2005 HIV Estimates in the Philippines

2005 CONSENSUS REPORT ON HIV AND AIDS EPIDEMIOLOGY

Table of Contents

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
BRL	Bureau of Research Laboratories
BSS	Behavioral Sentinel Surveillance
DDB	Dangerous Drugs Board
DOH	Department of Health
FHI	Family Health International
FLSW	Freelance female sex worker
FSW	Female sex worker
HIV	Human Immunodeficiency Virus
HRG	High risk group
HSS	HIV Surveillance System
IDUs	Injecting drug users
IEC	Information and Education Campaign
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
LGU	Local Government Units
LRG	Low risk group
LIA	Line Immuno Assay
LWHA	Living with HIV/AIDS
MENSSA	Men's Study of Sexuality and AIDS
MSH	Management Sciences for Health
MSM	Men having sex with men
MSTD	Male STD patients
NADPA	National Anti-Drug Program of Action
NASPCP	National AIDS/STI Prevention and Control Program
NCDPC	National Center for Disease Prevention and Control
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NEC	National Epidemiology Center
NHSSS	National HIV Serologic Sentinel Surveillance System
NGO	Non-government organization
NRG	No risk group
NSO	National Statistics Office
NVBSP	National Voluntary Blood Services Program
OCW	Overseas Contract Worker
OFW	Overseas Filipino Worker
PA	Particle Agglutination
PDSC	Physicians Diagnostic Services Center
PNRC	Philippine National Red Cross
RAS	Rapid Assessment Survey
RITM	Research Institute for Tropical Medicine
RFSW	Registered Female Sex Worker
RTI	Reproductive Tract Infections
SACCL	STI/AIDS Cooperative Central Laboratory
SLH	San Lazaro Hospital
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Disease
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
WB	Western Blot
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

Every two to three years, the Department of Health (DOH) initiates a consensus-building process during which the number of prevalent HIV infections in the Philippines is estimated. Generating reasonable estimates of the number of HIV infections in the country is important, not only for monitoring trends in the prevalence of infection, but also for more rational planning of effective responses against the problem. The data will also facilitate a more systematic assessment of the effectiveness of current prevention and control as well as care and support initiatives of the public and private sectors.

Previous attempts to estimate the number of HIV infections in the past resulted to figures, which did not only vary markedly over time, but which were also difficult to interpret because of the different methods employed in the estimation processes. The estimates made from 1993 to 2002 showed a declining trend in the prevalence of HIV infection. However, this decline in prevalence could not be attributed to reduced incidence of infection but mainly to the differences in the methodology and assumptions used to generate these estimates. The data needed to arrive at reasonable estimates of infection prevalence were lacking, especially for the first few estimates.

The Workbook Method is a mathematical modeling technique that can be used in estimating the number of HIV infected persons in the entire country. This method relies on estimates of the current size of populations exposed to specific risks and the prevalence of infection within these populations.

The 2005 estimate of HIV prevalence was a product of a thorough consultative process with the participation of DOH officials and program managers, researchers, NGOs in AIDS prevention, care and support work, and other stakeholders. A Technical Working Group (TWG), assisted by consultants and a secretariat, played a central role in generating estimates of HIV infections for high risk and lower risk groups. The preliminary estimates were presented for approval to a bigger audience composed of stakeholders and HIV experts through consensus-building.

For the year 2005, the prevalence of HIV infection among Filipino adults (15-49 years old) was 0.03%. This prevalence translated to some 11,200 adults infected with HIV of which 40% were females. Although IDUs made up only 3% of the infected individuals, this number could increase within a short period of time since transmission of infection is most efficient in this group.

The results of the estimation process placed the ratio of the number of infected persons in the LRG at 3:1 relative to the HRG. The sheer size of the general population compared to the HRG would expectedly result to a much bigger number of HIV infected persons.

The recommendations include, among others, the use of these estimates for advocacy among policy makers about the real threat of an AIDS epidemic in the country. The opportunity to be involved in the estimation and consensus-building activities can by themselves be advocacy strategies for local officials to emphasize AIDS as a public health problem.

Targeted interventions to reduce transmission of HIV in the high risk populations should continue so that the rate of transmission from HRG to the LRG populations will be controlled.

