinics as a part of clinical assessment. However, the treatment of TB and HIV has been provided in each clinic separately, despite the strong demand by co-infected clients for a one-stop service. It is recommended that arrangements be made within the health system to submit to this demand.

Recommendation 2.6.2c A mechanism to make drugs for the treatment of opportunistic infections accessible, at least in the country's treatment hubs, must be forged. This is especially important for drugs that are either quite costly or are not usually part of hospital formularies.

Recommendation 2.6.2d Laboratory capacity of treatment hubs to diagnose opportunistic infections must be strengthened. Sputum-staining methods for PCP diagnosis, serology for toxoplasma infection, and stool-concentration and staining methods for diagnosing protozoan intestinal infections are examples of laboratory exams that must be more widely available to aid in diagnosis of opportunistic infections.

Recommendation 2.6.2e Reporting and recording of diagnosis and treatment for opportunistic infections should be more consistent. Developing a systematic method of organizing data for opportunistic infections from the country's treatment hubs will help characterize the quality of the treatment of opportunistic infections received by PLHIV. Many PLHIV are treated for opportunistic infections in public and private hospitals outside of treatment hubs. Therefore, devising a method by which data on the treatment

of opportunistic infections from these hospitals can be collected will also help track progress in the diagnosis and treatment of opportunistic infections. Integrating reports from TB-DOTS centres and treatment hubs will also yield a more accurate picture of TB in PLHIV.

Norms, standards and practices of antiretroviral therapy

Recommendation 2.7.1a There is a need to develop transition plans to ensure the sustainability of the cadre of treatment enablers and site implementation officers whose positions currently are either funded or are filled by volunteers.

Recommendation 2.7.1b All counsellors, site implementation officers and nongovernmental organization treatment enablers should undergo standardized adherence support and care counsellor training that incorporates skills rehearsal focusing on how to assess and facilitate ongoing HIV transmission risk reduction, as well as appropriate partner disclosure counselling. It is recommended that simple treatment literacy adherence tools be developed and the use of these be rehearsed in training. Tools that have been developed need to be more broadly disseminated. Counsellors who have undertaken HIV counsellor training without the inclusion of partner disclosure strategies should be offered a one-day, skill-focused course on the topic. DOH is advised to finalize the current review and consider implementation of current WHO guidance on the management of sero-discordant partners.

Recommendation 2.7.2a In order to maximize the impact of ART services, a formal follow-up system for ART clients should be established urgently at treatment hubs. Strengthening communication between treatment hubs and CBOs and, through them, to patients would be a valid approach.

Recommendation 2.7.2b Decentralization of ART services is urgently needed, in particular if the criteria for ART enrolment change and suddenly more PLHIV become eligible for treatment. The large gap between the numbers of HIV testing sites and treatment hubs must be narrowed promptly. Scaling up satellite treatment hubs could be one solution. However, the feasibility, cost-effectiveness and capacity-building efforts needed to decentralize quality ART services should be examined prior to any decision on a structural change.

Recommendation 2.7.2c As a means to monitor and evaluate the continuum of ART services, cohort analysis should be introduced in each treatment hub. The results should be utilized to improve services. A national database should also be built by aggregating all data from treatment hubs. Along with the cohort analysis, operational research on the reasons for loss to follow-up and death could contribute to improve the quality of services.

Recommendations 2.7.3 The existing guidance document on palliative care should be reproduced, shared with all treatment hubs, nongovernmental organization partners and SHCs. All personnel of treatment hubs and nongovernmental organization partners engaged in the continuum of care should receive training in palliative care, including hospital directors and administrators who should be made aware of palliative care needs and best practices.

Prevention of Mother to Child Transmission of HIV and Paediatric HIV

Recommendation 2.8.1a If DOH is to consider implementing opt-out testing in antenatal care facilities, close collaboration between NASPCP and the MCH programme at national, regional and local offices should be strengthened in order for guidelines to be disseminated, implemented and closely supervised. Adequate coverage with proper recording and reporting should strive to produce pertinent data.

Recommendation 2.8.1b Technical assistance for capacity-building in health centres (lying-in centres) should also be provided as additional services are expected to be implemented. The implementation PMTCT for HIV, especially PICT (opt-out testing), as part of antenatal care services entails the need for structural, logistical and human resource-related support from the national level and LGU.

Recommendation 2.8.1c Given the structural make-up and diverse medical services provided in health centres by overburdened health-care workers, tools that are focused and target-specific for clients in antenatal care are not only helpful but can also provide a standardized messaging and improved quality of services.

Recommendation 2.8.1d As pregnant women living with HIV are being provided antenatal care services in treatment hubs, DOH may consider the integration of some services in these facilities (e.g., the one-stop shop concept, with reproductive health and related commodities). This is convenient for clients and also allows them to receive a more comprehensive package of care.

Recommendation 2.8.1e To ensure continuity of care from prevention to treatment and care among pregnant women living with HIV, all levels of care in priority areas need to be strengthened to provide a targeted and comprehensive PMTCT services (following DOH guidelines) with functional referral system and an effective tracking mechanism. Establishing partnerships with nongovernmental organization for TCS close monitoring, tracking and provision of peer support can be helpful in reducing loss to follow-up, as this issue is problematic in some sites.

Recommendation 2.8.2a With the July 2013 release of the WHO Consolidated Guideline on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection, which also covers treatment for paediatric patients, DOH may consider revisiting its guideline on the management of paediatric HIV and AIDS developed three years ago.

Recommendation 2.8.2b It is recommended that DOH continue to provide technical assistance to treatment hubs to ensure their readiness to handle cases of paediatric HIV. This is necessary for several reasons, including the rapid turnover of trained health-care workers and because not all treatment hubs are capable of providing holistic treatment, care and support services to children living with HIV. Given that the number of HIV cases among pregnant women seen in many sites and the increasing number in some sites, institutionalizing or contracting the conduct of training by an organization with solid experience in handling paediatric HIV would be a plus.

Recommendation 2.8.2c: Treatment hubs should consider investing in equipment to powder adult ARV tablets for the paediatric second-line regimen. The service for powdering ARVs must be provided with minimal charge, or in a socialized scheme – not just for HIV infected children on ARV but for other children with various conditions. The service is needed at treatment hubs where ARV prescriptions are filled. DOH may consider supporting this need, prioritizing facilities where cases of paediatric HIV are being managed.

Recommendation 2.8.2d An efficient and capable social welfare system may need to be in place to address issues of orphaned, abandoned and even abused children affected and infected by HIV. Close collaboration, partnership and functional referrals and linkages between treatment hubs and social services from government or private organizations may need to be established and should be considered as one of the roles of HACT. This would serve as preparation to deal with these cases.

Clinical and biological monitoring and viral resistance

Recommendation 2.9.2a Additional investment in laboratory services should be considered. Decentralization of laboratory services could be one option to cover additional laboratory examinations, decreasing missed opportunities of PLHIV to receive proper monitoring. Ideally, each treatment hub should provide laboratory services together with treatment and care. Further investments in human resources, commodities and machines will be essential to strengthen the capacity of existing laboratories.

Recommendation 2.9.2b A great number of laboratory services need to be covered by PhilHealth and/or other sources to ensure appropriate monitoring of treatment. Out-of-pocket expenses should not become a barrier to monitoring. Otherwise, it might create increased financial needs for treatment of ARV toxicity and drug-resistant HIV.

Recommendation 2.9.2c A surveillance system of HIV drug resistance (HIVDR) should be established immediately. Monitoring early-warning indicators (EWIs) of HIVDR can alert ART programmes to situations that favour the emergence of HIVDR and provide an opportunity for corrective action to be taken. It is recommended that all clinics providing ART monitor EWIs annually as a component of routine programme monitoring and evaluation. Individual indicators should not be aggregated beyond the clinic, however, national results should include the proportion of clinics able to achieve each target. Annual viral load monitoring is essential for this monitoring, therefore the scaling up of viral load examinations needs to be considered.

Recommendation 2.9.2d A surveillance system to monitor HIVDR should be established along with a monitoring and evaluation system of ART services in each treatment hub, feeding into a national database. This would help at the national level in projecting demand for second- and third-line ARVs.

Recommendations 2.9.3 NASPCP must be prepared to estimate and respond to future procurement requirements. Additional workers should be hired and trained to assist in procurement, distribution and monitoring, both within NASPCP and within DOH's procurement service. DOH procurement staff must be part of yearly programme implementation reviews.

Overcoming Contextual, Structural and Systemic Barriers

Recommendation 2.10.1a It is of utmost importance that the formulation of the new law amending or replacing the Philippine AIDS Prevention and Control Act of 1998 takes into account the advancement of knowledge about effective health facility-based and community-based responses to HIV, which can be highly effective if accompanied by appropriate legal and social measures. These include encouraging active participation of key populations in prevention, care and treatment programmes intended for their benefit. The formulation of the law should receive input from people representing these communities. Its potential impacts – both desirable and undesirable – on access to services by key populations should be carefully studied before the law is enacted. Once passed, the law should be widely disseminated, along with quality and targeted documentation on how to interpret and apply the law in different settings, in particular for LGU authorities, the judiciary, law enforcement and health systems, and also among key populations and their service providers.

Recommendation 2.10.1b Operational research on the needle and syringe programme should be expedited to inform the scale up of the programme and to enable an amendment of the Dangerous Drugs Act. In addition to revising the local AIDs ordinance, it is important to undertake structured and well-planned advocacy campaigns at the local level, building on evidence, demands from affected communities, and lessons learnt from other cities and municipalities and from other

countries. National guidelines should be widely disseminated and updated as new evidence is available. NASPCP should consider updating its website as a means to widely disseminate guidelines, the latest epidemiologic data and advocacy tools.

Recommendation 2.10.2 Collaboration between PNAC and NASPCP should continue to be articulated and strengthened around the next AIDS Medium-Term Plan (AMTP) and should serve as a strategic reference and accountability framework for both parties. DOH will require a more detailed strategic plan than AMTP6 can accommodate in view of the vast agenda it has to develop in order to further expand its outreach, fulfil adequately its diverse roles, and strengthen its normative, implementing and monitoring functions.

Recommendation 2.10.3a The normative role of the national level should be strengthened through interaction with the regional and local levels, empowered by national directives and greater financial means and human resources. The production, updating, dissemination, and monitoring and evaluation of guidelines and SOPs should be supported by a highly experienced technical working group. Safety nets and monitoring mechanisms should be in place to maximize positive effects and minimize negative effects of decentralization within the health sector.

Recommendation 2.10.3b To reinforce the alignment of local actions on HIV with national norms and standards, and as part of the capacity-building and standardization of services across the national health system, job descriptions and minimum eligibility criteria should be developed for the hiring and deployment of staff (e.g., SHC personnel, treatment providers at hubs and satellite hubs, peer educators, and counsellors). Minimum staffing patterns for SHCs should be reviewed and revised to reflect current service needs.

Recommendation 2.10.3c A common minimum package of interventions at the LGU level, including minimum requirements (staffing and resources, roles and responsibilities, and accountability mechanisms) should be established as a national norm, advocated by PNAC and promoted on the regional and LGU levels.

Recommendation 2.10.3d Given the serious implications for HIV and for health in general of a dysfunctional decentralization of health services, a bold effort should be made by DOH to seek and analyse evidence regarding the efficiency of the decentralized health system and to consider mechanisms to re-centralize some of the peripheral functions to the national level, ensuring appropriate resources to scale up prevention, HIV testing and counselling and ART services.

Recommendation 2.10.4a Personnel at SHCs must be commended for and supported in the performance of their work through better recognition, the improvement of their working environment, and the creation of incentives and the enhancement of their skills.

Recommendation 2.10.4b The role, outcome and impact of regular visits by sex workers to SHCs need a thorough assessment to determine if the clinics do fulfil their expected role or whether a different approach to STIs and HIV would result in improved diagnostic and treatment capacity and yield more meaningful data on the vulnerability and risks to which clients are exposed. This implies shifting the mind-set of SHC personnel and LGU leaders from the current emphasis on regulatory function performed by SHCs to the provision of a wider array of services to a diversified clientele, including MSM and transgender people.

Recommendation 2.10.4c Increase the effectiveness and efficiency in clinics by shifting from weekly and bimonthly check-ups of registered sex workers to a monthly check-up while, at the same time, improving the array and quality of services being provided.

Recommendation 2.10.4d The programme management capacity of SHCs should be strengthened by a more efficient use of collected data to determine epidemiological trends, coverage and uptake in each of the key populations they serve.

Recommendation 2.10.4e The income generated by SHCs from user fees should be utilized to improve services, the physical infrastructure of the facilities, logistical support and capacity-building, as well as to increase staff (laboratory technicians, clinical nurses, dedicated counsellors and peer educators).

Recommendation 2.10.5 In order to ensure that high-quality HIV/STI interventions are brought to scale and standardized, human resources must be expanded and health-care workers must be offered standardized training packages dictated by their roles. Intervention coverage, service uptake, sustainability and quality are key parameters that should be monitored and progressively improved by means of systematic capacity-building, incentive schemes and supportive supervision.

Recommendation 2.10.6 Continuing education of public and private medical practitioners engaged in HIV/AIDS care and treatment, along with an accreditation scheme operated by medical associations, should ensure that treatment practices, in particular ART, are in line with DOH norms, standards and guidelines.

Health financing

Recommendation 2.11 There is a need to develop a dynamic HIV financing strategy that relies on key improvements in: (a) resource tracking – including a more comprehensive view on LGU HIV spending and OOP spending for HIV; (b) linking financial planning with the recent shifts in public funding and scenarios regarding international funding – this includes for example factoring in the developments of the PhilHealth package extension; (c) advocacy towards LGUs in increasing their contributions to HIV funding – including the national roll-out of the local HIV investment plans; and (d) efficiency – especially through a more comprehensive and strategic contractual approach to further increase the fluidity and reach of funding. This approach could also be extended to the private sector providers in line with what has been achieved through accreditation of private hospitals for ARV distribution and follow-up. But any expansion of contracting with private providers should be accomplished in parallel to a strategy of capacity-building and monitoring of private practitioners (as discussed in recommendation 2.11).

Research: generating new knowledge

Recommendation 2.12a The evaluation team recommends that the 2012 Research Agenda published by PNAC be funded and gradually implemented and that research findings be made publicly available and used by policy- and decision- makers, managers, and local actors to orient and update the national response to HIV/AIDS on the basis of the new information generated.

Recommendation 12.2b Greater emphasis should be placed on the development of new knowledge, with a firm commitment to share results in a timely fashion and actively consider their impact on programme direction. Increase the priority given to publishing research results. Make available to universities and research institutes datasets such as IHBSS and AIDS registries for secondary analysis to answer various research questions. Consideration should be given to developing local capacity to engage with local data for the improvement of services. Agreement on the highest- priority research questions should be achieved, with a secure source of seed funding available to allow the development of proposals for research funding. Recognition of the importance of new knowledge for improving the quality and effectiveness of prevention, care, treatment and support is sorely needed.

ANNEX 4

Key Recommendations from the Evaluation of HIV and STI Program and Strategies for MSM, TG and PWID in the Philippines, May 2014

The evaluation focuses on Peer Education Program as an essential strategy for MSM, TG and PWID. The following were the Priority Recommendations of the evaluation. The recommendations offered in this report are extensive, and all are considered important to fulfilling the aims and the objectives of the National Strategic Plan. Moreover, all of the recommendations are considered integral to ensuring a quality services that key populations will want to access, and continue to attend. The following recommendations are considered urgent and key to addressing critical issues observed in the field.

1. National strategic planning and close Impact monitoring is required to ensure Peer Education activities are planned to maximize impact. Publish updated Cascade single graphic periodically to provide “at-a- glance” summary how the current service cascade is responding to the epidemic.
2. Review peer education and HCT targets to ensure that a balance is struck between meeting donor and program numeric targets and ensuring quality service delivery. Quality influences uptake and retention in the service cascade.
3. Urgently address the confusion surrounding the provision of results. An AO and/or Memorandum should go out to all civil society organizations and government services providing HIV testing.
4. Seek clarification on the HIV testing memorandum that requires private clinics to cease rapid testing and require EIA testing to be performed.
5. Invest in practical, population-oriented training. Revamp training curricula and methodologies. Ensure that the curriculum content moves beyond “HIV 101” and meets the needs of service delivery to specific populations. Ensure the right people are trained. Develop entry criteria
6. Invest in infrastructure improvements that allow services to grow at local level and ensure these services plan designated appropriate space to ensure civil society efforts can be delivered effectively in government services.
7. Develop guidance and SOP templates for the delivery of mobile and outreach HCT.
8. Develop national templates to guide recruitment and implementation at service level. These can then be tailored at the regional and local service delivery level.
9. Build a sustainable civil society effort. Harmonize stipends through collaborative effort and the sponsorship of a key stakeholder, donor and interagency meeting. Foster the development and planning for non-monetary incentives. Ensure worker safety. Provide LGU authorized ID to outreach workers and volunteers.
10. Improve multisectoral collaboration. This requires regularly coordinated meetings of key stakeholders at the local level. The national government can foster regular annual problem solving summits.
11. Develop a program quality improvement plan and appoint a person to oversee quality assurance and quality improvement planning for peer education, peer counseling and site implementation services.
12. Fund expanded hot spot mapping to maximize yield on the HIV funding investment. Fund research to gain information on sub population segmentation.
13. Ensure funding is made available to review prevention and treatment and care services in prisons and other closed settings and explore linkages external health services including government civil society HIV services. Foster partnerships between government health services, custodial services and civil society peer-based services.

ANNEX 5

AIDS Epidemic Model Impact Modeling and Analysis 2014 Philippine Case Study Executive Summary

Starting in 2011, the Global Fund to Fight AIDS, TB, and Malaria (GF-ATM) adopted the “investing for impact” strategy. Central to this strategy was the development of an investment package that yields the most impact for the lowest cost possible. To develop this, valid localized epidemic models were needed.

To meet the data need for this funding strategy, the GF-ATM, together with UNAIDS and the World Health Organization (WHO) partnered with the East-West Center Research Program (EWC) for the Estimating HIV Program Impacts Using the AIDS Epidemic Model for Low-Level & Concentrated Epidemics (AEM-LLC) project. The project trained a group of researchers from six countries, including the Philippines, in using the AIDS Epidemic Model (AEM) suite of tools to generate epidemic models. The Philippine AEM Team is composed of representatives from the National Epidemiology Center of the Department of Health (NEC-DOH), Philippine National AIDS Council (PNAC), National AIDS/STD Prevention and Control Program (NASPCP), Health Action Information Network (an NGO PNAC Member), UNAIDS Country Office, and the National Economic and Development Authority (NEDA).

AEM method and process

A. Sites and key populations

- The 2012 Philippine Priority Areas for HIV Intervention (PAHI), Integrated HIV Behavioral and Serologic Surveillance (IHBSS), and the Philippine HIV and AIDS Registry were used as bases in selecting the sites
- Six sub-national models were developed to reflect the diverse nature of the epidemic: Greater Metro Manila (GMM), Cebu Province, Pampanga Cities, Davao City, Category B, and Rest of the Country (ROTC). These were later merged to generate a national model
- Key populations covered were registered and freelance female sex workers (FSW), males having sex with males (MSM), and people who inject drugs (PWID).