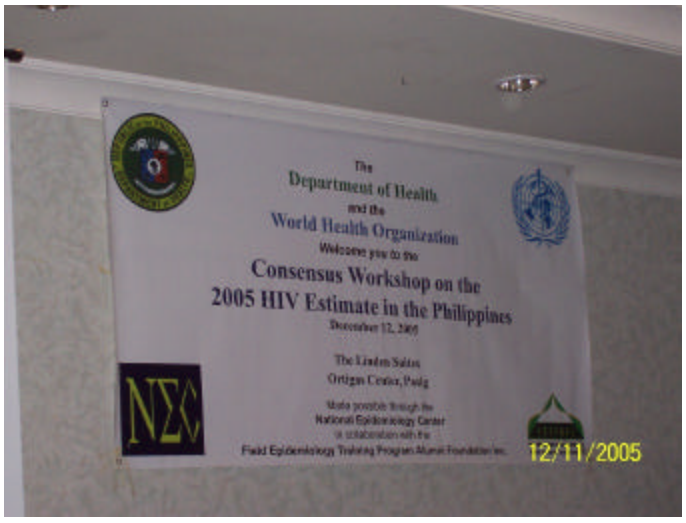
The lack of valid and reliable data on population size and prevalence estimates of various risk groups hampered the estimation process. Hence, efforts to collect relevant and good quality data should be made so that better estimates will be generated in future estimation activities.

Introduction

Every two to three years, the DOH, in cooperation with WHO, sponsor efforts to estimate the number of prevalent HIV cases in the Philippines. With a fairly accurate estimate of population sizes of high-risk groups, the NASPCP can plan intervention programs interventions more effectively, ensure better program coverage, and more rational assessment of the effectiveness of current intervention programs.

Ten years ago, estimates of the prevalence of HIV infections were virtually absent. Attempts to come up with estimates were made through the use of models (i.e., EPIMODEL), review of available data from various HIV testing facilities and from the results of HIV serologic surveillance in selected sentinel sites. Results of small *ad hoc* studies also provided supplementary data on HIV prevalence in selected suspected risk groups.

Very recently, UNAIDS and WHO jointly developed and tested various techniques to estimate prevalence of HIV infections and to predict the magnitude and trends in the levels of infection for the country as a whole or for its smaller sub-units. To arrive at these reasonable estimates, population sizes of risk groups and corresponding prevalence estimates of these are required.



The streamer for the Consensus Workshop and its major sponsors

The Workbook Method is a mathematical modeling technique which can be used to estimate the point prevalence of HIV infection in countries where the epidemic is at a low level, i.e., the infection is still concentrated among smaller populations with behaviors that place them at a higher risk of HIV infection or the population at risk is exposed through the risk behaviors of their sexual partners. This report presents the estimated prevalence of HIV infection for 2005 and the procedures that were followed to arrive at these estimates.

Epidemiological Situation

HIV in the Philippines --- Trends in Prevalence

Although about 2,393 HIV seropositive individuals have been reported by the HIV/AIDS Registry as of the end of November 2005, a reasonably good estimate of the number of existing cases in the country continues to elude HIV experts and DOH program managers ever since the infection was first identified in 1984. The Registry collects and collates data from all DOH-accredited laboratories that perform HIV tests as well as blood screening activities conducted under the NVBSP. However, since only data on number of tests done and not the number of individuals tested is available, the prevalence of HIV infection could not be determined from the Registry. Most of the data on the prevalence of HIV infection come from the sentinel surveillance of selected high-risk groups in a few large urban centers of the country.

The present exercise to estimate the number of existing HIV cases in the Philippines is the sixth estimation process which began in 1993. Using the EPIMODEL, a software that calculated the number of HIV prevalent infections, it was estimated that some 58,000 HIV infections were present in the country for that year. During the 1996 Consensus of Experts, however, the estimate was reduced by half since the HIV serologic surveillance, ongoing since 1993, was unable to detect this large amount of infection even among the HRG. In the absence of additional information to generate a new estimate, the experts during the 1998 Consensus, decided to retain the 1996 estimates. The estimated number of prevalent HIV infection was further reduced to 6,000 during the 2000 Consensus. The last estimate was based on review of available data from various sources such as the HSS and the HIV/AIDS Registry of the DOH, HIV antibody test results from government and private laboratories, RITM, PNRC and UP-CPH among others. It was difficult to describe the magnitude of the prevalence of HIV infection, much less predict its trend, because of the paucity of available information especially during the early years of the epidemic. The different techniques/approaches used in the estimation procedures over time also made direct comparison of the estimates almost impossible.

The Table 1 below shows the past estimates including the procedures employed in the estimation process.

Table 1. Estimates of HIV Positive Individuals in the Philippines, 1993-2002

Year	Method of Estimation	Estimates/Projections
1993	EPIMODEL	1993 Estimate --- 58,000 2000 Projection --- 92,000
1996	DOH/WHO Model of 1996	1996 Estimate --- 28,300 2000 Projection --- 38,000
1998	Consensus of experts through review of data (NHSSS, NASPCP, BRL, RITM, UPCPH)	28,300 (retained 1996 estimate)
2000	Consensus of experts through review of data (HIV Serosurveillance, AIDS Registry, Behavioral Monitoring Surveys, MENSSA, STI Surveys, PNRC, BRL)	10,000
2002	Consensus of experts, review of HIV/AIDS and STI data from various sources	6002

Estimates of population size and HIV prevalence among different populations

Tables 2-12 present the HIV prevalence according to risk group. The population size estimates, if available, are also given.

I. Low Risk Groups

Table 2. HIV Prevalence Estimates Among Overseas Contract Workers

Study/Author	Year	Method	Results	Remarks
HIV Screening tests at Physicians Diagnostic Services Center (PDSC) and confirmed at SACCL	2005	▪ 54,187 samples tested	5 tested positive prevalence: **0.01%** (95% CI: 0.00-0.02%)	▪ Sample included OFWs who seek medical clearance at PDSC
HIV Screening tests at Physicians Diagnostic Services Center (PDSC) and confirmed at SACCL	2004	▪ 52,278 samples tested	2 tested positive prevalence: **0.003%** (95% CI: <0.001-0.01%)	▪ Sample included OFWs who seek medical clearance at PDSC
Annual Census of Testing Laboratories on HIV/Dominguez N, Agdamag DM	2002-2004	▪ Passive surveillance ▪ PA, Rapid Test in the local laboratories ▪ WIA, WB in SACCL ▪ 16,536 OCWs tested in diagnostic lab ▪ 1004 OCWs tested in private hospitals	none tested positive in either diagnostic lab samples or those of private hospitals *prevalence:* for OCWs in diagnostic lab -→ **0.0%** (95% CI: 0.0-0.02%) for OCWs in private hospitals → **0.0%** (95% CI: 0.0-0.04%)	▪ Only 19 testing laboratories whose medical technologists were trained by SACCL is represented in this data ▪ Sample pop'n undergo mandatory blood testing hence may have good representation of general population
The Vulnerabilities of Filipino Seafarers to HIV/STIs (FHI)	2002	▪ Two-stage cluster sampling design using probability sampling proportionate to size ▪ Blood samples tested at SACCL ▪ 420 seafarers participated	none tested positive prevalence: **0.0%** (95% CI: 0.0-0.9%)	–

Table 3. HIV Prevalence Estimates Among Blood Donors

Study/Author	Year	Method	Results	Remarks
Philippine National Red Cross	2004	▪ 30,000 blood units collected	1 tested positive prevalence: **0.003%** (95% CI: 0.0-0.02%)	▪ Source of data does not provide a stable estimate as compared to NVBSP data since sample collected was very small
Annual Census of Testing Laboratories on HIV/Dominguez N, Agdamag DM	2002-2004	▪ Passive surveillance ▪ PA, Rapid Test in the local laboratories ▪ EIA, WB in SACCL ▪ 12,611 samples from private hospitals were tested ▪ 9841 samples from government hospitals were tested	4 tested positive in samples from private hospitals prevalence: **4/12,611=0.03%** (95% CI: 0.0-0.08%) none tested positive in samples from government hospitals prevalence: **0.0%** (95% CI: 0.0-0.04%)	▪ Only 19 testing laboratories whose medical technologists were trained by SACCL is represented in this data ▪ Sample pop'n undergo mandatory blood testing hence may have high representation
Study of HIV+ among Blood Donors/Corpuz A	2000-2004	▪ Source data: National Voluntary Blood Services Program ▪ 1,572,551 blood units collected	63 tested positive prevalence: **0.004%** (95% CI: 0.003-0.005%)	▪ Those with known risk factors already screened out ▪ Sequential testing: all blood positive for Hep B, malaria and syphilis were excluded resulting to an underestimate of the HIV prevalence in the general population