B. Data generation

- Data from the IHBSS and Philippine HIV and AIDS Registry were used as inputs to AEM. Issues and concerns with data were settled either through triangulation or calibration using a set of formula.
- For the costing, the AEM team referred to the 5th AIDS Medium Term Plan (AMTP) and UNAIDS costing analysis. One concern that emerged was that the unit costs were too varied, depending on geographic location or program. Consultations with various stakeholders were then conducted to arrive at a consensus.

In 2012, DOH issued the Philippine Priority Areas for HIV intervention or PAHI, which identified

70 cities and municipalities out of 122 cities and 1514 municipalities in the country. These areas were strategically divided into three categories – A, B, C - based on the immediacy and need for intervention. PAHI and other evidences were the bases for the selection of sites for modeling in AEM.

These sites, except for Davao City, were clustered to form the 6 sub-national models and were combined to form the Philippine national model.

Philippines or national – the result of combining 6 sub-national models

1. Greater Metro Manila – this sub-national model is composed of 16 cities and a municipality in Metro Manila and 11 adjacent cities and municipalities from nearby provinces of Rizal, Laguna, Cavite and Bulacan.
2. Cebu Province – this includes Cebu, Lapu-lapu and Mandaue Cities
3. Davao City
4. Category B – composed of 9 cities of Bacolod, Baguio, Batangas, Butuan, Cagayan de Oro, General Santos, Iloilo, Puerto Princesa, and Zamboanga
5. Pampanga Province - includes Angeles, Mabalacat, and San Fernando Cities
6. Rest of the Country or ROTC – this includes all other areas not included in the models above

Key findings

A. Baseline scenario

The baseline scenario showed the current intervention programs and where the epidemic would lead if current level of intervention is maintained.

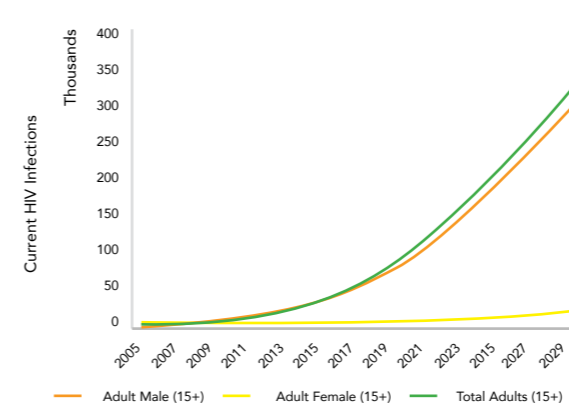


Figure 2. New Infections by MARP, 2005-2030

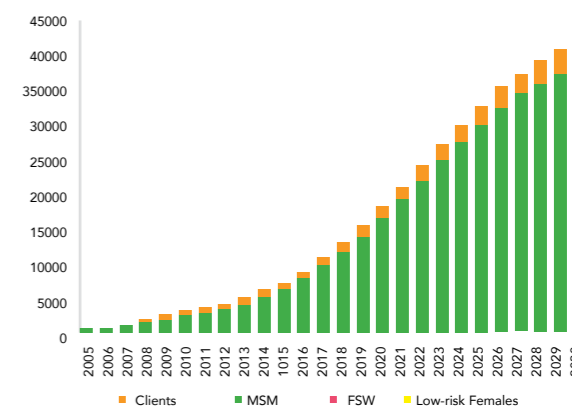


Figure 1. Current HIV Infections, 2005-2030

■ IDU

- If current level and coverage of intervention will be maintained, infections will continue to increase. By 2017, there will be around 57,236 PLHIV and by 2030, this will increase to 336,181.
- MSM will continue to be the most affected population. In 2017, there will be 10, 273 new infections among MSM, amounting 90% of all new HIV infections. This proportion will continue to increase and reach 91% (38,643) of all new HIV infections by 2030.

B. Strategic actions and scenarios

With the results of the baseline scenario, the AEM team proceeded with the development of various policy scenarios that can be adapted by the country. In consultation with stakeholders, the team identified three strategic actions to address the HIV epidemic. For each strategic action, scenarios were generated to identify the program that could deliver the most impact for the least cost possible. The targets of all scenarios presented here incrementally increase from the baseline until it reaches the target coverage by the year 2017.

Table 1. Baseline Prevention and Treatment Coverage per Sub-Epidemic Model

Sub-Epidemic Model	FFSW	RFSW	IDU	MSM	ART - Male	ART - Female
Angeles	14%	11%	1%	9%	28%	23%
Cat B	7%	49%	18%	8%	40%	31%
Cebu	10%	62%	-	9%	15%	18%
Davao	12%	41%	-	15%	78%	61%
GMM	11%	28%	-	7%	69%	71%
ROTC	4%	10%	-	2%	40%	31%

1. Prioritize the intervention among MARPs

This first set of policy scenarios looked at the prioritization among MARPs. Considering the limited resources of the country and the rapidly growing epidemic, there is a need to prioritize the resources while still achieving significant impact.

- Scenario 1: Prevention 80% (all Key Populations), ART 90% @ CD4 350
- Scenario 2: Prevention 80% (MSM and IDU), ART 90% @ CD4 350
- Scenario 3: Prevention 80% (MSM), ART 90% @ CD4 350
- Scenario 4: Prevention 80% (MSM) only
- Scenario 5: Prevention 80% (IDU) only
- Scenario 6: Sustain prevention, Treat All (ART only)

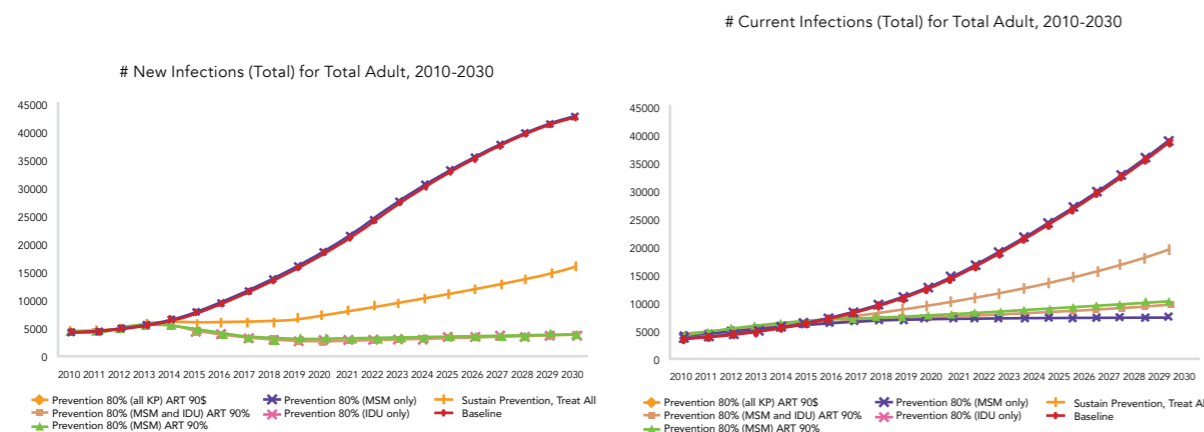


Figure 3. Priority interventions among MARPs & NEW infections, 2010-2030

Figure 4. Priority interventions among MARPs & CURRENT infections, 2010-2030

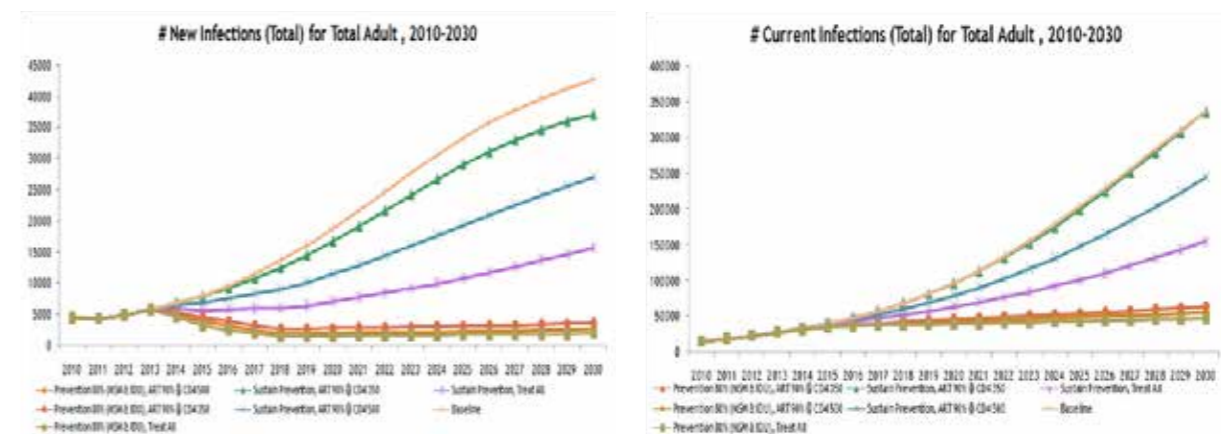


Figure 5. Strategic use of ART and total number of NEW HIV infections, 2010-2030

Figure 6. Strategic use of ART and total number of CURRENT HIV infections, 2010-2030

- Scenario 3 (Prevention 80% (MSM & IDU), Treat All) will result to the highest number of infections averted. However, it is also the most expensive, requiring \$85 million for 2022 and \$97 million for 2030. Considering the limited resources of the country, Scenario 1 or Scenario 2 may be more feasible options. These scenarios will avert a significant number of HIV infections while requiring less resources than the 3rd Scenario.
- Considering the country's limited resources, another good option would be Scenario 2 (Prevention 80% [MSM & IDU], ART 90% @ CD4 500). The country would be able to avert around 22,000 infections in 2022. This intervention scenario would cost USD 83 million if this would be fully implemented in 2022.
- Furthermore, the results showed that focusing on scale up of treatment alone (Scenarios 4, 5, & 6) while sustaining prevention would not result to maximum impact.

Overall, the key to significantly decreasing the number of new HIV infections is to scale-up the prevention coverage of MSM and IDU, sustain prevention coverage of FSW, and at the same time, scale-up ART coverage among PLHIV.

3. Scale-up prevention coverage among MSM and IDU and treatment coverage for PLHIV

While the first two policy scenarios already provided strategic actions, the country still has to consider its limitations in terms of resources, policies, and other factors that could affect the implementation of a scenario and consequently, its effects on the epidemic. Thus, a third set of policy scenarios was developed to look at the specific prevention coverage and treatment coverage that is feasible for the country to target while still yielding significant outcomes.

- Scenario 1: Prevention 80%(MSM & IDU), ART 90% @ CD4 350
- Scenario 2: Prevention 60%(MSM & IDU), ART 90% @ CD4 350
- Scenario 3: Prevention 60% (MSM & IDU),Treat All

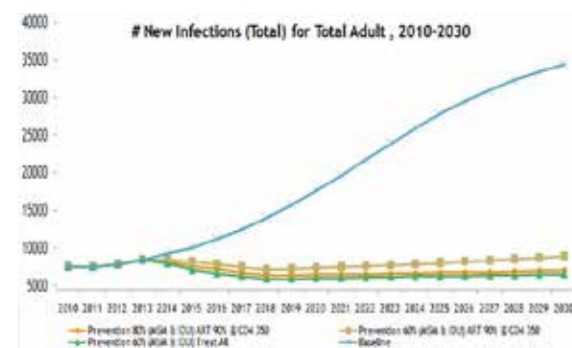


Figure 7. MSM, IDU & ART focused interventions and total number of NEW HIV Infections. 2010-2030

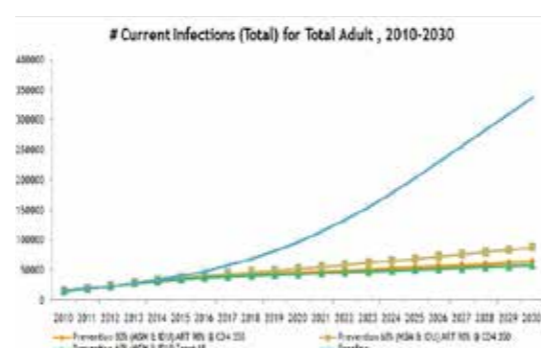


Figure 8. MSM, IDU and ART focused interventions and total number of current HIV infections, 2010-2030

Table 2. Annual Infections Averted and Total Resource Needs (in thousands) - 2013, 2022, 2030

Scenario	2013		2022		2030	
	Infections Averted (Annually)	Resource Needs (USD)	Infections Averted (Annually)	Resource Needs (USD)	Infections Averted (Annually)	Resource Needs (USD)
1. Prevention 80% (MSM & IDU) ART 90% @ CD4 350	23	18,329	21,779	78,401	39,007	94,329
2. Prevention 60% (MSM & IDU) ART 90% @ CD4 350	18	15,873	20,181	65,999	36,256	85,386
3. Prevention 60% (MSM & IDU) Treat All	18	15,873	22,306	74,601	39,605	88,299

- Among the three scenarios, Scenario 3 (Prevention 60% (MSM & IDU), Treat All) seemed to be the best option as it will result in the highest number of infections averted at the lowest cost possible. Full implementation of Scenario 3 would avert 39,605 infections in 2030 and would cost \$75 million in 2022 and \$88 million in 2030.
- However, there are also other factors that should be considered if this scenario would be adopted. One major barrier would be the low testing coverage in the country (e.g. 8% among MSM based on 2013 IHBSS results). If not all PLHIV (or at least 90%) could be identified through HIV testing, then the Treat All scenario could not be successfully implemented. Initially, the country needs to strengthen the prevention coverage before it aims to treat all PLHIV. Moreover, policy barriers and the readiness of the country to adopt a Treat All Policy also needs to be considered before this scenario could be fully implemented.
- Thus, Scenario 1 (Prevention 80% (MSM & IDU), ART 90% @ CD4 350) should be adopted by the country instead. This scenario will also avert a significant number of HIV infections - 21,779 in 2022 and 39,007 in 2030 with corresponding cost requirement of \$78 million in 2022 and \$94 million in 2030.
- Scenario 1 would require resources of around \$40 million in 2015, \$53 million in 2016, and \$66 million in 2017. During various dialogues with stakeholders and partners, it was suggested that geographic prioritization should be applied considering the limitations of the country in terms of resources. Thus, the AEM team in coordination with NASPCP and partners, used the AEM tool to apply geographic prioritization and further trim down resource needs while still reversing the trend of the epidemic.

Conclusions and Recommendations

The Philippine AIDS Epidemic Model (AEM) showed that the HIV epidemic in the country would continue to increase at a rapid rate if the country simply sustains its current prevention and treatment interventions and coverage. Majority of new HIV infections would be coming from the combination of four sub-epidemic models – Greater Metro Manila (GMM), Cebu Province, Pampanga Cities, and Davao City. Furthermore, around 90% of all new HIV infections will be coming from the MSM population by 2022. To address this problem, the AEM team developed several scenarios that would guide program and policy decisions.

Considering the resource limitations of the country, there is a need to prioritize intervention among the MARPs, the AEM scenarios were able to show that scaling up the prevention coverage on MSM and IDU while sustaining the current coverage for FSW would already lead to a significant decrease in the epidemic.

Furthermore, it is clear from the modeling results that the ART only scenarios would not result to maximum impact and would lead to a continuous increase of the epidemic. The key to significantly decreasing the number of new HIV infections is to scale-up the prevention coverage of MSM and IDU, sustain prevention coverage of FSW, and at the same time, scale-up ART coverage among PLHIV.

The combination of Prevention 60% (MSM & IDU) and Treat All showed the highest averted infections and lower cost requirement in comparison to other scenarios. However, there are other factors that were considered by the team in making a recommendation. With the currently low testing coverage in the country, few PLHIV are identified from the pool of all PLHIV in the country. Thus, it would not be feasible to treat all PLHIV unless they are encouraged to get tested and then enrolled to treatment. It is recommended that the country optimizes its prevention coverage which would lead to averted infections and simultaneously lead to the diagnosis of PLHIV and eventually, to their linkage to care.

Therefore, with the various policy scenarios developed, the AEM team recommends the country to adapt this scenario – Scale-up Prevention Coverage to 80% of MSM and IDU, Sustain Prevention Coverage among FSW, and Scale-up Treatment Coverage to 90% of PLHIV with CD4 of 350 and below. In addition to averting thousands of HIV infections, this policy could contribute to systems strengthening.

DOH Action

AEM was used to guide the development of the Health Sector Plan (HSP) 2015-2017. Data generated by the AEM were used to inform the plan and to evaluate the impact of the national response. The Prevention 80% (MSM & IDU), ART 90% @ CD4 350 was adapted by the country, as recommended by the AIDS Epidemic Model. This scenario would require resources of around \$40 million in 2015, \$53 million in 2016, and \$66 million in 2017. During various dialogues with stakeholders and partners, it was suggested that geographic prioritization should be applied considering the limitations of the country in terms of resources. Thus, the AEM team in coordination with NASPCP and partners, used the AEM tool to apply geographic prioritization and further trim down resource needs while still reversing the trend of the epidemic.

Table 3 shows the targets that were adopted by the Health Sector Plan. Baseline results of the AEM showed that majority of new HIV infections would come from Greater Metro Manila, Cebu Province, Pampanga Cities, and Davao City combined. Thus, highest prioritization was given to

Category	KPs	Target
A	MSM	80%
	IDU	80%
	FFSW	60%
	RFSW	60%
	PLHIV on ART	90%
B	MSM	60%
	IDU	40%
	FFSW	60%
	RFSW	60%
	PLHIV on ART	90%
C and ROTC	MSM	40%
	IDU	40%
	FFSW	40%
	RFSW	40%
	PLHIV on ART	90%

these models (Category A). They will fully implement the recommended targets of AEM. Category B was given the next level of prioritization due to its significant share of HIV infections, with scaled down targets while Category C and the rest of the country (ROTC) will be included in the HSP but would be given the least priority in terms of HIV interventions. The AEM team developed a policy scenario adopting these targets. Results showed that a significant number of HIV infections will be averted – a total of 17,718 infections will be averted within the HSP period of 2015 to 2017 with corresponding resource needs of \$32 million in 2015, \$43 million in 2016, and \$53 million in 2017.