Table 4. HIV Prevalence Estimates Among Women in Antenatal Care

Study/Author	Year	Method	Results	Remarks
HIV, Hep B and C and Syphilis Prevalence among ANC women in Cebu City/Tac-an I	2002-2005	▪ Total of 200 samples	none tested positive prevalence: **0.0%** (95% CI: 0.0-1.8%)	–

Table 5. HIV Prevalence Estimates Among TB Patients

Study/Author	Year	Method	Results	Remarks
Study on TB patients at San Lazaro Hospital		▪ 160 TB patients included	10 tested positive prevalence: **6.25%** (95% CI: 5.55-6.95%)	–
HIV Prevalence and High Risk Behaviors among TB patients/Mateo R, Agdamag DM	2003	▪ Simple random sampling ▪ Voluntary linked anonymous method ▪ Blood samples tested at SACCL ▪ 387 blood samples	none tested positive prevalence: 0.0% (95% CI: 0.0--0.95%)	▪ Sample pop'n undergo mandatory blood testing hence may under-represent prevalence in the general population

Table 6. HIV Prevalence Estimates Among Prison Inmates

Study/Author	Year	Method	Results	Remarks
HIV Prevalence Survey among Male prison inmates in NCR/Mateo R, Agdamag DM	2003	▪ Two-stage cluster sampling design using probability sampling proportionate to size ▪ Voluntary linked anonymous method ▪ Blood samples tested at SACCL ▪ 380 blood samples	none tested positive prevalence: **0.0%** (95% CI: 0.0-1.0%)	–

Table 7. HIV Prevalence Estimates Among Male Truckers

Study/Author	Year	Method	Results	Remarks
HIV Prevalence Survey among Male Truckers in Central Luzon/Mateo R, Agdamag DM	2003	▪ Purposive sampling ▪ Voluntary linked anonymous method ▪ Blood samples tested at SACCL ▪ 350 blood samples	none tested positive prevalence: **0.0%** (95% CI: 0.0—1.0%)	–

Table 8. HIV Prevalence Estimates Among the General Population

Study/Author	Year	Method	Results	Remarks
Annual Census of Testing Laboratories on HIV/Dominguez N, Agdamag DM	2002-2004	▪ Passive surveillance ▪ PA, Rapid Test in the local laboratories ▪ LIA, WB in SACCL ▪ 634 tested in diagnostic lab ▪ 583 tested in private hospitals ▪ 2 tested in gov't hospitals	2 tested positive in samples from private hospitals prevalence: **0.4%** (95% CI: 0.04-1.34%) none tested positive in samples from diagnostic labs prevalence: **0.0%** (95% CI: 0.0-0.6%) 0.0% prevalence for government hospitals	▪ Only 19 testing laboratories whose medical technologists were trained by SACCL is represented in this data ▪ Sample pop'n consist of walk-in patients or those who undergo voluntary blood testing hence may under-represent prevalence in the general population

II. High-risk groups

Table 9. Population Size and HIV Prevalence Estimates Among Female Sex Workers

Study/Author	Year	Method	Results	Remarks
Rapid Assessment Survey (RAS) in Angeles City/Pacho AJ, Lopez SV for FHI	2005	▪ Records review of data from Reproductive Health and Wellness Center [RHWC] (formerly SHC) of Angeles City	**RFSW: 2582**	▪ No estimate for FLSW although a list of their cruising sites was obtained
Rapid Assessment Survey (RAS) in Baguio City/De Castro M, Brillantes CF for FHI	2005	▪ Count of female sex workers in establishments, pick-up points, cruising sites and hang-outs in Baguio City	**RFSW: 611** **Unregistered FSW: 286**	▪ The figures may be an underestimate of the true pop'n size of FSW as data from the Baguio City HIV Surveillance Team/SHC 2004 revealed that there are at least 750 up to 3500 RFSW in the area. ▪ The 611 RFSW reported included only those who are active in the registry of the SHC.
Rapid Assessment Survey (RAS) in Pasay City City/Uysingco P, San Juan A for FHI	2005	▪ Mapping of health center catchment areas and estimating pop'n size in establishments and cruising sites of FSWs	**FSW: 2566**	▪ Since both registered establishments and cruising sites were included in the estimation, the corresponding estimate obtained could be valid. There is a need, however to present calculations involved in estimating the pop'n size.
Rapid Assessment Survey (RAS) in Zamboanga City/Lim ML, Sabido L for FHI	2004	▪ head count in 94 establishments	**RFSW: 404** **FLSW: 400**	▪ The frequency distribution according to number of establishments of the risk group was not presented, hence, there is no way to validate the pop'n estimate presented
Rapid Assessment Survey (RAS) in Davao City/Roxas J II, Cueto R for FHI	2004	▪ Population size estimates were calculated in the absence of a scientific system and based only on records of the RWHC and actual count in establishments, cruising sites and pick-up points of FSWs and a set of assumptions	**RFSW: 2000-3000** **Unregistered FSW: 400-600 in a given week**	▪ Estimates were subjectively made without reference to any formula or mathematical derivation
Estimating the population size of Freelance Sex Workers in Angeles City: Application of the Capture-Recapture Technique/Saniel OP for PATH	2001	▪ Capture-Recapture Technique using a series of three cross-sectional surveys ▪ best-fitting model using log-linear models to estimate population size of FLSWs	Definite Recaptures: **1817** (95% CI: 1134-3374) All Recaptures: **868** (95% CI: 694-1234)	▪ pop'n size estimate for FSWs only ▪ still an underestimate of the true number of FLSWs since no sample was taken from sites such as shopping malls, small parks & street corners where FLSWs also recruit clients.
Integrated HIV Behavioral and Serologic Surveillance	2005	▪ Serologic surveillance in 10 sites ▪ 3845 samples tested	6 tested positive prevalence: **0.16%** (95% CI: 0.06-0.34%)	–
HIV Seropositives by Site and Surveillance Rounds	2003	▪ Serologic surveillance in 10 sites ▪ PA % Western Blot testing ▪ 5707 samples tested	1 tested positive prevalence: **0.02%** (95% CI: <0.0001-0.10%)	–
HIV Seropositives by Site and Surveillance Rounds	2002	▪ Serologic surveillance in 10 sites ▪ PA % Western Blot testing ▪ 5845 samples tested	6 tested positive prevalence: **0.10%** (95% CI: 0.04-0.22%)	–

Table 10. HIV Prevalence Estimates Among Injecting Drug Users

Study/Author	Year	Method	Results	Remarks
HIV Seropositives by Site and Surveillance Rounds	2005	▪ Serologic surveillance ▪ 243 samples tested	2 tested positive prevalence: **0.8%** (95% CI: 0.1-2.9%)	–
HIV, Hep B and Hep C Prevalence among IDUs in Cebu City/Tac-an I	2002-2005	▪ Convenience sampling ▪ PA testing ▪ 350 samples tested	none tested positive prevalence: **0.0%** (95% CI: 0.00-0.01%)	–
HIV Seropositives by Site and Surveillance Rounds	2003	▪ Serologic surveillance in 10 sites ▪ PA % Western Blot testing ▪ 230 samples tested	none tested positive prevalence: **0.0%** (95% CI: 0.00-0.02%)	–
HIV Seropositives by Site and Surveillance Rounds	2002	▪ Serologic surveillance in 10 sites ▪ PA % Western Blot testing ▪ 296 samples tested	none tested positive prevalence: **0.0%** (95% CI: 0.00-0.01%)	–

Table 11. Population Size and HIV Prevalence Estimates Among Men Who Have Sex with Men (MSM)