ANNEX 6. DETAILED OPERATIONAL PLANNING MATRIX OF THE HEALTH SECTOR PLAN FOR 2015-2017

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Strategy # 1: Continuum of HIV / STI prevention , diagnosis, treatment and care service to KP	Indicator 1.1: Number (#)& % of key populations who received condoms and lubricants	Training	45 pax	Php656,124.00	45 pax	Php656,124.00	45 pax	Php656,124.00
		Advocacy, Communication and Social Mobilization	2 pax	Php68,800.00	2 pax	Php68,800.00	2 pax	Php68,800.00
			30 pax	Php297,976.00	30 pax	Php297,976.00	30 pax	Php297,976.00
Activity #3	Augment commodities (condoms and lubes) FSW	Health Products- Prophylactic	94,569pcs	Php340,447.46	889,189pcs	Php3,201,079.64	1,084,146pcs	Php3,902,926.93
	Augment commodities (condoms and lubes) RFSW	Health Products- Prophylactic	1,879,711pcs	Php6,766,960.44	2,168,254pcs	Php7,805,715.89	2,465,894pcs	Php8,877,217.10
	Augment commodities (condoms and lubes) MSM	Health Products- Prophylactic	9,827,296pcs	Php94,342,043.66	12,811,241pcs	Php122,987,917.63	15,894,144pcs	Php152,583,784.24
	Augment commodities (condoms and lubes)PWID	Health Products- Prophylactic	42,180pcs	Php404,926.19	53,081pcs	Php509,573.68	64,306pcs	Php617,342.27
Activity# 4	Integrate PE approach in the healthcare delivery system							
	4.1 Establish national guidelines on peer education and outreach							
	a) policy issuances on the national guidelines on peer education	Planning and Administration	20 pax	Php9,000.00				
	Review of peer education and HCT targets	Planning and Administration	30 pax	Php40,500.00	30 pax	Php40,500.00	30 pax	Php40,500.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Develop a national module on training of peer educators b) hiring of consultant to write guidelines c) development and finalization of guidelines d) orientation of Loc Govt Units and key stakeholders on the guidelines Develop national guidelines on recruitment, selection, hiring and retention of peer educators a) consultation meetings with stakeholders b) hiring of consultant to write guidelines c) development and finalization of guidelines d) orientation of Loc Govt Units and key stakeholders on the guidelines 4 Recruitment, selection and hiring of qualified peer educators & peer educator supervisors / SIO for MSM 5) Regular meetings of peer educators and SHC staff 6 Coaching and mentoring of peer educators a) recording and reporting b) regular updating of knowledge c) regular de-briefing session	Develop a national module on training of peer educators							
	b) hiring of consultant to write guidelines							
	c) development and finalization of guidelines							
	d) orientation of Loc Govt Units and key stakeholders on the guidelines	Planning and Administration	70 pax	Php501,200.00	70 pax	Php501,200.00	70 pax	Php501,200.00
	Develop national guidelines on recruitment, selection, hiring and retention of peer educators	Planning and Administration	30 pax	Php40,500.00	30 pax	Php40,500.00	30 pax	Php40,500.00
	a) consultation meetings with stakeholders	Planning and Administration	30 pax	Php13,500.00	30 pax	Php13,500.00	30 pax	Php13,500.00
	b) hiring of consultant to write guidelines	Technical Assistance	1 pax	Php267,000.00	1 pax	Php267,000.00	1 pax	Php267,000.00
	c) development and finalization of guidelines	Planning and Administration	30 pax	Php27,000.00	30 pax	Php27,000.00	30 pax	Php27,000.00
	d) orientation of Loc Govt Units and key stakeholders on the guidelines	Planning and Administration	70 pax	Php501,200.00	70 pax	Php501,200.00	70 pax	Php501,200.00
	4 Recruitment, selection and hiring of qualified peer educators & peer educator supervisors / SIO for MSM	Human Resources	787 SIO/PE	Php94,493,232.83	1027 SIO/PE	Php123,185,013.65	1274 SIO/PE	Php152,828,309.54
	5) Regular meetings of peer educators and SHC staff	Planning and Administration	832 pax	Php1,498,398.49	1072 pax	Php1,928,775.20	1319 pax	Php2,373,424.64
	6 Coaching and mentoring of peer educators	Planning and Administration						
	a) recording and reporting							
	b) regular updating of knowledge							
	c) regular de-briefing session							

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Indicator 1.2: No. & Percent (%) of PWID who received clean syringes in the last year (UNGASS-GARPR)	d) skills enhancement							
	7 Monitoring of peer education activities	Monitoring and Evaluation	3 pax	Php43,960.00	3 pax	Php43,960.00	3 pax	Php43,960.00
	8 Augmentation staff for prevention activities (NASPCP)	Technical Assistance	3 pax	Php1,706,112.00	3 pax	Php1,706,112.00	3 pax	Php1,706,112.00
Indicator 1.3: Mean number (#) of clean syringes received per PWID/yr								
Activity #1	Capability building on PWID interventions for health workers and other key stakeholders	Training	51	Php743,607.20	51	Php743,607.20	51	Php743,607.20
Activity #2	Augment commodities (needles and syringe, disinfectants, IEC materials)	Health Products- Prophylactic	2,952,587pcs	Php14,190,132.26	3,715,641 pcs	Php17,857,372.52	4,501,454 pcs	Php21,633,988.34
Indicator 1.4: Number (#) of PWID referred to drug treatment and rehabilitation center								
Activity #1	Psychosocial support services	Human Resources	4 pax	Php832,000.00	4.00	Php832,000.00	4.00	Php832,000.00
Activity#2	"Drug dependence counseling - health workers, service providers, social workers	Training	30	Php439,600.00	30	Php439,600.00	30	Php439,600.00
Activity #3	Referral of PWID to Drug Treatment and Rehab Center	Living Support to Clients/Target Pop / Human Resource	50	Php1,850,000.00	50	Php1,850,000.00	50	Php1,850,000.00
Activity #4	Capability building for health workers and key stakeholders on: Psychosocial support, PWID interventions, health workers sensitization	Training	30 pax	Php439,600.00	30 pax	Php439,600.00	30 pax	Php439,600.00
Activity#5	"Development and finalization of Manual of Operations for PWID - c/o BCP Orientation on Manual of Operations for PWID	Planning and Administration	40 pax	Php 706,664.00			40 pax	Php 706,664.00
Activity #6	Implement and monitor Community-based Comprehensive Services for PWID in Kamagayan	Monitoring and Evaluation	3 pax	Php87,920.00	3 pax	Php87,920.00	3 pax	Php87,920.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Indicator 1.5: Number (#) and Percent (%) of KP screened for syphilis	Activity #1							
	Procurement of lab reagents, supplies and equipment for syphilis and other STIs							
	STI Cost for diagnosis (30,000 cases x 2 visits)		182,395					
	1 Gram Stain kit (C violet, iodine, alcohol, safranin) set/4/500 ml	Health Products-Testing	182,395	Php2,735,918.80	234,900	Php364,789.17	289,139	Php364,789.17
	2 TPPA-Syphilis Confirmatory test, Particle Agglutination	Health Products-Testing	182,395	Php31,371,868.92	234,900	Php15,685,934.46	289,139	Php15,685,934.46
	3 Syphilis Test Kit (Rapid Test)	Health Products-Testing	182,395	Php36,478,917.35	234,900	Php18,239,458.67	289,139	Php18,239,458.67
	Syphilis test kit, immunochromatographic assay for the qualitative detection of antibodies of all isotypes (IgG, IgM, IgA)							
	4 Cryovial 2ml (internally threaded box of 500)	Health Products-Testing	182,395	Php3,283,102.56	234,900	Php1,641,551.28	289,139	Php1,641,551.28
	5 Blood Collection Tube, Red (100 tubes per pack)	Health Products-Testing	182,395	Php729,578.35	234,900	Php1,215,963.91	289,139	Php1,215,963.91
	6 Yellow Tip (pack of 1000)	Health Products-Testing	182,395	Php182,394.59	234,900	Php3,039,909.78	289,139	Php3,039,909.78
	7 Disposable Gloves, Medium	Health Products-Testing	182,395	Php638,381.05	234,900	Php319,190.53	289,139	Php319,190.53
	8 Glass slide, frosted end (72 pcs per pack)	Health Products-Testing	182,395	Php303,990.98	234,900	Php151,995.49	289,139	Php151,995.49
9 Applicator Stick with cotton on one end	Health Products-Testing	182,395	Php729,578.35	234,900	Php364,789.17	289,139	Php364,789.17	
10 Disposable syringes 5ml, G21	Health Products-Testing	182,395	Php729,578.35	234,900	Php364,789.17	289,139	Php364,789.17	
11 Disposable mask, non-porous, non-absorbent ear loop typed, plastic sealed	Health Products-Testing	182,395	Php1,459,156.69	234,900	Php729,578.35	289,139	Php729,578.35	
Activity #2	Augment human resource requirement (Medtech, MD and RN)	Human Resources	45	Php11,880,000.00	45	Php11,880,000.00	45	Php11,880,000.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Indicator 1.6: Number (#) and Percent (%) of KP treated for syphilis								
Activity #1	Procurement of drugs for syphilis and other STIs			Php25,258,620.31		Php30,733,322.99		Php35,218,549.87
1	Azithromycin 500mg (pack of 100's in blister of 2 tabs) FDA registered	Pharmaceutical Products (Drugs/Medicines)						
	Azithromycin 500mg (pack of 100's in blister of 2 tabs) FDA registered - MSM	Pharmaceutical Products (Drugs/Medicines)	16788 patient/s	Php4,432,110.59	21886 patient/s	Php5,777,869.88	27152 patient/s	Php7,168,259.03
	Azithromycin 500mg (pack of 100's in blister of 2 tabs) FDA registered - PWID	Pharmaceutical Products (Drugs/Medicines)	288 patient/s	Php76,092.38	3403 patient/s	Php898,286.93	4122 patient/s	Php1,088,263.63
	Azithromycin 500mg (pack of 100's in blister of 2 tabs) FDA registered - FSW (FFSW&RFSW)	Pharmaceutical Products (Drugs/Medicines)	20945 patient/s	Php5,529,461.65	24858 patient/s	Php6,562,544.55	28897 patient/s	Php7,628,721.02
2	Cefixime 400mg capsules (30 caps per pack)	Pharmaceutical Products (Drugs/Medicines)						
	Cefixime 400mg capsules (30 caps per pack) - MSM	Pharmaceutical Products (Drugs/Medicines)	30427 patient/s	Php4,868,291.36	39666 patient/s	Php6,346,491.90	49211 patient/s	Php7,873,714.51
	Cefixime 400mg capsules (30 caps per pack) – PWID	Pharmaceutical Products (Drugs/Medicines)	522 patient/s	Php83,580.92	657 patient/s	Php105,181.23	796 patient/s	Php127,425.78
	Cefixime 400mg capsules (30 caps per pack) - FSW (FFSW&RFSW)	Pharmaceutical Products (Drugs/Medicines)	20714 patient/s	Php3,314,312.72	23459 patient/s	Php3,753,469.90	23459 patient/s	Php3,753,469.90
3	Penicillin G. Benzathine 1.2M unit power for IM	Pharmaceutical Products (Drugs/Medicines)						
	Penicillin G. Benzathine 1.2M unit power for IM – MSM	Pharmaceutical Products (Drugs/Medicines)	3071 patient/s	Php881,692.73	4004 patient/s	Php1,149,408.57	4967 patient/s	Php1,426,002.75
	Penicillin G. Benzathine 1.2M unit power for IM – PWID	Pharmaceutical Products (Drugs/Medicines)	165 patient/s	Php47,430.14	208 patient/s	Php59,687.80	252 patient/s	Php72,311.04

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	Penicillin G. Benzathine 1.2M unit power for IM - FSW (FFSW)	Pharmaceutical Products (Drugs/Medicines)	20700 patient/s	Php5,942,849.49	20890 patient/s	Php5,997,583.91	20890 patient/s	Php5,997,583.91
	Metronidazole	Pharmaceutical Products (Drugs/Medicines)	20700 patient/s	Php82,798.32	20700 patient/s	Php82,798.32	20700 patient/s	Php82,798.32
Indicator 1.7: Number (#) & % of facilities offering HCT testing accessible to each KAP group								
Activity #1	Expand HIV Counseling and / or Testing (HCT) service in priority cities and provinces:							
	1.1 Mapping of facilities							
	1.2 Training on HCT	Training	50 pax	Php1,486,520.00	50 pax	Php1,486,520.00	50 pax	Php1,486,520.00
	1.3 Training on HIV Proficiency for Medtechs	Training	50 pax	Php800,000.00	50 pax	Php800,000.00	50 pax	Php800,000.00
	1.4 Counseling Training for Outreach Workers	Training	50 pax	Php1,486,520.00	50 pax	Php1,486,520.00	50 pax	Php1,486,520.00
	1.5 Establishment of HCT space in health facilities							
	1.5.1. Refurbishment/Renovation	Infrastructure	20	Php20,000,000.00	20	Php20,000,000.00	5	Php5,000,000.00
	1.5.2. Expansion/Construction	Infrastructure	20	Php20,000,000.00	20	Php20,000,000.00	5	Php5,000,000.00
	1.6 Procurement of HIV testing commodities		480,842.40		619,650.84		763,059.21	
	HIV testing commodities - MSM	Health Products-Testing	406363 test	Php60,954,514.82	530955 test	Php79,643,232.66	659696 test	Php98,954,399.57
	HIV testing commodities - Sex Worker	Health Products-Testing	66367 test	Php6,636,746.20	78488 test	Php7,848,815.06	90997 test	Php9,099,657.70
	HIV testing commodities- PWID	Health Products-Testing	8112 test	Php1,216,725.34	10208 test	Php1,531,170.90	12367 test	Php1,854,994.82
	1.7 Human Resource augmentation at SHCs and treatment hub	Human Resources						
	1.8 Conduct of HCT services							
	1.8.1 facility based - Conduct of HCT services	Human Resources	45 LGUs	Php1,215,000,000.00	45 LGUs	Php1,215,000,000.00	45 LGUs	Php1,215,000,000.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Activity #2	1.8.2 Mobile/Outreach - Conduct of HCT services	Planning and Administration	45 LGUs	Php5,400,000.00	45 LGUs	Php5,400,000.00	45 LGUs	Php5,400,000.00
	Establishment of National Reference Laboratory - Satellite facilities	Infrastructure	2	Php1,000,000.00				
	> Centrifuge - 12 capacity centrifuge	Health Equipment	2	Php500,000.00				
	> ELISA reader	Health Equipment	2	Php400,000.00				
	> Computer set (1 per site)	Health Equipment	2	Php120,000.00				
	2.2 Training of staff - 7 days training	Training	8	Php483,840.00				
	2.3 Human Resource augmentation							
	> 1 MD	Human Resources	2	Php960,000.00	2	Php960,000.00	2	Php960,000.00
	> 3 Medtechs	Human Resources	2	Php1,800,000.00	2	Php1,800,000.00	2	Php1,800,000.00
	> 2 Support staff	Human Resources	2	Php816,000.00	2	Php816,000.00	2	Php816,000.00
Activity #3	2.4 Courier service	Health Products	2	Php1,000,000.00	2	Php1,000,000.00	2	Php1,000,000.00
	2.5 Monitoring and supervision visits	Monitoring and Evaluation	2	Php275,200.00	2	Php275,200.00	2	Php275,200.00
	2.6 Procurement of Reagents							
Activity #3	> HIV test	Health Products-Testing	2000	Php1,800,000.00	3000	Php2,700,000.00	3000	Php2,700,000.00
	Advocacy to Loc Govt Units to adopt and implement policy on HCT	Advocacy, Communication and Social Mobilization	30 pax	Php40,500.00				
Activity #4	Develop National Guidelines / SOPs for mobile HCT:	Planning and Administration	30 pax	Php54,000.00				
	1) Review of current HCT activities	Planning and Administration	30 pax	Php40,500.00				
	2) Workshop on development of national guidelines / SOPs for community-based testing or mobile HCT	Training	50 pax	Php366,333.33				

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	3) Drafting and finalization of the national guidelines for community-based testing or mobile HCT	Planning and Administration	30 pax	Php40,500.00				
	4) Consultant fee	Technical Assistance	1 pax	Php222,500.00				
Indicator 1.8: No. of CBO-organized HIV counseling and testing initiatives linked to SHC conducted or Loc Govt Unit-CBO partnerships established								
Activity #1	Establish and maintain public-private partnership in the delivery of STI and HIV services for key population							
	1.1. Scanning and scoping of CBOs, private hospitals and clinics and private sector	Planning and Administration	20 pax	Php54,000.00				
	1.2. Loc Govt Unit-CBO -Private sector consultation meetings	Planning and Administration	20 pax	Php54,000.00	20 pax	Php54,000.00	20 pax	Php54,000.00
	1.3. Forging / formalizing Public-Private Partnership	Planning and Administration	20 pax	Php54,000.00	20 pax	Php54,000.00	20 pax	Php54,000.00
	1.4. Capability building of CBOs and private sector partners	Planning and Administration	20 pax	Php54,000.00	20 pax	Php54,000.00	20 pax	Php54,000.00
	1.5 Performance-based funding for CBOs / small grants support for CBOs	Technical Assistance	5 CBOs/NGOs	Php5,000,000.00	5 CBOs/NGOs	Php5,000,000.00	5 CBOs/NGOs	Php5,000,000.00
Activity #2	Conduct CBO-organized STI and HCT activities							
	1.5.1 site / community preparation	Planning and Administration	45	Php67,500.00	45	Php67,500.00	45	Php67,500.00
	1.5.2 provide funding / logistics support to CBOs for HCT activity	Planning and Administration	45	Php900,000.00	45	Php900,000.00	45	Php900,000.00
	1.5.3 HR augmentation (medtechs & counselors)	Human Resources	45	Php45,000.00	45	Php45,000.00	45	Php45,000.00
Indicator 1.9: No. & Percent (%) of pregnant women tested for HIV								
Activity #1	Implement PMTCT activities (testing of pregnant women) in NCR and Cebu City							

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	Procurement of test kits - Cebu PMTCT	Health Products-Testing	86679	Php5,200,740.00	86679	Php5,200,740.00	86679	Php5,200,740.00
	Procurement of test kits - NCR PMTCT	Health Products-Testing	139862	Php8,391,720.00	139862	Php8,391,720.00	139862	Php8,391,720.00
Activity #2	Capacity building to all NCR and Cebu City service delivery points	Training	50 pax	Php496,626.67	50 pax	Php496,626.67	50 pax	Php496,626.67
Activity #3	Training on PMTCT to all ANC staff in NCR and Cebu City	Training	50 pax	Php496,626.67	50 pax	Php496,626.67	50 pax	Php496,626.67
Activity #4	Integrate PMTCT in the HIV service points (hubs, SHC, HCT, PE, NGO)	Planning and Administration	20 pax	Php48,000.00	20 pax	Php48,000.00	20 pax	Php48,000.00
Indicator 1.10: No. & Percent (%) of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth (UNGASS-GARPR)								
Activity #1	Link to activities on the expansion of HCT sites and conduct of HCT							
Activity #2	Procurement of virological test for HIV for infants	Health Products-Testing	50	Php600,000.00	60	Php720,000.00	70	Php840,000.00
Indicator 1.11: No. & Percent of TB clients provided with HIV counselling and testing among aged 15 y.o and above								
Activity #1	Coordination with TB program	Planning and Administration	50 pax	Php22,500.00	50 pax	Php22,500.00	50 pax	Php22,500.00
Activity #2	Capacity building for Health Service Providers in TB-DOTS facilities in C45							
	HIV proficiency training for med tech	Human Resources	50 pax	Php800,000.00	50 pax	Php800,000.00	50 pax	Php800,000.00
	Provision of HIV test kits for HIV testing	Health Products-Testing						
Indicator 1.12: No. & Percent of drug resistant TB cases provided with HIV counselling and testing among aged 15 y.o and above								
Activity #1	Capacity building for Health Service Providers in PMDT facilities in C45							
	HCT Training - Health Service Providers in PMDT facilities in C45	Training	50 pax	Php1,167,320.00	50 pax	Php1,167,320.00	50 pax	Php1,167,320.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	HIV proficiency training for med tech - Health Service Providers in PMDT facilities in C45	Training	30 pax	Php480,000.00	30 pax	Php480,000.00	30 pax	Php480,000.00
	Provision of HIV test kits for HIV testing - Health Service Providers in PMDT facilities in C45	Health Products-Testing						
Indicator 1.13: Percent (%) of newly diagnosed PLHIV who know their baseline CD4 count within the first 3 months of HIV diagnosis								
Activity #1	Expand Pilot sites for shorter HIV testing algorithm							Php30,919,936.00
	1.1 Development of policy issuances for the expansion of pilot sites for shorter testing algorithm	Planning and Administration	30 pax	Php54,000.00	30 pax		30 pax	Php54,000.00
	1.2 Conduct of training/orientation of shorter testing algorithm (facility and community based)	Training	30 pax	Php297,976.00	30 pax	Php297,976.00	30 pax	Php297,976.00
	Manpower augmentation including partnership with CBOs/Community	Human Resources	7 site/s	Php7,000,000.00	7 site/s	Php7,000,000.00	7 site/s	Php7,000,000.00
	Provision logistical support (reagents, instruments, supplies)							
	a. procurement of test kits (particle agglutination) to pilot sites for shorter HIV testing algorithm	Health Products-Testing	3600	Php1,440,000.00	3600	Php1,440,000.00	3600	Php1,440,000.00
	b. procurement of instruments (particle agglutination) to pilot sites for shorter HIV testing algorithm	Health Equipment	4	Php760,000.00				
	Centrifuge for pilot sites for shorter HIV testing algorithm	Health Equipment						
	Pipettor for pilot sites for shorter HIV testing algorithm	Health Equipment						

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	Rotator for pilot sites for shorter HIV testing algorithm	Health Equipment						
	c. procurement of supplies for pilot sites for shorter HIV testing algorithm	Health Products-Testing						
	Support for mobile HCT for pilot sites for shorter HIV testing algorithm							
	=> procurement of instruments, furniture	Infrastructure	45	Php4,500,000.00				
	=> Support to mobile HCT operations	Planning and Administration	4	Php960,000.00	4	Php960,000.00	4	Php960,000.00
	Close monitoring for implementation	Monitoring and Evaluation	3 pax	Php41,960.00	3 pax	Php41,960.00	3 pax	Php41,960.00
Activity #2	Provide free baseline CD4 to indigent patients							
	1. Advocate for the expansion of OHAT to include baseline CD4							
	2. Free baseline CD4 testing	Health Products-Reagents	5,000	Php7,500,000.00	5,000	Php7,500,000.00	5,000	Php7,500,000.00
	3. Manpower augmentation to ensure access of CD4 including partnership with CBOs	Human Resources	20	Php6,000,000.00	20	Php6,000,000.00	20	Php6,000,000.00
	4. Procurement of CD4 machine	Health Equipment	20	Php11,000,000.00	20	Php20,000,000.00		
	5. Procurement of CD4 reagents	Health Products-Reagents	5,000	Php7,500,000.00	5,000	Php7,500,000.00	5,000	Php7,500,000.00
Activity #3	Establish partnership between private testing facility and CBO							
	1. Development of Standard Operation Procedure	Planning and Administration	30 pax	Php54,000.00	30 pax	Php54,000.00	30 pax	Php54,000.00
	2. Consultation meeting with CBOs and private testing facility	Planning and Administration	40 pax	Php72,000.00	40 pax	Php72,000.00	40 pax	Php72,000.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Indicator 1.14: No. & Percent (%) of HIV-positive pregnant women who received ARV according to the national guidelines								
Activity 1:	Training of Treatment Hubs on PMTCT including Reproductive Health needs, ARV treatment guidelines and adherence	Training		Php349,666.67		Php349,666.67		Php349,666.67
Activity 2:	Development of IEC materials specific for HIV positive women on PMTCT	Training	50 pax	Php349,666.67	50 pax	Php349,666.67	50 pax	Php349,666.67
Indicator 1.15: No. & Percent (%) of adults and children enrolled in ART who are adherent by ARV pick-up (EWI)								
Activity 1:	Training on support and Adherence Counseling	Training	50 pax	Php919,240.00	50 pax	Php919,240.00	50 pax	Php919,240.00
Activity 2:	Manpower augmentation including partnership with CBOs	Human Resources	50 SIO	Php9,000,000.00	50 SIO	Php9,000,000.00	50 SIO	Php9,000,000.00
Activity 3:	Development of IEC materials on positive living	Planning and Administration	30 pax	Php54,000.00	30 pax	Php54,000.00	30 pax	Php54,000.00
Activity 4:	Technical Assistance for PSM Strengthening of Procurement Supply Management Chain from National to Treatment Hub	Planning and Administration			1	Php510,000.00		
Activity 5:	Procurement of ARV drugs	Pharmaceutical Products (Drugs/Medicines)						
	ARV drugs	Pharmaceutical Products (ARV Drugs/Medicines)	22,256	Php189,868,664.62	32,443	Php 542,940,056.25	37,735	Php688,901,200.15
Activity 6:	Augmentation staff for prevention activities	Human Resources	2 pax	Php1,128,000.00	2 pax	Php1,128,000.00	2 pax	Php1,128,000.00
Activity 7:	Procurement of Viral load reagents (for monitoring)	Health Products-Reagents	4451 PLHIV	Php26,706,000.00	5168 PLHIV	Php31,008,000.00	5833 PLHIV	Php34,998,000.00
Activity 8:	Procurement of reagents for Drug resistance study	Health Products-Reagents	1112 PLHIV	Php8,896,000.00	1292 PLHIV	Php10,336,000.00	1458 PLHIV	Php11,664,000.00
Activity 9:	Facility enhancement (space conducive for counseling)	Infrastructure	25	Php12,500,000.00	25	Php12,500,000.00	25	Php12,500,000.00
Activity 10:	Develop system to remind clients on the timely pick up of ARV	ACSM	50 pax	Php349,666.67	50 pax	Php349,666.67	50 pax	Php349,666.67

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	1. Meeting with the community (PLHIV)	Planning and Administration	30 pax	Php54,000.00	30 pax	Php54,000.00	30 pax	Php54,000.00
	2. Use of technology (SMS, emails, social media, phone apps)	ACSM	25	Php360,000.00	25	Php360,000.00	25	Php360,000.00
Activity 11:	Treatment Hub Conference	Training	50 pax	Php993,253.33	50 pax	Php993,253.33	50 pax	Php993,253.33
Activity 12:	Set up additional satellite treatment hub							
	a. Mapping of SHC or facility to be come satellite treatment hub	Planning and Administration	3 pax	Php125,880.00	3 pax	Php125,880.00	3 pax	Php125,880.00
	b. Training of additional satellite treatment hub on ARV and Data management	Training	30 pax	Php523,152.00	30 pax	Php523,152.00	30 pax	Php523,152.00
	c. Support to Operations	Planning and Administration	6	Php240,000.00	6	Php240,000.00	6	Php240,000.00
Activity 13:	Establishment/Strengthen of local KP specific support group among PLHIV toward healthier positive living							
	a. Meeting with PLHIV community	Planning and Administration	30 pax	Php24,000.00	30 pax	Php24,000.00	30 pax	Php24,000.00
	b. Training orientation on formation of support group	Training	30 pax	Php523,152.00	30 pax	Php523,152.00	30 pax	Php523,152.00
Activity 14:	Integrate/Strengthen PLHIV peer approach in the provision of psychosocial services and support to adherence and partner disclosure in the treatment hub (GIPA - MIPA)							
	1) Capability building of PLHIV Peer Educators / Site Implementation Officer / Care Managers	Training	50 SIO	Php871,920.00	50 SIO	Php871,920.00	50 SIO	Php871,920.00
	a) HIV treatment and literacy training including ARV adherence							
	b) Home-based care training							
	c) Psychosocial Support for PLHIV							

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	2 Recruitment, selection and hiring of qualified PLHIV peer educators & peer educator supervisors / SIO							
	3 Regular meetings of peer educators and Treatment Hub	Planning and Administration	25	Php180,000.00	25	Php180,000.00	25	Php180,000.00
	4 Peer education activities and outreach for PLHIV including provision of psychosocial support and home visits and fit-up of clients	Human Resources						
	Confirmatory reagents for HIV Diagnosis	Health Products-Reagents	9,000.00	Php27,000,000.00	9,000.00	Php27,000,000.00	9,000.00	Php27,000,000.00
	Parallel testing with new algorithm	Health Products-Testing	9,000.00	Php8,100,000.00	9,000.00	Php8,100,000.00	9,000.00	Php8,100,000.00
	Additional 7 RMT for SLH-SACCL Laboratory package based on ART guidelines (pre-ART)	Human Resources	7	Php1,890,000.00	7	Php1,890,000.00	7	Php1,890,000.00
	CBC							
		Health Products-Reagents	4,000.00	Php1,400,000.00	4,000.00	Php1,400,000.00	4,000.00	Php1,400,000.00
	TB Screening	Health Products-Reagents	4,000.00	Php4,557,160.00	4,000.00	Php4,557,160.00	4,000.00	Php4,557,160.00
	Pregnancy Test	Health Products-Reagents	4,000.00	Php640,000.00	4,000.00	Php640,000.00	4,000.00	Php640,000.00
	Hepatitis B Screening	Health Products-Reagents	4,000.00	Php1,200,000.00	4,000.00	Php1,200,000.00	4,000.00	Php1,200,000.00
Activity 15:	Provision of Enablers fund to support for Laboratory needs	Living Support to Clients/Target Population / HR	2685 PLHIV	Php6,713,000.00	717 PLHIV	Php1,792,000.00	665 PLHIV	Php1,662,500.00
	Monitoring laboratory diagnostics package	Health Products-Reagents	20,030	Php250,099,574.40	23,256	Php290,374,416.00	26,249	Php327,738,771.00
Activity 16:	Vaccines for PLHIV							
	1) Hepatitis B vaccine: Php30/dose assumption: ,	Pharmaceutical Products (Drugs/Medicines)	4,500	Php405,000.00	4,500	Php405,000.00	4,500	Php405,000.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	2) Flu vaccine: Php170/dose;	Pharmaceutical Products (Drugs/Medicines)	20,030	Php10,215,504.00	23,256	Php11,860,560.00	26,249	Php13,386,735.00
	3) Pneumococcal	Pharmaceutical Products (Drugs/Medicines)	17,805	Php6,463,142.40	7,681	Php2,788,130.40	9177.6	Php3,331,468.80
	4) HPV vaccine for female PLHIV	Pharmaceutical Products (Drugs/Medicines)			500.00	Php2,250,000.00	500.00	Php2,250,000.00
	Development of National guidelines on administration of HPV vaccine consultation meetings and finalization	Planning and Administration	3.00	Php72,000.00	2.00	Php48,000.00		
Activity 17:	Prophylaxis for PLHIV	Pharmaceutical Products (Drugs/Medicines)				Php0.00		Php0.00
	Cotrimoxazole Preventive Therapy Package:	Pharmaceutical Products (Drugs/Medicines)	3,338	Php2,450,385.60	3,876	Php2,844,984.00	4,375	Php3,211,066.50
	Hepatitis C	Pharmaceutical Products (Drugs/Medicines)	317	Php31,707,720.00	380	Php38,019,960.00	454	Php45,429,120.00
	TB treatment	Pharmaceutical Products (Drugs/Medicines)	6,677	Php24,036,480.00	7,752	Php27,907,200.00	8,750	Php31,498,200.00
Indicator 1.20 No. & Percentage of HIV-positive patients who were screened for TB				Php82,804,320.10		Php89,126,507.70		Php95,443,800.20
Activity #1	Collaboration with TB program			c/o TB		c/o TB		c/o TB
Activity #2	Training on OI management including screening for OIs	Training		c/o TB		c/o TB		c/o TB
	a. Update and disseminate guidelines on management of Opportunistic Infections			c/o TB		c/o TB		c/o TB
Activity #3	Procurement of OI drugs other than for TB							

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	Procurement of valgancyclovir (induction)	Pharmaceutical Products (Drugs/Medicines)	4200 tab/s	Php51,397,500.00	4200 tab/s	Php51,397,500.00	4200 tab/s	Php51,397,500.00
	Procurement of Ganciclovir: Intravitreal Injection: 0.1 cc/injection (1 vial=10ml)	Pharmaceutical Products (Drugs/Medicines)	100 patient/s	Php376,194.00	100 patient/s	Php376,194.00	100 patient/s	Php376,194.00
	Procurement of valgancyclovir (maintenance)	Pharmaceutical Products (Drugs/Medicines)	600 tab/s	Php7,342,500.00	600 tab/s	Php7,342,500.00	600 tab/s	Php7,342,500.00
	Fluconazole 200mg, tablet or capsule	Pharmaceutical Products (Drugs/Medicines)	36000 tab/s	Php3,455,280.00	36000 tab/s	Php3,455,280.00	36000 tab/s	Php3,455,280.00
	Fluconazole 200mg, tablet or capsule	Pharmaceutical Products (Drugs/Medicines)	5600 tab/s	Php537,488.00	5600 tab/s	Php537,488.00	5600 tab/s	Php537,488.00
	Amphotericin B	Pharmaceutical Products (Drugs/Medicines)	50 patient/s	Php2,100,000.00	50 patient/s	Php2,100,000.00	50 patient/s	Php2,100,000.00
	Clarithromycin 500 mg	Pharmaceutical Products (Drugs/Medicines)	2003 patient/s	Php420,638.40	2326 patient/s	Php488,376.00	2625 patient/s	Php551,218.50
Activity #5	PLHIV diagnosis TB annual screening	Health Products-Reagents	13730 patient/s	Php15,642,451.70	18730 patient/s	Php21,338,901.70	23730 patient/s	Php27,035,351.70
Activity #6	Procurement of INH for IPT	Pharmaceutical Products (Drugs/Medicines)	8238	Php1,532,268.00	11238	Php2,090,268.00	14238	Php2,648,268.00
Indicator 1. 21 No. & Percent (%) of treatment hubs that report they are able to successfully follow-up with HIV patients within one month of a missed appointment				Php9,159,876.67		Php11,159,876.67		Php12,663,250.00
Activity #1	Provision of Enablers fund to support home visits	Living Support to Clients/Target Population / HR	1373 patient/s	Php5,492,000.00	1873 patient/s	Php7,492,000.00	2373 patient/s	Php9,492,000.00
Activity #2	Project Aide for treatment hubs (To assist TH in the management of ARVs)	Technical Assistance	10	Php2,700,000.00	10	Php2,700,000.00	10	Php2,700,000.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Activity #3	Training of Trainers in the conduct of LGS	Training	50 pax	Php496,626.67	50 pax	Php496,626.67		Php0.00
Activity #4	Conduct of LGS in treatment hubs	Planning and Administration	15	Php371,250.00	15	Php371,250.00	15	Php371,250.00
Activity #5	Provision of Tents for Treatment hubs with no adequate venue for LGS	Infrastructure	5	Php100,000.00	5	Php100,000.00	5	Php100,000.00
Strategy 2: Health Promotion and Communication on HIV and STI prevention and care services				Php77,196,646.11		Php23,035,334.72		Php20,267,291.02
Indicator 2.1 Number of accessible BCC tools and distributed materials that help generate demand for STI and HIV services				Php70,115,938.99		Php10,962,066.64		Php9,960,800.70
Activity #1	National Communication Plan (NCP)	Advocacy, Communication and Social Mobilization						
	CORE Plan Design	ACSM						
	TA Provider: CORE Plan	ACSM		Php2,520,411.84		Php0.00		Php0.00
	CORE Plan Implementation Reviews	ACSM		Php0.00		Php18,800.00		Php18,800.00
	TA Provider: CORE Plan Evaluation	ACSM		Php0.00		Php0.00		Php1,169,992.22
	CORE Plan Promotion	ACSM						
	Outdoor Brand Visibility	ACSM		Php11,160,000.00		Php0.00		Php0.00
	Tri-Media Launch Campaign	ACSM		Php44,120,000.00		Php0.00		Php0.00
	Tri-Media Sustaining Campaign	ACSM		Php0.00		Php4,100,000.00		Php4,100,000.00
	PSA on Government Broadcast	ACSM		Php0.00		Php72,100.00		Php0.00
	PSA on Private Sector Broadcast	ACSM		Php0.00		Php130,100.00		Php0.00
Activity# 2	ICT-Based BCC Tools	ACSM						
	National Fixed-Line Info Service	ACSM						
	TA Provider: Systems Development	ACSM		Php689,553.86		Php0.00		Php0.00
	Training: Help Line Personnel	ACSM		Php59,700.00		Php0.00		Php0.00
	Launch Advisory Cascade	ACSM		Php197,400.00		Php0.00		Php0.00
	Updates: Help Line Info Book	ACSM		Php14,800.00		Php14,800.00		Php14,800.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	National Mobile SMS Info Service	ACSM						
	TA Provider: Technology Development	ACSM		Php0.00		Php1,149,256.44		Php0.00
	Launch Advisory Cascade	ACSM		Php0.00		Php197,400.00		Php0.00
	Smartphone Application Info Service	ACSM						
	TA Provider: Technology Development	ACSM		Php0.00		Php0.00		Php1,149,256.44
	Launch Advisory Cascade	ACSM		Php0.00		Php0.00		Php188,300.00
	Web-based Info Resource Portals	ACSM						
	TA Provider: Systems Development	ACSM		Php965,842.49		Php0.00		Php0.00
	Training: CMS Co-Managers	ACSM		Php46,200.00		Php0.00		Php0.00
	Launch Advisory Cascade	ACSM		Php0.00		Php0.00		Php0.00
	Updates: Portals CMS	ACSM		Php46,200.00		Php46,200.00		Php46,200.00
	BCC Materials for Info Services	ACSM						
	KISS Materials Production	ACSM						
	TA Provider: Materials Development	ACSM		Php1,706,360.04		Php0.00		Php0.00
	KISS Production (Initial)	ACSM		Php7,533,000.00		Php2,486,000.00		Php531,000.00
	KISS Production (Replenishment)	ACSM		Php0.00		Php1,966,500.00		Php1,966,500.00
	KISS Packages Distribution	ACSM						
	Strategy Meeting: Distribution Agents	ACSM		Php816,000.00		Php0.00		Php0.00
	KISS Delivery (Initial)	ACSM		Php240,470.76		Php614,811.84		Php609,853.68
	KISS Delivery (Replenishment)	ACSM		Php0.00		Php166,098.36		Php166,098.36
	Indicator 2.2: Number of advocacy events conducted that help generate demand for STI and HIV services			Php1,160,980.00		Php4,848,877.76		Php3,548,100.00
Activity #1	Media and Digital Advocacy	ACSM						
	CHARMS Initiative	ACSM		Php0.00				Php0.00
	TA Provider: Systems Development	ACSM		Php0.00		Php977,657.76		Php0.00
	Training: CHARMS Spokespersons	ACSM		Php0.00		Php518,400.00		Php0.00
	CHARMS Anchor Publicity	ACSM						
	National Publicity Events	ACSM		Php240,000.00		Php268,800.00		Php268,800.00
	Press Briefings and Advisories	ACSM		Php35,000.00		Php47,800.00		Php47,800.00
	Citizens Content Generation	ACSM		Php0.00		Php118,400.00		Php118,400.00
	Citizens Content Monitoring	ACSM		Php0.00		Php114,400.00		Php118,400.00
Activity #2	Community-Based Advocacy	ACSM						
	Support to LGU Mobilization	ACSM		Php183,380.00		Php424,820.00		Php616,100.00
	Local Social Mobilization Visuals	ACSM		Php0.00		Php997,600.00		Php997,600.00
	Local Social Mobilization Visibility							