Study/Author	Year	Method	Results	Remarks
Rapid Assessment Survey (RAS) in Baguio City/De Castro M, Brillantes CF for FHI	2005	▪ Count of registered male sex workers in gay bars in Baguio City	**MSM: 26**	▪ Number may be an underestimate of the true pop'n size of MSM since only those registered at SHC were included.
Rapid Assessment Survey (RAS) in Pasay City City/Uysingco P, San Juan A for FHI	2005	▪ Mapping of health center catchment areas and estimating pop'n size in cruising sites, bath houses and gay bars	**MSM: 376**	▪ Since cruising sites were visited during the estimation, the corresponding estimate could be valid. There is need, however to present calculations used in estimating the pop'n size.
Rapid Assessment Survey (RAS) in Zamboanga City/Lim ML, Sabido L for FHI	2004	▪ head count in 94 establishments	**MSM: 187**	▪ The frequency distribution according to number of MSM by establishments was not presented, hence, there is no way to validate the pop'n estimate presented
Rapid Assessment Survey (RAS) in Davao City/Roxas J II, Cueto R for FHI	2004	▪ Population size were based only on actual count of MSMs seen in cruising sites	**MSM: 500-700 in a given week**	▪ Estimates were subjectively made without reference to any formula or mathematical derivation
Rapid Assessment Survey (RAS) in General Santos City/Roquero LB, Mateo RJ, Jr., Bidad W	2004	▪ Count of male sex workers in cluster areas consisting of beach resorts, bars and pick-up points for male sex workers	**MSM: 237**	▪ The number of MSMs in a given week cannot be ascertained due to limited data gathering period of the study, hence, pop'n size could be an underestimate.
Serologic Surveillance/Corpuz A	2005	▪ Time location sampling in Cebu City and Gen. Santos City ▪ A total of 410 MSMs ▪ HIV testing used: ELISA	none tested positive prevalence: **0.0%** (95% CI: 0.00-0.90%)	▪ population size used: 190,000 – 950,000 ▪ 1% prevalence (NDHS) ▪ 5% based on Asian Epidemic (UNAIDS)
Integrated Biological and Behavioral Survey among MSMs in Baguio City/FHI	2004-2005	▪ Two-stage sampling strategy: time location and random sampling ▪ Standard lab testing at SACCL ▪ 261 MSMs participated	none tested positive prevalence: **0.0%** (95% CI: 0.00-1.4%)	▪ High refusal rate (48%)
Integrated Biological and Behavioral Survey among MSMs in Metro Manila cities (Pasay, QC, Mla.)/FHI	2004-2005	▪ Two-stage sampling strategy: time location and random sampling ▪ Standard lab testing at SACCL ▪ 260 MSMs participated	none tested positive prevalence: **0.0%** (95% CI: 0.00-0.01%)	▪ High refusal rate (48%)
HIV Seropositives by Site and Surveillance Rounds	2003	▪ Serologic surveillance in 10 sites ▪ PA % Western Blot testing ▪ 1000 samples tested	1 tested positive in Cebu City prevalence: **0.10%** (95% CI: 0.00-0.6%)	▪
HIV Seropositives by Site and Surveillance Rounds	2002	▪ Serologic surveillance in 10 sites ▪ PA % Western Blot testing ▪ 1120 samples tested	none tested positive prevalence: **0.0%** (95% CI: 0.00-0.3%)	▪

Table 12. Population Size and HIV Prevalence Estimates Among Male Clients of Female Sex Workers

Study/Author	Year	Method	Results	Remarks
National and Demographic Health Survey (NDHS)	2003	▪	**2% of men reported paying for sex in the past 12 months**	▪ The figure could still be an underestimate assuming some male respondents gave not trustworthy answers
Integrated HIV Behavioral and Serologic Surveillance	2005	▪ Convenience sampling in 10 sites ▪ HIV testing used: ELISA ▪ 888 samples	1 tested positive prevalence: **0.11%** (95% CI: 0.00-0.6%)	▪ Since there is no data available for Male Clients of FSW, figures used were estimates for Male STD patients (assuming that the said group are most likely clients of FSW)

Objectives of HIV Estimation

In general, the objective of the consensus workshop was to provide an estimate of HIV prevalence for 2005 using the Workbook Method. Specifically, it estimated the number and prevalence of HIV infection among high and low-risk groups in the country.

Methodology: Estimation of HIV Infections by End of 2005

The preparation process

The WHO and UNAIDS have developed guidelines in the process of estimating the number of HIV cases in a particular country (or regions within the country) at particular points in time. These guidelines included the development of methods which can be more or less universally applied to estimate the burden of HIV infection. The guidelines also underscored the need to create a Technical Working Group who will assist in identifying, collating and assessing the quality of data to be used in the estimation process. The TWG will generate preliminary estimates of the HIV prevalence as well as the number of existing HIV infected persons and to submit these estimates for validation to a bigger body composed of various stakeholders such as DOH program managers, representatives of various agencies and other experts who also generate service statistics on HIV and who may have data on population size of those infected with the virus. When these estimates are "approved" through a consensus, then the data becomes official and ready for dissemination to various stakeholders.

The TWG members in action during the 2nd TWG meeting in Cebu City last Nov. 21, 2005

For this year, the TWG was composed of representatives from various offices of the DOH working on prevention and control of STI and AIDS such as the NEC, SACCL/SLH, NCDPC, foreign-assisted AIDS prevention projects (MSH/FHI Philippines), the academe (UP-CPH), selected LGU health offices and representatives from UNAIDS and WHO/WPRO (Annex A). The TWG also had a Secretariat which assisted in scheduling a series of TWG meetings and provided the members with information and other related materials needed to estimate the latest number of HIV infected persons in the country.