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	Training: CSO Media Engagement	ACSM		Php0.00		Php464,000.00		Php464,000.00
	Support to CSO Event Participation	ACSM		Php0.00		Php464,000.00		Php464,000.00
Activity #3	Private Health Sector Advocacy							
	Medical and Health Professionals	ACSM						
	Strategy Meeting: Professionals' Agenda	ACSM		Php34,600.00		Php0.00		Php0.00
	Policy Meeting: Health Professionals	ACSM		Php0.00		Php271,800.00		Php271,800.00
	Medical and Health Institutions	ACSM						
	Strategy Meeting: Entrepreneurs' Agenda	ACSM		Php34,600.00		Php0.00		Php0.00
	Policy Meeting: Health Entrepreneurs	ACSM		Php0.00		Php181,200.00		Php181,200.00
	Indicator 2.3 Number of public and private, national and local health facilities competent on STI and HIV information services			Php5,919,727.12		Php7,224,390.32		Php6,758,390.32
Activity #1	Health Facility Info Services							
	Info Services Programming			Php1,319,813.56		Php534,800.00		Php534,800.00
	TA Provider: Program Development			Php624,013.56		Php0.00		Php0.00
	Training: Info Services Trainers			Php695,800.00		Php534,800.00		Php534,800.00
	Info Services Competence Building			Php1,640,050.00		Php1,756,400.00		Php1,749,000.00
	Training: Health Facility Info Services			Php358,900.00		Php917,600.00		Php910,200.00
	Training: CBOs and Support Groups			Php1,258,200.00		Php838,800.00		Php838,800.00
	Strategy Meeting: Family Health Guides			Php22,950.00		Php0.00		Php0.00
Activity #2	Human Development Convergence							
	SPARK Initiative			Php0.00		Php1,320,995.16		Php0.00
	TA Provider: Systems Development			Php0.00		Php404,795.16		Php0.00
	Policy Meeting: Local Governance			Php0.00		Php169,000.00		Php0.00
	Training: RAAT Social Marketing			Php0.00		Php747,200.00		Php0.00
	SPARKLE Initiative			Php0.00		Php0.00		Php1,095,395.16
	TA Provider: Systems Development			Php0.00		Php0.00		Php588,395.16
	Policy Meeting: Social Welfare			Php0.00		Php0.00		Php169,000.00
	Policy Meeting: Education			Php0.00		Php0.00		Php169,000.00
	Policy Meeting: Labor and Employment			Php0.00		Php0.00		Php169,000.00
	Strategy # 3: Enhanced Strategic Information Systems			Php78,384,924.00		Php52,245,984.00		Php67,341,124.00
	Indicator 3.1: Number (#) of surveillance sites utilizing IHBSS data through local dissemination forums	Research and Surveillance		Php27,877,184.00		Php9,000,000.00		Php27,877,184.00
Activity #1	Implement surveillance activities							

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	1.1 IBSS							
	1.1.1 Revision of protocol, tools, and training design to be used in the IBSS			Php15,000,000.00				Php15,000,000.00
	1.1.2 Training of Trainers, Orientation on Mapping, Team preparation						21 IBSS sites	
	1.1.3 Data Collection (Field Work)							
	1.1.4 Data Encoding and Processing							
	1.1.5 Development of In-Depth Analysis Protocol and Training Design			Php472,000.00				Php472,000.00
	1.1.6 Training on In-Depth Data Analysis			Php415,184.00				Php415,184.00
	1.1.7 Data Analysis			-				-
	1.1.8 Publication of factsheets and report			Php60,000.00				Php60,000.00
	1.1.9 National dissemination forum			Php930,000.00				Php930,000.00
	1.2 DOH EB Support to SACCL for surveillance activities			Php11,000,000.00		Php9,000,000.00		Php11,000,000.00
	Indicator 3.2: Number (#) of Annual Reports prepared and submitted by DOH and PNAC to appropriate National and International Agencies	Monitoring and Evaluation		Php8,884,200.00		Php5,884,200.00		Php5,884,200.00
	1.3 AIDS Registry (Form A, B, D)							
	1.3.1 Revision of Form Guidelines & Training Design (Form B)				Form A: All Public and Private Facilities			
	1.3.2 Orientation and dissemination of guidelines			Php214,800.00		Php214,800.00		Php214,800.00
	1.3.3 Data Collection from reporting units to DOH EB		Form B: (1) Treatment Hubs, (2) Major Hospitals in NCR		Form B: (1) Treatment Hubs, (2) Major Hospitals in NCR			
	1.3.4 Data Processing & Analysis							
	1.3.5 Publication of Monthly & Annual HIV AIDS Registry and Annual HIV Program Reports (HIV Cascade)		Form D: All Public and Private Facilities	Php12,500.00		Php12,500.00		Php12,500.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	1.4 SESS/SDSS							
	1.4.1 Revision of Protocol, Tools, and Training Design							
	1.4.2 Orientation and dissemination of guidelines			Php214,800.00		Php214,800.00		Php214,800.00
	1.4.3 Data Collection from reporting units to RESU		SSESS: 50 SHCs		SSESS: 60SHCs			
	1.4.4 Data Collection from RESU to EB		SDSS: All public and private facilities		SDSS: All public and private facilities			
	1.4.5 Data Processing & Analysis							
	1.4.6 Publication of Quarterly & Annual SSESS and SDSS Report			Php12,500.00		Php12,500.00		Php12,500.00

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
Activity #3	3.1 UIC							
	3.1.1 Orientation and dissemination of guidelines			Php214,800.00		Php214,800.00		Php214,800.00
	3.1.2 Data Collection from reporting units to EB						(1) SHCs supported by GF-NFM, (2) Other SHCs	
	3.1.3 Data Processing & Analysis							
	3.2 Submission of Annual HIV Program Report to NASPCP							
	3.3 Technical Support			Php5,000,000.00		Php2,000,000.00		Php2,000,000.00
	3.4 Development of National M&E System							
	3.5 Technical Assistance			Php214,800.00 Php3,000,000.00		Php214,800.00 Php3,000,000.00		Php214,800.00 Php3,000,000.00
Indicator 3.3: Number (#) of high-risk sites with MARP estimates and local map of HIV hotspots				Php 0.00		Php 5,724,984.00		Php 0.00
Activity #4	Implement activities related to estimates and projections							
	4.1 Rapid Assessment of HIV Vulnerability (RAV)						21 C-45 sites not included in the IHBSS, 40 ROTC	
	4.1.1 Revision of Protocol, Tools, and Training Design					Php3,840,000.00		
	4.1.2 Training of Trainers, Team preparation						sites, 4 sites per region	
	4.1.3 Data Collection (Field Work)							
	4.1.4 Data Processing							
	4.1.5 Data Analysis							
	4.1.6 Publication of factsheets							
	4.1.7 Integration in the MARP Size Estimates Report							
	4.2 AEM, EPP Spectrum							
	4.2.1 Hiring of international consultant for training					Php157,000.00		
	4.2.2. Hiring of documentor					Php425,000.00		
	4.2.3 Training on the AEM and EPP Spectrum					Php1,073,184.00		
	4.2.4 Collection of relevant data						National and Sub-epidemic models	

STRATEGY	ACTIVITY	COST CATEGORY	2015		2016		2017	
			TARGET	BUDGET REQ.	TARGET	BUDGET REQ.	TARGET	BUDGET REQ.
	4.2.5 Data Processing							
	4.2.6 Data Interpretation & Analysis							
	4.2.7 Consultation and Consensus Workshops					Php219,800.00		
	4.2.8 Publication of PLHIV Estimates Report					Php10,000.00		
	4.2.9 Dissemination of Report							
	Indicator 3.4: Number (#) of special studies conducted			Php21,875,600.00		Php21,100,000.00		Php21,875,600.00
	Activity #5							
	Implement special studies							
	5.1 Ethnographic Behavioral Survey among MSM					Php2,300,000.00		
	5.2 Bed Assay			Php75,600.00				Php75,600.00
	5.3 Viral Load Suppression/Drug Resistance Studies			Php2,800,000.00		Php2,800,000.00		Php2,800,000.00
	5.4 Special Surveillance of STI (Multiplex)			Php2,000,000.00		Php2,000,000.00		Php2,000,000.00
	5.5 Link of knowledge and behavior outcomes for 15-24yo							
	5.6 Prevalence of different sub-types of HIV			Php3,000,000.00				Php3,000,000.00
	5.7 DOH EB Support to RITM			Php4,000,000.00		Php4,000,000.00		Php4,000,000.00
	5.8 PreP			Php10,000,000.00		Php10,000,000.00		Php10,000,000.00
Indicator 3.5: Percentage (%) of LGUs with Local AIDS plans and programs guided by up to date IHBSS, RAV, and Special Studies				Php4,800,000.00		Php4,800,000.00		Php4,800,000.00
Activity #6	Implement data utilization activities in sites							
	6.1 Conduct local dissemination forums for IHBSS, AIDS Registry, SSES/SDSS, RAV and other surveillance data		21 IHBSS sites	Php4,800,000.00		21 IHBSS sites		Php4,800,000.00
	6.2 Develop LGU Data Utilization Scorecards		IHBSS			IHBSS		
	6.2.1 Develop LGU data utilization tools		Factsheets: 21 IHBSS sites, MARP Size Estimates: (1) 21 IHBSS			Factsheets: 21 IHBSS sites, MARP Size Estimates: (1) 21 IHBSS		
	6.2.2 Orientation and dissemination of guidelines to LGUs							

	6.4.1.b. Orientation and dissemination of guidelines		clinics in selected NCR and Cebu sites	Php214,800.00	selected NCR and Cebu sites		selected NCR and Cebu sites	
	6.4.1.c. Data Collection from reporting units to EB							
	6.4.1.d. Data validation of reporting facilities			Php64,000.00			Php64,000.00	
	6.4.1.d. Data Processing & Analysis							
	6.4.1.e. Disseminate PMTCT information to NASPCP and other concerned agencies							
	6.4.2 Monitoring of PMTCT treatment and care services							
	6.4.2.a. Development of Protocol, Tools, and Training Design (Pregnant PLHIV and infant)		Pilot antenatal clinics in selected NCR and Cebu sites		Antenatal clinics in selected NCR and Cebu sites			
	6.4.2.b. Orientation and dissemination of guidelines			Php214,800.00				
	6.4.2.c. Data Collection from reporting units to EB							
	6.4.2.d. Data Processing & Analysis							
	6.4.2.e. Disseminate PMTCT information to NASPCP and other concerned agencies							
STRATEGY	ACTIVITY	COST CATEGORY	TARGET	2015 BUDGET REQ.	TARGET	2016 BUDGET REQ.	TARGET	2017 BUDGET REQ.
	6.5 Development of electronic health information system in treatment hubs							
	6.5.1 Development of electronic health information system software, including medical records, appointment system, notification system (e.g. automatic SMS message to client for follow-up visits), referral system, and report modules			Php5,000,000.00				
	6.5.2 Provision of computer units and LAN equipment			Php1,500,000.00				
	6.5.3 Revision of ART Protocol & Training Design to include electronic health information system		Treatment and Satellite Hubs		Treatment and Satellite Hubs			

	6.5.4 Training of HIAT in software usage			Php 899,400.00				
	6.5.5 Data Processing in treatment hubs							
	6.5.6 Data Analysis in EB							
	6.5.7 Publication of Monthly & Annual HIV AIDS Registry and Annual HIV Program Reports (HIV Cascade)							
	6.6 TB-HIV Reporting							
	6.6.1 Revision of TB-HIV Program Protocol & Training Design	Treatment and Satellite Hubs			Treatment and Satellite Hubs			
	6.6.2 Orientation and dissemination of guidelines			Php 214,800.00				
	6.6.3 Data Collection from treatment hubs to NEC							
	6.6.4 Data Processing & Analysis							
	6.6.5 Disseminate TB-HIV information to NASPCP and other concerned agencies							
	6.7 Program Implementation Review (NASPCP)	16 Regional HIV/STI Program		Php3,000,000.00	16 Regional HIV/STI Program	Php3,000,000.00		Php3,000,000.00
STRATEGY	ACTIVITY	COST CATEGORY	TARGET	2015 BUDGET REQ.	TARGET	2016 BUDGET REQ.	TARGET	2017 BUDGET REQ.
Strategy # 4: Strengthened Health System Platform for Broader Health Outcomes								
Indicator 4.1: Number (#) of policies developed								
Activity #1	Development of policy/guidelines/standards*							
	1.1 Consultation meeting with stakeholders	30		Php3,553,200.00	30	Php3,553,200.00	30	Php3,553,200.00
	1.2 Drafting/ Finalize/Package/Submission of policy/guideline/standard	3		Php774,000.00	3	Php774,000.00	3	Php774,000.00
	1.3 Policy forum to present and validate draft							
	1.4 Signing/approval of policy/guideline	30		Php2,967,300.00	30	Php2,967,300.00	30	Php2,967,300.00

	1.5 Dissemination Forum on policy on strengthened health system platform for broader health outcomes		60	Php2,044,800.00	60	Php2,044,800.00	60	Php2,044,800.00
Activity #2	Updating/strengthening of existing policies/guidelines**							
	2.1 Consultative Meeting and Workshop with HIV TWG to review existing policies and guidelines	15		Php298,399.80	15 pax (TWG) x 1 policies	15 pax (TWG) x 1 policies		Php298,399.80
	2.3 Drafting of revised policy				1 policy	1 policy		
	2.4 Disseminate via email for feedback				1 policy	1 policy		
	2.5 Finalize revised policy				1 policy	1 policy		
	2.6 Signing/approval of revised policy				1 policy	1 policy		
	2.7 Dissemination forum on Updating/strengthening of existing policies/guidelines	30			2 forum	1 forum		
Indicator 4.2: Number (#) and Percentage (%) of LGUs with functional local coordinating body (category A and B)								
Activity #3	Organization and Strengthening of LAC which includes a local community organization as an active member through an ordinance							
	3.1 Stakeholders Forum on HIV & AIDS	45		Php5,728,725.00	45	Php5,728,725.00	45	Php5,728,725.00
STRATEGY	ACTIVITY	COST CATEGORY	2015	2016	2017	BUDGET REQ.	TARGET	BUDGET REQ.
	3.1.1 Mapping of existing CBOs, CSOs and PLHIV support groups in the locality							
	3.1.2 Forum to introduce the work/activities of CBOs/CSOs/PLHIV groups	1 forum/area x 12 areas						
	3.1.3 Action planning that would operationalize involvement of CBOs/CSOs/PLHIV groups in the local HIV response							
	3.1.4 Formalization of the new LAC or inclusion of the CBO in the existing LAC for strengthening							

	3.2. Establishment of MOUs between LGU and CBO/CSO/PLHIV group		4 meetings x 15 pax		1 meeting per area at 4 areas			
			45 MOU		10 MOU			
			45 MOU		4 meetings x 15 pax at 10 areas			
	3.3 Conduct LAC meetings regularly		4 Meetings x 15 pax/area with 45 areas		4 meetings x 15 pax at 4 areas			
	3.4 Capacity building for Local community (CBO) to become champions of LAC		45	Php3,819,150.00				
Activity #4	Provincial/City LGUs –Private sectors partnership/collaboration to support HIV programs/plans in their localities (resource sharing and mobilization)		x12 areas	Php28,010,700.45		Php27,541,000.00		Php27,541,000.00
	4.1 Collaboration and partnership with local partners both private and government to map out available resources and planning for specific areas			Php470,700.45				
	4.1.1 Preparatory Meeting to establish/renew partnership and resource identification		1 meeting per area of 45		1 meeting per area of 4			
STRATEGY	ACTIVITY	COST CATEGORY	2015	2016	2017	BUDGET REQ.	TARGET	BUDGET REQ.
	4.1.2 Mapping and Planning Workshop for the local HIV program plan.	1 workshop x 25 pax x 2 days per area of 12					1 workshop x 25 pax x 2 days	
	4.2 Conduct local reviews			Php16,525,000.00		Php16,525,000.00		Php16,525,000.00
	4.3 Establish service delivery network with hospitals, clinics and laboratories, both private and government.	45		Php11,016,000.00		Php11,016,000.00	45	Php11,016,000.00
	4.3.1 Coordination and Partnership with professional societies on establishment of redress mechanism and enhance psycho-social support provision to PHIV	45		Php11,016,000.00		Php11,016,000.00	45	Php11,016,000.00

	4.3.2 Collaboration and Partnership with police, prison, drug rehabilitation centers in the local areas as maybe applicable to implement activities on HIV and STI prevention and continuum of care		45	Php22,032,000.00	1 mtg x 10 pax	Php22,032,000.00	45	Php22,032,000.00	
Indicator 4.3: Percentage of LGUs developing and implementing HIV-related stigma reduction policies and programs/activities (Category A and B)									
Activity # 5	5.1 LAC assessment and Planning for 45 sites	Planning and administration	45	Php19,139,400	1 workshop x 36 pax x 2 days	Php19,139,400		Php65,615,400.00	Php8,197,200.00
	5.2 Capacity Building based on the findings of the LAC assessment (HIV 101; Gender and Sexuality; M&E; PLHIV inclusive planning ; PLHIV Rights; Sensitive Communication) in C45 sites	Training	45	Php38,278,800.00	1 training x 36 pax/area x 3 days in 45 sites	Php38,278,800.00			
Activity #6	Organization and conduct of HIV and STI advocacy and stigma reduction activities			Php8,197,200		Php8,197,200.00			Php8,197,200
	6.1 Conduct advocacy activities with multisectoral participation	ACSM							
	6.1.1 Mapping of relevant service providers in the locality	Research and Surveillance	45	Php8,197,200	1 event x 2 x 45 sites	Php8,197,200.00			1 event x 2 x 45 sites Php8,197,200
STRATEGY	ACTIVITY	COST CATEGORY	2015 TARGET	2015 BUDGET REQ.	2016 TARGET	2016 BUDGET REQ.	2017 TARGET	2017 BUDGET REQ.	
	6.1.2 Advocacy and communication planning	Planning & administration							
	6.1.3 next steps	Planning and administration							
	6.1.4 documentation report	Planning and administration							
GRAND TOTAL INDICATIVE BUDGET			Php2,742,007,063.68		Php3,126,857,573.55		Php3,332,246,259.69		

ANNEX 7

Monitoring & Evaluation of the Philippine Health Sector's Strategic Plan for HIV 2015-2017

August 2015 Department of Health Manila, Philippines

Inputs for this document came from a series of consultations with different agencies and regional offices of the Department of Health, local government units, community based organizations, members of the Philippine National AIDS Council, development partners, and other multi-sectoral stakeholders that collaborate with the Department of Health in the country's health sector response to the HIV epidemic.

This document was written & edited by: Genesis May Samonte MD, Noel Palaypayon RN, Krizelle Anne

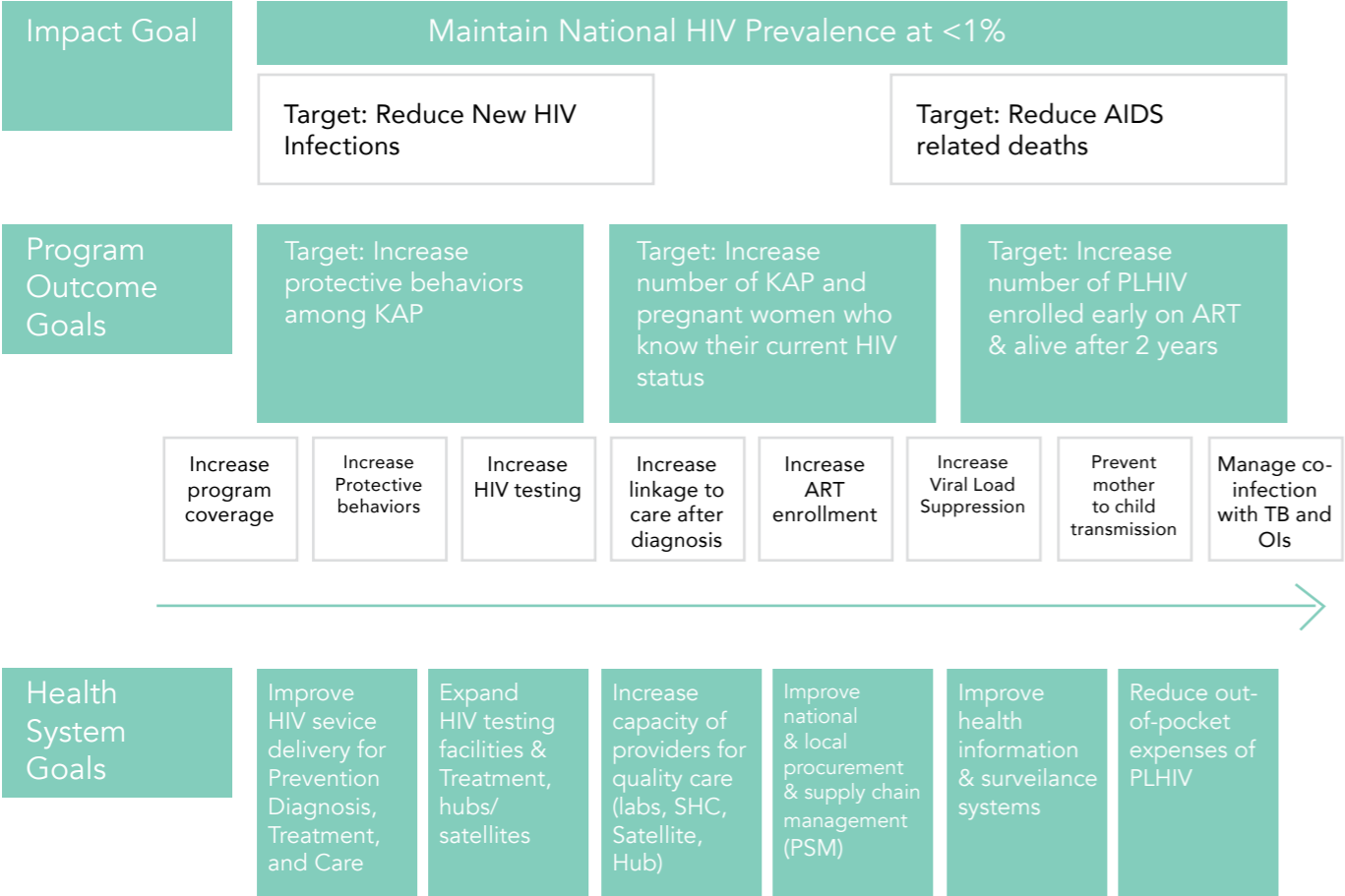
Health Sector Strategic Plan M&E Framework

The M&E plan for the Philippines' health sector response to HIV seeks to track the epidemic and the whole health system, as well as the health information system. It has the following objectives:

1. Measure the magnitude of the HIV situation in the Philippines;
2. Monitor the health sector's overall response to the HIV epidemic ;
3. Provide the necessary information for planning programs, improving health service delivery strategies, and health policy development; and,
4. Assess the different health information systems' performance in meeting the data needs of the health system.

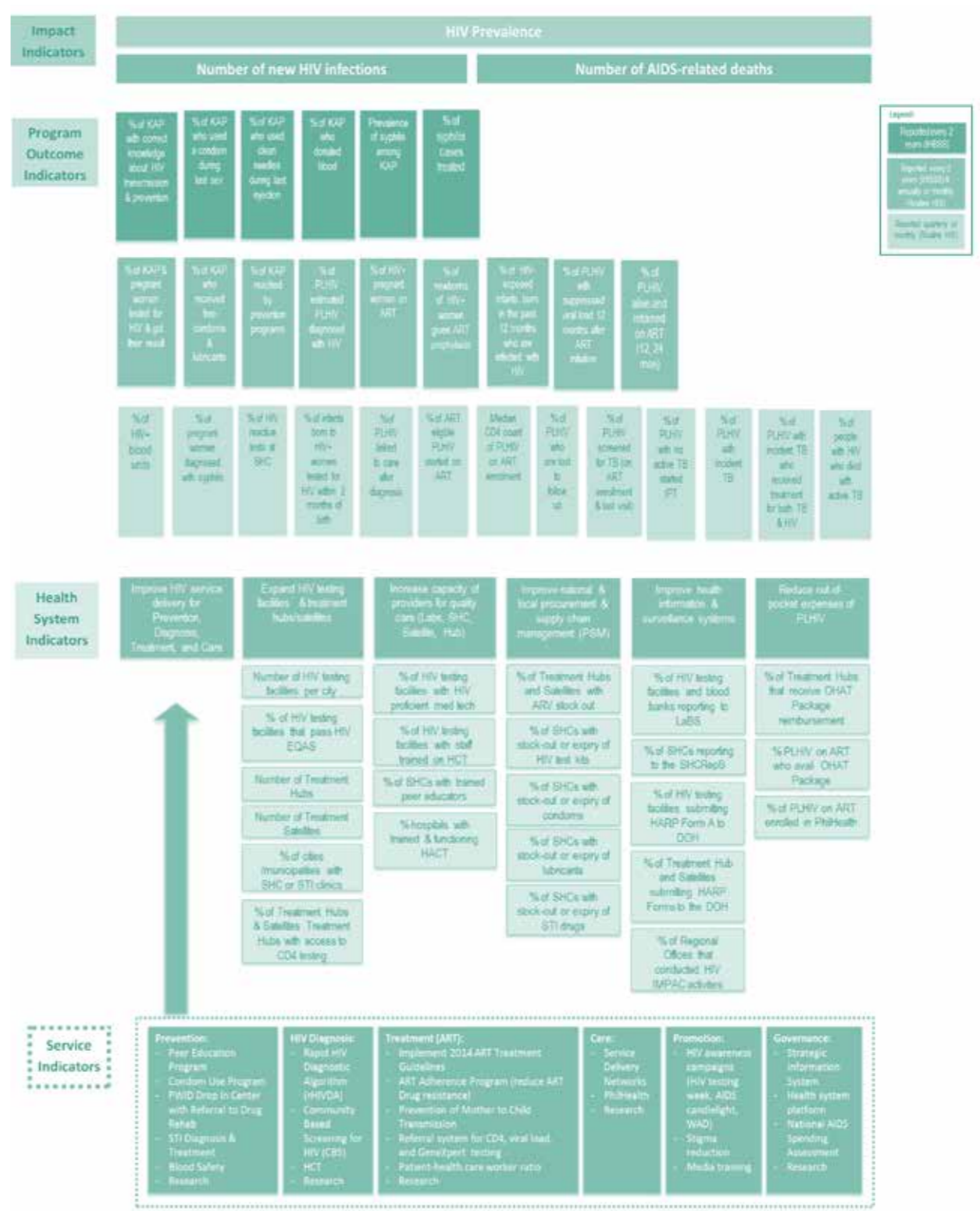
This M&E plan focuses on country goals set for 2015 to 2017, and has major three components: impact goals, program outcome goals, and health system strengthening goals (Figure 1).

Figure 1. Health Sector Strategic Goals for 2015-2017



The major indicators of the National Health Sector Strategic Plan for 2015 to 2017 are also divided into the three components: impact indicators, program outcome indicators and health system indicators (Figure 2).

Figure 2. National Health Sector Strategic Plan Indicators for 2015 - 2017



Note: Number of new HIV infections & number of AIDS-related deaths are not reported

The HSSP acknowledges that there may be local level, project specific, or special program indicators stemming from special activities or projects that aim to improve delivery of HIV prevention, HIV diagnosis, treatment, care, and health promotion services. These indicators may be specific to certain cities or projects only, or conducted as a special event or activity. In this document, these local level special activity or project specific indicators are labeled as Service Level Indicators. The specific Service Level Indicators can vary. Therefore, they are indicated with dashed lines in Figure 2, are not included in the list of national HSSP indicators, and therefore not discussed one by one in this document. Reporting to the Epidemiology Bureau of these Service Level Indicators may or may not be required but should be agreed upon prior to start of the activity or project.

The impact indicators are not directly measured in the Philippines (Table 1). Estimates from the country's EPP/Spectrum version 5.32 projections were used for these indicators. These estimates may change as new epidemiological information becomes available or newer versions of the EPP/Spectrum software are released by UNAIDS. Also, there are no set targets for the six impact indicators since these are modelled. The estimates of each impact indicator for 2015 to 2017 are shown in Table 1, assuming the current HIV prevalence and service coverage remain the same until 2017.

Table 1. List of Impact Indicators and their Estimates from 2014 to 2017

#	Impact Indicator	2014	2015	2016	2017
1	Percentage of Mother-to-Child transmission of HIV (modelled) N: Estimated number of children (0-14 years old) who will be newly infected with HIV by the end of the reporting year based on EPP/Spectrum projections D: Estimated number of HIV-positive women needing PMTCT by the end of the reporting year based on EPP/Spectrum projections	35.7% 105/294	34.4% 115/334	38.2% 153/401	34.5% 157/455
2	Estimated number of new HIV infections (modelled) Estimated number of people newly infected with HIV within the reporting year based on EPP/Spectrum	6,434	7,500	8,691	7,452
3	Estimated number of HIV related deaths (modelled) Estimated number of people infected with HIV who died due to HIV related causes within the reporting year based on EPP/Spectrum projections	480	425	410	386
4	Estimated number of people living with HIV (modelled) Estimated number of people living with HIV (PLHIV) by the end of the reporting year based on EPP/Spectrum projections	35,453	42,219	50,216	56,985
5	Estimated number of people living with HIV needing ART (modelled) Estimated number of PLHIV needing ART by the end of the reporting year based on EPP/Spectrum projections with the following eligibility assumptions: CD4 < 350 cells/μL starting year 2012 CD4 < 500 cells/μL plus all patients with TB starting year 2016	9,778	14,215	32,150	37,661
6	HIV Prevalence (modelled) Estimated national HIV prevalence of 15 to 49 year olds based on EPP/Spectrum projections	64 per 100,000	74 per 100,000	86 per 100,000	96 per 100,000

Source: EPP/Spectrum Estimates version 5.32 (Projection File: 20may2015 on ver5.32 8aug2015) This projection was based on prevalence data from 2013 & 2014, and ART data from 2014. The projection uses these numbers for the 2015 to 2017 estimates. If more recent data become available, succeeding estimates may change.

The major indicators of the National Health Sector Strategic Plan that will be monitored from 2015 to 2017 are listed in Tables 2 & 3, which also includes the definition of the indicator, its baseline, annual targets, data source and frequency of reporting. All baseline values were for year 2014 unless specified. Program Outcome Indicators are divided into the following categories: Prevention, HIV Diagnosis, Linked to Care, ART, TB-HIV, and PMTCT. Health System Indicators are divided into the following categories: Infrastructure, Health Human Resources (HR), Laboratory and Medical Products, Health Financing, and Health Information System (HIS).

Table 2. List of Program Outcome Indicators & their Baseline, Targets, Data Source & Frequency of Reporting

#	Category	Program Outcome Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency* of Reporting
1	Program Outcome: Prevention	Percentage of KAP reached* by prevention programs N: Number of individuals who received free condoms and received information about HIV prevention and transmission, and where to get tested during the reporting period D: Estimated number of key affected populations or Sampled KAP in the IHBSS Disaggregation: MSM, TGW, IDU, RFSW, FFSW *A KAP is counted as "reached" when he/she listened to an HIV information session and received free condoms. The information session can be conducted by a peer educator, SHC or health staff, health provider, CBO or NGO worker. The minimum topics of the information session should include HIV transmission & prevention, and where to get an HIV test.	MSM: 23% RFSW: 93% FFSW: 43% IDU: 33% (2013 IHBSS)	MSM: 80% RFSW: 80% FFSW: 80% IDU: 80%	MSM: 80% RFSW: 80% FFSW: 80% IDU: 80%	MSM: 80% RFSW: 80% FFSW: 80% IDU: 80%	N: SHC Reporting System (SHCRepS) D: Pop Size Estimates Or IHBSS	Monthly (P) Quarterly (N)
2	Program Outcome: Prevention	Percentage of KAP who received free condoms and lubricants N: Number of individuals who received free condoms from the Social Hygiene Clinic (facility or peer educators) during the reporting period D: Estimated number of key affected populations or Sampled KAP Disaggregation: MSM, TGW, IDU, RFSW, FFSW	MSM: 24% RFSW: 90% FFSW: 41% IDU: 24% (2013 IHBSS)	MSM: 60% RFSW: 60% FFSW: 60% IDU: 60%	MSM: 70% RFSW: 70% FFSW: 70% IDU: 70%	MSM: 80% RFSW: 80% FFSW: 80% IDU: 80%	N: SHCRepS D: Pop Size Estimates or IHBSS	Monthly (P) Quarterly (N)
3	Program Outcome: Prevention	Percentage of KAP with correct knowledge about HIV transmission and prevention N: Number of individuals who answered the five standard questions about HIV transmission and prevention correctly D: Number of KAP sampled Disaggregation: MSM, TGW, IDU, RFSW, FFSW	MSM: 35% RFSW: 47% FFSW: 21% IDU: 35% (2013 IHBSS)	MSM: 50% RFSW: 50% FFSW: 50% IDU: 50%		MSM: 70% RFSW: 70% FFSW: 70% IDU: 70%	IHBSS	Every 2 years
4	Program Outcome: Prevention	Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner N: Number of MSM who reported that a condom was used the last time they had anal sex D: Number of MSM who reported having anal sex with a male partner in the past 12 months	41% (2013 IHBSS)	80%		80%	IHBSS	Every 2 years
5	Program Outcome: Prevention	Percentage of FSW reporting the use of a condom with their most recent client N: Number of FSW who reported that a condom was used with their last client D: Number of FSW who reported having transactional sex with a client in the past 1 month	RFSW: 82% FFSW: 63% (2013 IHBSS)	RFSW: 80% FFSW: 80%		RFSW: 85% FFSW: 85%	IHBSS	Every 2 years
6	Program Outcome: Prevention	Percentage of IDU reporting the use of a condom the last time they had sex N: Number of IDU who reported that a condom was used the last time they had sex D: Number of IDU who reported having had sex (regardless of type of partner) in the past 12 months	13% (2013 IHBSS)	80%		80%	IHBSS	Every 2 years

*P – peripheral, N – national

#	Category	Program Outcome Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency* of Reporting
7	Program Outcome: <i>Prevention</i>	Percentage of IDU reporting the use of clean injecting equipment the last time they injected drugs N: Number of IDU who reported using a needle from a clean source and without sharing during their last injection in the past 6 months D: Number of IDU who reported injecting drugs in the past 6 months	31% (2013 IHBSS)	40%		60%	IHBSS	Every 2 years
8	Program Outcome: <i>Prevention</i>	Percentage of KAP who donated blood N: Number of KAP who reported donating blood D: Number of KAP sampled Disaggregation: MSM, TGW, IDU, RFSW, FFSW	MSM: 12% IDU: 14% RFSW: 4% FFSW: 3% (2011 IHBSS)	None		<10%	IHBSS	Every 2 years
9	Program Outcome: <i>Prevention</i>	Percentage of HIV positive blood units N: Number of donated blood units that are positive for HIV D: Total number of blood units donated during the reporting period	0.07%, 438/650,000 (NVBSP) Denominator is only initial data from NVBSP	None	0%	0%	NVBSP Reports	Annual
10	Program Outcome: <i>Prevention</i>	Percentage of pregnant women diagnosed with syphilis N: Number of pregnant women who tested positive for syphilis D: Number of pregnant women tested for syphilis	None. New indicator.	<1%	<1%	<1%	SHCRepS & Laboratory and Blood Bank Surveillance for HIV & STI (LaBS)	Monthly (P) Quarterly (N)
11	Program Outcome: <i>Prevention</i>	Prevalence of syphilis among KAP N: Number of KAP who tested positive for syphilis D: Number of sampled KAP tested Disaggregation: MSM, TGW, IDU, RFSW, FFSW	MSM: 1.95% RFSW: 0.83% FFSW: 3.18% IDU: 4.60% (2013 IHBSS)	MSM: <1.5% RFSW: <1.5% FFSW: <1.5% IDU: <1.5%		MSM: <1.5% RFSW: <1.5% FFSW: <1.5% IDU: <1.5%	IHBSS	Every 2 years
12	Program Outcome: <i>Prevention</i>	Percentage of syphilis cases treated N: Number of KAP and pregnant women who were treated for Syphilis D: Total number of KAP and pregnant women diagnosed with Syphilis during the reporting period Disaggregation: MSM, TGW, IDU, RFSW, FFSW, and pregnant women	Female: 93%, 28108/30129 Male: 96%, 2535/2628 (SESS, Disaggregation by KAP & pregnant women not available)	Female: 80% Male: 80%	Female: 80% Male: 80%	Female: 80% Male: 80%	SHCRepS	Monthly (P) Quarterly (N)