The role of the TWG was central in the success of the estimation process. This group was tasked to identify and agree on the method, among other methods available, that will be employed for the latest HIV Estimation Process and to identify and provide data sources to be used for the estimation. The TWG was also expected to resolve any technical issues in producing the estimate of the number of HIV infected persons in the country aside from reviewing the technical report of the Consultants hired to assist in the estimation process. At this time, DOH decided that a local consultant be hired to assist the TWG, instead of an international consultant. See Annex B for the TOR of the consultant. Drs. Ofelia Saniel and Jesus Sarol, Jr., of UP-CPH, agreed to serve as consultants to this 2005 HIV Estimation process.

Consensus meetings

The process of estimating the burden of HIV infection for 2005 closely followed the WHO/UNAIDS guidelines mentioned above. Key persons from the NEC-DOH and FHI Philippines were trained on the HIV estimation process in Bangkok in April 2005. An inter-agency meeting between WHO/WPRO, DOH, and FHI Philippines was held in September of the same year to agree on broad plans regarding this year's estimation process. Next, the TWG met in Cebu City on Sept. 15-16, 2005 to introduce the Workbook Method of Estimation. During this meeting, an inventory of all available data that could be used for the estimation was also identified and some of the members of the TWG were assigned to facilitate the collection of the pertinent data. More detailed plans for the Consensus building were made during this meeting.

Data needed for the estimation procedure included past HIV consensus reports such as Malaysia 2004 and Philippines 2000 and 2002 reports HIV, seroprevalence data from the IHBSS, prevalence data from blood donors, AIDS case reports compiled in the AIDS Registry, relevant data from NDHS, HIV prevalence results in special populations (seafarers, prisoners, TB patients, general population) and reports on special STI/RTI surveys. A data inventory was also prepared to document information needed for the estimation process. Members of the TWG were assigned to facilitate the collection of the information from various sources.

After a few initial meetings with DOH and WHO/WPRO officials to initiate the 2005 HIV estimation exercise, the first formal TWG meeting was held on 10 November 2005 at the College of Public Health, University of the Philippines Manila. During this meeting, previous estimates of HIV infection and the methods utilized for these earlier projections were reviewed. The members of the working group also reviewed the population groups and subgroups at risk of HIV infection. This was an attempt to validate among the group of experts the risk level of the various population groups/subgroups included in the list. Table 13 shows these various subgroups and their corresponding level of risk of HIV infection.

Table 13. Distribution of Population According to HIV Risk Level

Population	HIV Risk Level
Injecting drug users	High
Female sex workers	High
Men who have sex with men	High
Clients of sex workers	High
Military men	Low
Overseas contract workers (including seafarers)	Low
Prisoners	Low
Women in antenatal clinics	Low
Deep sea fishermen	Low
Youth and children	Low
Blood donors	Low
TB patients	Low
Truck drivers	Low
General population	Low

Dr. Eric Tayag welcoming the participants to the Consensus Workshop last December 12, 2005

During the same meeting, the TWG reviewed the inventory of data, which could be used for the estimation of the number HIV cases in the country, and the sources of these data were identified. The quality of the data was an important criterion considered before any data was used as basis for the estimation. In assessing the quality of data, methodological issues affecting the validity of the sample population and the time of conduct of the study was verified whether or not it was relevant to the period of interest for the estimation. Data validity refers to the influence of a number of methodological factors such as population size and quality of data collected (i.e., the manner by which sample population was drawn, the method of data collection and the appropriateness of data analysis). During this meeting, additional data sources were also identified.