*P – peripheral, N – national

#	Category	Program Outcome Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency* of Reporting
13	Program Outcome: <i>HIV Diagnosis</i>	Percentage of KAP tested for HIV and got their results N: Number of KAP who got an HIV test and got their HIV test results (verbal results if screening is non-reactive; SACCL confirmatory results if screening is reactive), and received post-test counseling during the reporting period D: Estimated number of KAP D: Number of KAP sampled Disaggregation: MSM, TGW, IDU, RFSW, and FFSW	MSM: 74% of target in GF sites PWID: 90% of target in GF sites (July – Dec 2014 GF PUDR) IHBSS: 9% (MSM in the past 12 months); 5% (TGW); 7% (Male IDU); 6% (Female IDU)	MSM, RFSW, FFSW, IDU, TGW At least 40% (Natl) At least 60% (in Cat A & B areas)	MSM, RFSW, FFSW, IDU, TGW At least 60% (Natl) At least 80% (in Cat A & B areas)	MSM, RFSW, FFSW, IDU, TGW At least 60% (Natl) At least 80% (in Cat A & B areas)	SHCRepS	Monthly (P) Quarterly (N)
14	Program Outcome: <i>HIV Diagnosis</i>	Percentage of pregnant women tested for HIV and got their results (NCR and Cebu only) N: Number of pregnant women who got an HIV test and got their HIV test results (verbal results if screening is non-reactive; SACCL confirmatory results if screening is reactive), and received post-test counseling during the reporting period D: Estimated number of pregnant women	NCR: 40,091 (Total number tested) Cebu: 1,839 (Total number tested) No data available on got result	60%	80%	80%	N: SHCRepS & LaBS D: Estimates	Monthly (P) Quarterly (N)
15	Program Outcome: <i>HIV Diagnosis</i>	Percentage of HIV reactive tests at SHC N: Number of HIV reactive tests at the SHC (facility, mobile HCT, outreach) D: Total number tested at SHC (facility, outreach) during the reporting period	1 to 50%	>30%	>30%	>30%	LaBS	Monthly (P) Quarterly (N)
16	Program Outcome: <i>HIV Diagnosis</i>	Percentage of estimated PLHIV diagnosed with HIV N: Number of individuals who are confirmed as HIV positive by SACCL D: Estimated number of new HIV infections (EPP/Spectrum)	55%, 22527/41035 (HARP)	National: 76%	National: 80%	National: 90%	N: HIV/AIDS & ART Registry (HARP) Form A D: Spectrum Estimates	Monthly (P) Quarterly (N)
17	Program Outcome: <i>Linked to Care</i>	Percentage of diagnosed HIV+ individuals linked to Treatment Hubs or Satellite Treatment Hubs N: Number of diagnosed HIV+ people assessed by the Treatment Hub or Satellite Treatment Hubs for assessment of ART eligibility D: Total number of people diagnosed with HIV during the reporting period	73% of PLHIV know their baseline CD4 count within 3 months of diagnosis at the SHC in GF sites (July – Dec 2014 GF PUDR)	70% of newly diagnosed with HIV	80% of newly diagnosed with HIV	90% of newly diagnosed with HIV	N: HARP Form B D: HARP Form A	Monthly (P) Quarterly (N)
18	Program Outcome: <i>ART</i>	Percentage of ART eligible PLHIV who are started on ART N: Number ART eligible PLHIV started on ART D: Total number of PLHIV who are eligible for ART during the reporting period	83% (2014 GARP report)	90% of ART eligible PLHIV	90% of ART eligible PLHIV	90% of ART eligible PLHIV	N: HARP Form C D: HARP Form B	Monthly (P) Quarterly (N)

*P – peripheral, N – national

#	Category	Program Outcome Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency* of Reporting
19	Program Outcome: ART	Median CD4 count of PLHIV on ART Enrollment Median CD4 count of all PLHIV started on ART during the reporting period	2012: 132 cells/uL 2013: 141 cells/uL 2014: 160 cells/uL (HARP)	250 cells/uL	300 cells/uL	350 cells/uL	HARP Form B	Monthly (P) Quarterly (N)
20	Program Outcome: ART	Percentage of PLHIV alive and retained on ART (12 and 24 months) N: Number of PLHIV who are still alive at 12 and 24 months after starting ART D: Total number of PLHIV who started ART in the reference year who were expected to achieve 12 and 24-month outcomes within the reporting period including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 12 and 24	86% - 12 months (2014 GARP report)	12 mos: 90% 24 mos: 90%	12 mos: 90% 24 mos: 90%	12 mos: 90% 24 mos: 90%	HARP Form C	Annual
21	Program Outcome: ART	Percentage of PLHIV on ART who are lost to follow up N: Number of PLHIV who have not returned 3 months after the last scheduled appointment (ie. 4 to 6 months since last visit). D: Total number of PLHIV on ART accessing Treatment Hubs or Satellite Treatment Hubs during the reporting period	8%, 716/9,218 (HARP) Lost to follow up is defined as 6 months for the previous reporting period	<8%	<5%	<5%	HARP Form C	Monthly
22	Program Outcome: ART	Percentage of PLHIV with suppressed viral load 12 months after ART initiation N1: Number of PLHIV tested for Viral Load 12 months after ART initiation and have suppression (<1,000 copies/μl) D1: Total number of PLHIV tested for Viral Load 12 months after ART initiation N2: Number of PLHIV on ART for 12 months that that were tested for viral load D2: Total number of PLHIV on ART for 12 months	95%, 71/75 (HARP) 3% (HARP)	90%	90%	90%	HARP Form C	Annual
23	Program Outcome: TB-HIV	Percentage of PLHIV screened for TB during ART enrollment N: Number of PLHIV who are newly enrolled in the ART program at Treatment Hubs or Satellite Treatment Hubs who were screened for TB through GeneXpert and/or chest x-ray D: Total number of PLHIV accessing Treatment Hubs or Satellite Treatment Hubs who are newly-enrolled in ART Program during the reporting period	None. New indicator.	90%	90%	90%	HARP Form B	Monthly (P) Semi-annual (N)
24	Program Outcome: TB-HIV	Percentage of PLHIV screened for TB during the last visit N: Number of PLHIV screened for signs and/or symptoms of TB during their last follow-up visit D: Total number of PLHIV accessing Treatment Hubs or Satellite Treatment Hubs for follow-up HIV care during the reporting period	62%, 5995/9644 *Total screened for reporting period, not last visit (TB-HIV Report 2014)	90%	90%	90%	HARP Form B & C	Monthly (P) Semi-annual (N)

*P – peripheral, N – national

#	Category	Program Outcome Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency* of Reporting
25	Program Outcome: TB-HIV	Percentage of PLHIV with Incident TB N: Number of PLHIV diagnosed with TB D: Total number of PLHIV accessing Treatment Hubs or Satellite Treatment Hubs screened for TB during the reporting period	No baseline for this indicator	<30%	<30%	<30%	HARP Form B & C	Monthly (P) Semi-annual (N)
26	Program Outcome: TB-HIV	Percentage of PLHIV with Incident TB who received treatment for both TB and HIV N: Number of PLHIV with active TB started on TB treatment D: Total number of PLHIV enrolled in HIV care at Treatment Hubs or Satellite Treatment Hubs with active TB during the reporting period	97% 865/896 (TB-HIV Report 2014)	>90%	>90%	>90%	HARP Form B & C LABS & HARP	Monthly (P) Semi-annual (N)
27	Program Outcome: TB-HIV	Percentage of PLHIV with no active TB started on Isoniazid Preventive Therapy (IPT) N: Number of PLHIV newly enrolled in HIV care and without active TB who are started on IPT D: Total number of PLHIV accessing Treatment Hubs or Satellite Treatment Hubs newly enrolled in HIV care and without active TB during the reporting period	39%, 4497/11565 (NTP) NCR & PMDT Data only	60%	65%	70%	HARP Form B & C	Monthly (P) Semi-annual (N)
28	Program Outcome: TB-HIV	Percentage of people with HIV who died with active TB N: Number of HIV-positive individuals who died with active TB D: Total number of HIV+ individuals reported to have died during the reporting period	60% (TB-HIV Report July-Dec 2014)	30%	25%	25%	HARP Form D	Monthly (P) Semi-annual (N)
29	Program Outcome: PMTCT	Percentage of HIV+ pregnant women on ART N: Number of HIV-positive pregnant women on ART D: Estimated number of HIV+ women needing PMTCT during the reporting period	7.59%, 14/364 (2014 GARP report)	>90%	>90%	>90%	N: HARP D: EPP/Spectrum	Annual
30	Program Outcome: PMTCT	Percentage of newborns of HIV+ women given ART prophylaxis N: Number of infants born to HIV-infected women who received ART prophylaxis during the first 6 weeks of life D: Number of HIV positive women who delivered within the past 12 months.	74%, 20/27 (HARP)	90%	90%	90%	HARP	Annual
31	Program Outcome: PMTCT	Percentage of infants born to HIV+ women tested for HIV within 2 months of birth N: Number of infants who had a PCR tests for HIV within 2 months of birth D1: Estimated number of live births to pregnant HIV-infected women during the reporting period D2: Number of HIV positive women who delivered within the past 12 months.	0.27%, 1/364 (2014 GARP report) 4%, 1/27 (HARP)	80%	80%	80%	N: Program Data D1: EPP/Spectrum D2: HARP	Annual
32	Program Outcome: PMTCT	Percentage of HIV-exposed infants born in the past 12 months who are infected with HIV N: Number of HIV-exposed infants born within the past 12 months who are infected with HIV D: Number of reported HIV positive women who delivered within the past 12 months.	0%, 0/27 (HARP)	0%	0%	0%	HARP Form A-MC	Monthly (P) Semi-annual (N)

*P – peripheral, N – national

Table 3. List of Health System Indicators & their Baseline, Targets, Data Source & Frequency of Reporting

#	Category	Health System Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency of Reporting
1	Health System: <i>Infrastructure</i>	Number of facilities that provide HIV testing per city Disaggregation: % of facilities with HIV testing that offer it for free	643 (LaBS)	None	At least 3 per city	At least 5 per city	Program Data	Annual
2	Health System: <i>Infrastructure</i>	Percentage of HIV testing facilities that participate in HIV External Quality Assurance (EQAS) N: Number of HIV testing facilities that participate in HIV EQAS annually D: Total number of facilities that offer HIV testing	94% 607/643 24% 18/76 (N: SACCL Reports, D: LaBS)	None	90%	90%	Program Data	Annual
3	Health System: <i>Infrastructure</i>	Number of Treatment Hubs Disaggregation: % of regions with a Treatment Hub in their region % of DOH retained hospitals which are Treatment Hubs % of provincial hospitals which are Treatment Hubs	18 (NASPCP) 71% (12/17) regions with Tx Hubs 21% (15/70) DOH retained hospitals	None	1 per region	2 per region	Program Data	Annual
4	Health System: <i>Infrastructure</i>	Number of Satellite Treatment Hubs Disaggregation: % of Category A & B cities with a Satellite Treatment Hub in their city	4 (NASPCP) 10% (4/40) of Cat A & B cities	None	Cat A: 1 per city Cat B: 1 per province	Cat A: 2 per city Cat B: 2 per province	Program Data	Annual
5	Health System: <i>Infrastructure</i>	Percentage of cities and municipalities with Social Hygiene Clinics (SHC) or STI clinics N: Number of cities and municipalities with SHC or STI Clinics D: Number of cities and municipalities in the Philippines Disaggregation: % of Category A & B cities with SHCs in their city % of Category C & ROTC areas with STI clinics in their city/municipality	149 (NASPCP) 92% (37/40) of Cat A & B cities 77% (23/30) of Cat C cities	None	90%	100%	Program Data	Annual
6	Health System: <i>Infrastructure</i>	Percentage of Treatment Hubs & Satellite Treatment Hubs with access to CD4 testing N: Number of Treatment Hubs & Satellite Treatment Hubs with access to CD4 testing D: Number of Treatment Hubs and Satellite Treatment Hubs	11 (NASPCP)	None	100%	100%	Program Data	Annual
7	Health System: <i>HR</i>	Percentage of HIV testing facilities with HIV proficient Medical Technologists N: Number of HIV testing facilities with an HIV proficient Medical Technologist D: Total number of facilities that provide HIV testing	98%, 628/643 (LaBS)	None	100%	100%	Program Data	Annual

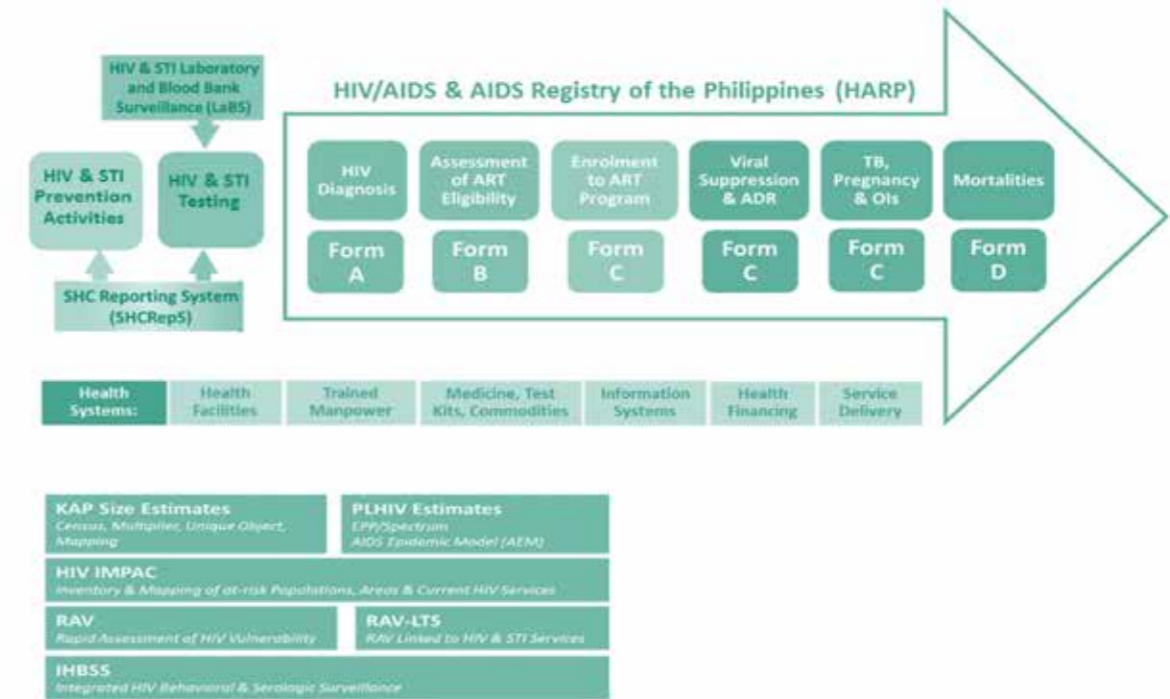
#	Category	Health System Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency of Reporting
8	Health System: <i>HR</i>	Percentage of HIV testing facilities with staff trained on HIV Counseling and Testing (HCT) N: Number of HIV testing facilities with a trained HIV counselor D: Total number of facilities that provide HIV testing	78%, 503/643 (LaBS)	None	80%	90%	Program Data	Annual
9	Health System: <i>HR</i>	Percentage of Social Hygiene Clinics with trained peer educators (in Cat A and B sites) N: Number of SHCs with trained peer educators D: Total number of SHCs	None. New indicator	None	80%	90%	Program Data	Annual
10	Health System: <i>HR</i>	Percentage of hospitals with trained and functioning HIV/AIDS Core Teams (HACT) N: Number of Treatment Hubs and Satellite Treatment Hubs with trained and functioning HACT D: Total number of DOH retained hospitals	None. New indicator	None	80%	90%	Program Data	Annual
11	Health System: <i>Lab & Med Products</i>	Percentage of Treatment Hubs and Satellite Treatment Hubs with ARV stock-out N: Number of Treatment Hubs with stock-out of at least one ARV within the reporting period D: Total number of Treatment Hubs	0% for Treatment hubs. (2014 GARP report) In the past, Satellite Tx Hubs ARV stocks were not counted separately from their "mother" Tx Hub's stocks.	0%	0%	0%	Program Data	Monthly
12	Health System: <i>Lab & Med Products</i>	Percentage of Social Hygiene Clinics with stock-out or expiry of HIV test kits within 3 months N: Number of SHCs that experienced a stock-out or expiry of HIV test kits during the reporting period D: Total number of SHCs providing free HIV testing	None. New indicator.	0%	0%	0%	SHCRepS	Monthly
13	Health System: <i>Lab & Med Products</i>	Percentage of Social Hygiene Clinics with stock-out or expiry of condoms within 3 months N: Number of SHCs that experienced a stock-out or expiry of condoms during the reporting period D: Total number of SHCs	None. New indicator.	0%	0%	0%	SHCRepS	Monthly
14	Health System: <i>Lab & Med Products</i>	Percentage of Social Hygiene Clinics with stock-out or expiry of lubricants within 3 months N: Number of SHCs that experienced a stock-out or expiry of lubricants during the reporting period D: Total number of SHCs	None. New indicator.	0%	0%	0%	SHCRepS	Monthly
15	Health System: <i>Lab & Med Products</i>	Percentage of Social Hygiene Clinics with stock-out or expiry of STI drugs within 3 months N: Number of SHCs with stock-outs or expiry of at least one STI drug during the reporting period D: Total number of SHCs	None. New indicator.	0%	0%	0%	SHCRepS	Monthly

#	Category	Health System Indicator	Baseline (data for 2014 unless specified)	Target for 2015	Target for 2016	Target for 2017	Data Source	Frequency of Reporting
16	Health System: Financing	Percentage of Treatment Hubs that receive OHAT package reimbursement N: Number of Treatment Hubs that receive OHAT package reimbursement during the reporting period D: Total number of Treatment Hubs	78% 14/18 (Treatment hubs)	80%	80%	80%	Program Data	Annual
17	Health System: Financing	Percentage of PLHIV on ART who avail OHAT package N: Number of PLHIV on ART who avail OHAT package D: Total number of PLHIV on ART during the reporting period	None. New Indicator.	None	80%	80%	Program Data	Annual
18	Health System: Financing	Percentage of PLHIV on ART in treatment hubs enrolled in PhilHealth N: Number of PLHIV on ART enrolled in PhilHealth D: Total number of PLHIV on ART during the reporting period	63%, 5384/8481 (HARP)*N does not include data for 1 tx hub	70%	80%	90%	Program Data	Annual
19	Health System: HIS	Percentage of HIV testing facilities and blood banks reporting to the HIV Laboratory Surveillance N: Number of HIV testing facilities and blood banks reporting to the HIV Laboratory Surveillance during the reporting period D: Total number of HIV testing facilities and blood banks reporting to the HIV Laboratory Surveillance	100%, 643/643 (N&D: LaBS)	60%	80%	100%	LaBS	Monthly (P) Quarterly (N)
20	Health System: HIS	Percentage of Social Hygiene Clinics reporting to the SHC Reporting System N: Number of SHCs reporting to the SHC Reporting System during the reporting period D: Total number of SHCs	28%, 42/149 (N:LaBS, D: NASPCP)	100% of SHCs in GF sites	80% of all SHCs nationwide	90% of all SHCs nationwide	SHCRepS	Monthly (P) Quarterly (N)
21	Health System: HIS	Percentage of HIV testing facilities submitting HARP Form A to the Department of Health N: Number of HIV testing facilities submitting HARP Form A to the DOH Epi Bureau during the reporting period D: Total number of HIV testing facilities	67%, 433/643 (N: LaBS, D: HARP)	100%	100%	100%	HARP	Monthly (P) Quarterly (N)
22	Health System: HIS	Percentage of Treatment Hub and Satellite Treatment Hubs submitting HARP Forms to the DOH N: Number of Treatment Hub and Satellite Treatment Hubs submitting HARP Forms to the DOH Epi Bureau during the reporting period D: Total number of Treatment Hubs and Satellite Treatment Hubs Disaggregation: Form B, Form C, Form D	100%, 23/23 (HARP)	100%	100%	100%	HARP	Monthly (P) Quarterly (N)
23	Health System: HIS	Percentage of Regional Offices that conducted HIV IMPAC activities N: Number of regional offices that conducted HIV IMPAC activities (mapping & inventory of current HIV services) during the reporting period D: Total number of Regional Offices Disaggregation: PAHI Category A, B, C and Rest of the Country	None. New Indicator	60%	100%	100%	HIV IMPAC reports	Annual

*P - peripheral, N - national

Data Sources and Flow of Reporting

Figure 3. HIV & STI Surveillance Systems

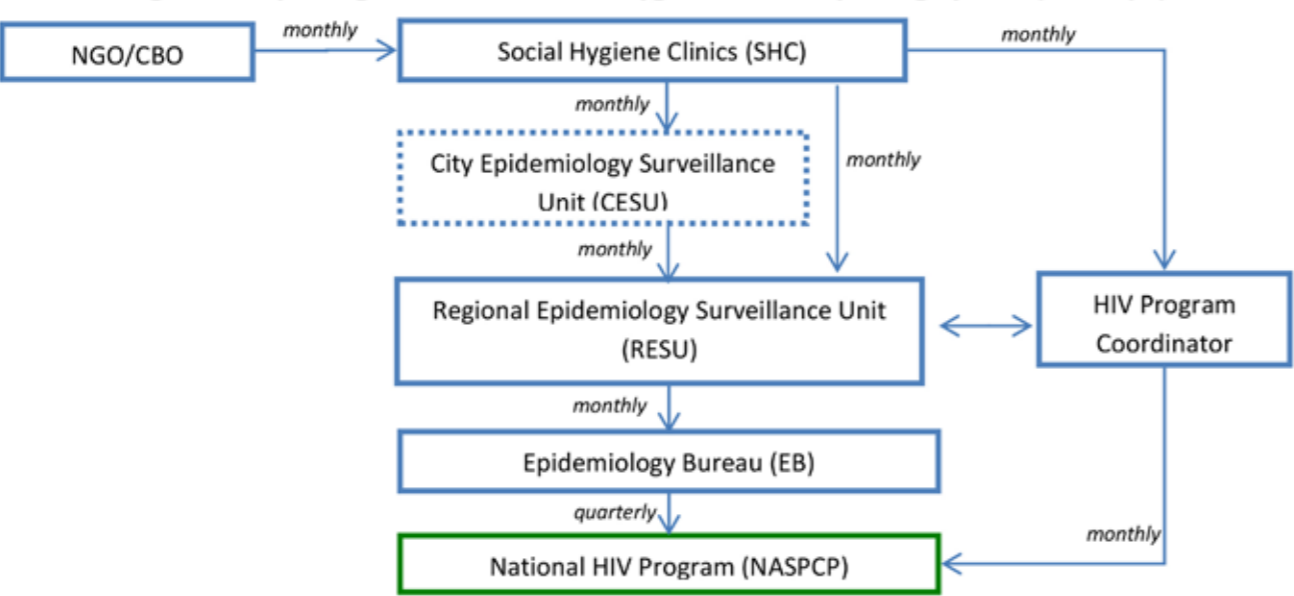


• The Social Hygiene Clinic Reporting System (SHCRepS) is a system that combines three previously separate reporting systems, namely, the NASPCP reporting of services, the STI Etiologic Surveillance System (SESS), and the project based reporting of medicine and test kit inventories. The new SHC Reporting System has four modules for reporting: (a) outreach and other prevention services; (b) profile of clinic clients; (c) SESS and HIV testing; and (d) inventory of commodities. Monthly reports are site- specific and submitted to the DOH Regional Epidemiology Surveillance Units (RESU). The RESU then submits the aggregated regional report to the Department of Health Epidemiology Bureau (DOH-EB) every month.

For the module on HIV testing, only aggregate numbers of those tested and their screening results (reactive or non-reactive) are captured and reported by the SHC Reporting System to the DOH-EB. The linkage of people reached by prevention services, those who access HIV testing and become HIV positive, without compromising confidentiality, will be through the Unique Identification Code (UIC) that is used in both the SHC Reporting System and the HIV/AIDS and ART Registry of the Philippines (Figure 4).

The data flow for the SHCRepS is summarized in the Figure 4. The SHCs submit reports to the City Epidemiology Surveillance Unit (if the city has a functional CESU) and to the RESU. The RESU then submits aggregate regional reports to DOH-EB the following reporting month. The reports are then submitted to NASPCP quarterly.

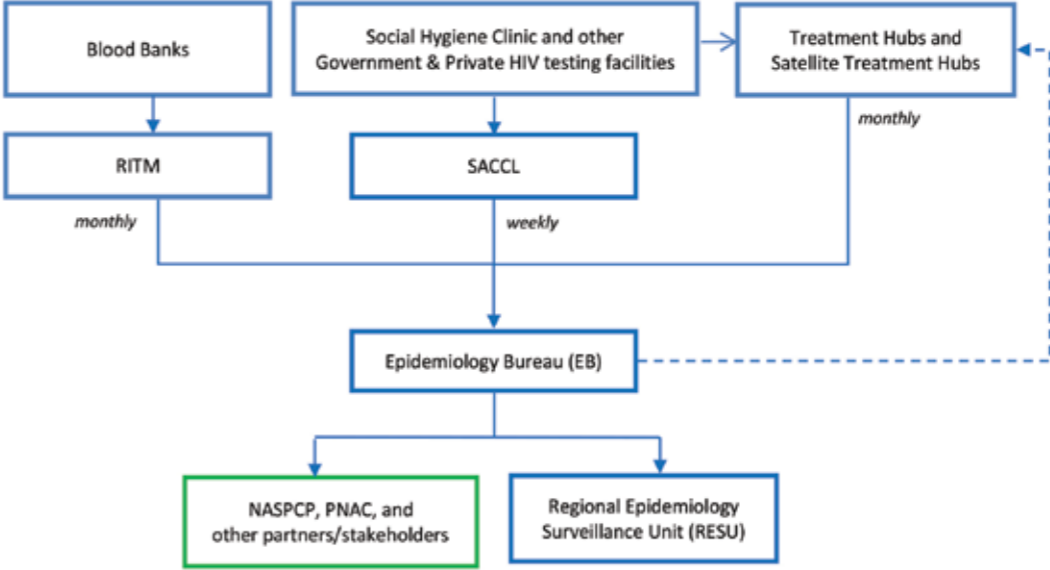
Figure 4. Reporting Flow for the Social Hygiene Clinic Reporting System (SHCRepS)



• **The HIV/AIDS & ART Registry of the Philippines (HARP)** is maintained by the Department of Health – Epidemiology Bureau which houses the National HIV/AIDS & STI Surveillance and Strategic Information Unit (NHSSS). The HARP is a national surveillance system mandated by Republic Act 8504. The Implementing Rules and Regulations of RA 8504 require strict confidentiality of the system and limit the information for public health purposes only. The HARP includes the HIV continuum of care cascade from HIV diagnosis, to linkage to care, to ART enrolment, to viral load suppression and to death. The database can only be accessed by a limited number of NHSSS personnel with appropriate clearance. It is strictly confidential and used for public health purposes only. Strategic information from the HARP database is released through a monthly report of aggregate data.

The data flow for the HARP is summarized in the Figure 5. All reactive samples of blood donors and blood units are sent to the National Voluntary Blood Services Program (NVBSP) of Research Institute for Tropical Medicine (RITM). While all reactive blood samples of patients are submitted to STD/AIDS Cooperative Central Laboratory (SACCL) for confirmatory testing. The data is submitted to DOH-EB. Treatment hubs and Satellite Treatment Hubs submit data on treatment, care, and support services including provision of ARVs. The HARP, ART Report, Treatment Hub Reports, HIV/AIDS Regional Reports, and HIV/AIDS PAHI Sites Reports are then submitted to the NASPCP, PNAC, and other partners and stakeholders.

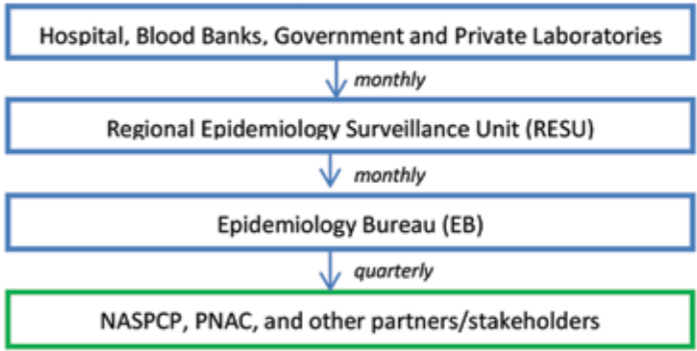
Figure 5. Reporting Flow for the HIV/AIDS & ART Registry of the Philippines (HARP)



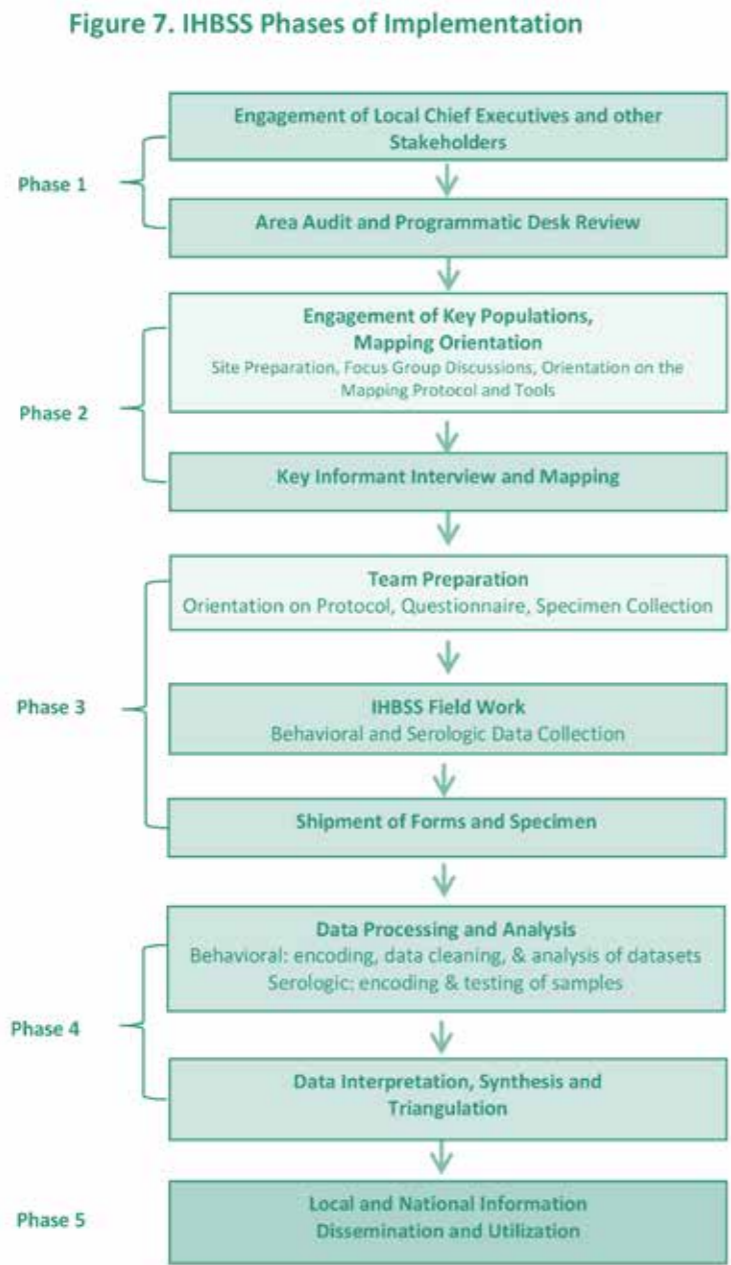
• **The Laboratory and Blood Bank Surveillance for HIV and STI (LaBS)** is one of the existing surveillance systems of DOH-EB Unit for determining and monitoring the magnitude and progression of HIV infection and Sexually Transmitted Infections (STI) in the Philippines. Pursuant to Administrative Order No. 55-A, “each HIV testing laboratory shall report and submit monthly the number of tests performed, results and referrals of sero-reactive samples and confirmed sero-active samples as required by RA 3573 (Law on Reporting Communicable Diseases). Further, as provided in DOH Administrative Order 2005-0027, reporting should include Syphilis, Hepatitis B, Hepatitis C, and Gonorrhea. These monthly reports are submitted by each laboratory and blood bank to the RESU. The RESU then submits the aggregated regional report to DOH-EB every month.

The data flow for the Laboratory and Blood Bank Surveillance for HIV and STI (LaBS) is summarized in the Figure 6. The hospital, blood banks, government and private laboratories submit reports to the RESU. Similar to the flow of the SHCRepS, the RESU submits to DOH-EB the following reporting month. The reports are then submitted to NASPCP, PNAC, and other stakeholders quarterly.

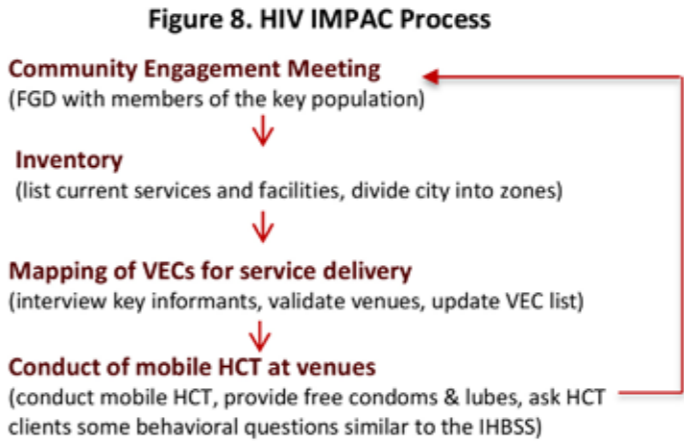
Figure 6. Reporting Flow for the Laboratory and Blood Bank Surveillance for HIV and STI (LaBS)



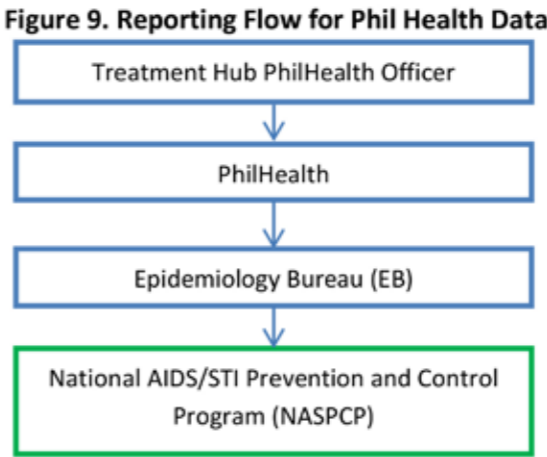
•The **Integrated HIV Behavioral and Serologic Surveillance (IHBSS)** is the country’s national active surveillance system among key populations which is conducted every 2 years. Sentinel serologic and sentinel behavioral surveillance started in the Philippines in 1993 and 1997 respectively. The two surveillance systems were integrated in 2005, and renamed the IHBSS, to have an in-depth understanding of the HIV situation in the country. The IHBSS seeks to (a) determine the prevalence of HIV and syphilis among the key populations and establish trend over time, (b) determine behavioral factors associated with STI and HIV transmission and its effect on the HIV epidemic in the country, (c) determine the outcome of STI and HIV intervention programs, and (d) provide strategic information to guide STI and HIV policies, programs and services. The key populations involved in the IHBSS include the FSW, IDU, MSM, MEW, TGW, and male clients of FSW. The IHBSS is the main data source of the country’s HIV prevalence and EPP/Spectrum projection models.



• **The HIV Inventory and Mapping of at-risk Populations, Areas & Current Response (HIV IMPAC)** is a monitoring tool of the High Impact 5 program launched by DOH in an effort to achieve Universal Health Care. It has the following objectives: (a) assess the area’s risk for HIV and identify key populations, (b) develop an inventory of the current HIV services provided by the city/municipality, and (c) map high-risk venues, events, and clans in the city/municipality where HIV services should be provided to reach the targeted population. HIV IMPAC is not just a surveillance activity, but also a programmatic activity to be conducted at least every 6 months to reflect the needs and/or accomplishments of the program and update the map of venues, events, and clans where key populations can be reached.



- The National AIDS and STI Prevention and Control Program (NASPCP) Reports are submitted by the treatment hubs monthly to NASPCP. This provides for the data in terms of facility expansion, capacity building, PSM, and OOP expense of PLHIV. This includes Pharmacy Inventory Report and data trained peer educators, hospitals with functional HACT, and HCT from the regional office.
- The Phil Health OHAT Package through the Board Resolution No. 1331, series of 2009 was implemented to increase the proportion of population having access to effective HIV/AIDS treatment and patient education measures. The OHAT Package will be paid through a case payment scheme and includes an annual reimbursement at 30,000 pesos per year for cases confirmed by SACCL. The data flow for the OHAT Package was and financing com-



Data Management

Access to the information collected will be limited to those involved in the monitoring and evaluation of the Philippine Health Sector Plan for HIV and STI. Data will be stored in a password protected database. Confidentiality of data shall be ensured by all health staff involved. All patient related information will be linked through the Unique Identification Code (UIC) to ensure confidentiality.

Data Dissemination and Use

The results of the M&E of the Health Sector Strategic Plan shall be used primarily within the country to improving existing HIV/AIDS prevention, diagnosis and treatment strategies, to program planning, and to policy formulation. Data will be disseminated to Department of Health and key stakeholders. Data communication and use will include targeted and comprehensive reporting, regular review process, and global reporting.