A second TWG meeting was held at the Marriott Hotel in Cebu City on 21 November 2006. During this meeting, preliminary estimates and the basis for the said estimates were presented by the Consultants to the TWG members. There was a lengthy discussion about the preliminary estimates as well as the acceptability of the data on which some of the estimates were based. For instance, data on the size of FSW population was almost non-existent and complex assumptions had to be made to arrive at a reasonable estimate of the population size of this particular risk group. For some population groups (clients of sex

Drs. Aura Corpuz, Jesus Sarol Jr, Ofelia Saniel together with Noel Palaypayon, Paulyn Claro and Joel Jacob (not in picture) are members of the Secretariat.

workers, general population), data on population sizes and HIV prevalence estimates were not available, thus, data on surrogate populations were used instead. Revised estimates were made by the TWG after reviewing the preliminary estimates and the underlying assumptions behind these. Since more data were needed to be obtained and validated, the TWG agreed that the current estimates were still tentative pending the availability of more information. The TWG Secretariat, with the assistance of the consultants, had to review the estimates again in the light of new available information. Tentative plans for the Consensus Workshop in December were then discussed. In between the formal TWG meetings, the Secretariat, composed of NEC staff and the consultants met a few more times to review and finalize the estimates and the assumptions used for the estimation before the Consensus Workshop in Manila.

The Consensus Workshop was held at the Linden Suites in Pasig City last December 12, 2005. Participants were the TWG, Consultants, DOH and WHO officials, representatives from other DOH offices involved in HIV/STI prevention and control programs, representatives from NGOs working on HIV/AIDS and the academe (Annex C). The past estimates and the method used were presented during the Consensus as well as the Workbook Method for HIV prevalence estimation. At the end of the meeting, the participants agreed to wait for the upcoming results of the surveillance on IDUs and to resolve some issues on the number of blood donors tested in the NVBSP before estimates were finalized.

Workbook methodology

For the methodology on the estimation of HIV/AIDS, the Workbook approach was chosen. This was developed by the UNAIDS and WHO specifically for use in countries with low level and concentrated epidemics. Low-level epidemics are characterized by levels of HIV prevalence not having consistently exceeded 5% in any defined subpopulation, even in the HRG. On the other hand, a concentrated epidemic is one where the HIV prevalence is consistently higher than 5% in at least one subpopulation but less than 1% in the general population. The procedures are implemented through the application of a spreadsheet.

Identification of groups to be included

The Workbook approach requires initial identification of geographically defined units and the HRG and LRG present in each geographic unit. For each risk group, low and high estimates of the population size and the HIV prevalence data are required. However, in the case of the Philippines, since there is no sufficient data on HRG by region, only one national estimate was determined since there was no sufficient data on HRG by region.

HRGs identified were the IDUs, MSMs, FSWs and male clients of female FSWs. The reason for this selection is the availability of data for both population size and HIV prevalence in these subgroups, or if not available, in suitable surrogates. All other members of the population who did not belong to any of these groups were lumped together into the general population.

Estimation of population sizes of risk groups

The number of IDUs was obtained from the reports of the NADPA and DDB in 1998 featured by Cesar Tordesillas in his Manila Times article dated 21 November 2005. From this report, the estimated number of drug users in the Philippines was provided. This number was multiplied by the proportion who reportedly used Nubain, since this was the injecting drug of choice.

To estimate the total number of MSMs, the proportion of MSMs in the Philippine population was first obtained. Estimates of this proportion were taken from the results of two studies: the NDHS 2003 and the MENSSA Study of Ramos-Jimenez and Lee, 2001. The NDHS study interviewed 3147 men aged 15-49 years where questions on sexual behaviors were asked. On the other hand, the MENSSA study was a study on male sexual risk behaviors and HIV/AIDS that covered 2148 men aged 15-44 years in three cities in the country, namely, Quezon City, Cebu City and Davao City. In both instances, males who admitted engaging in anal sex during the past 12 months were taken as the sample of MSMs. After the proportion of MSMs was obtained, it was multiplied to the total male population (NSO 2005) to obtain the estimated number of MSMs.

The number of local male clients of FSWs was obtained using the following procedures. The data on the proportion of men who ever had sex was taken from the 2003 NDHS and among them, the proportion who paid for sex in the last 12 months was obtained. This figure was then multiplied with the total population of males to obtain an estimate of the total male clients of FSWs.

For estimating the total number of FSWs, the size of the male clients computed above and combined with the estimates agreed upon during the meeting in Cebu and behavioral data from BSS and RAS (2004) were used. The number of male clients was multiplied by their average number of contacts with FSWs per year (obtained from the BSS) and the product was divided by the number of workdays per FSW per year (obtained from the 2005 Cebu meeting). The result was the estimated number of FSWs required to meet the local demand. The proportion of foreign clients (RAS, 2004) was incorporated to estimate the total number of FSWs to meet demands of both local and foreign clients.

Low and high estimates of the sizes of the HRG populations were obtained as follows: Whenever there were more than two available estimates of a particular HRG size, the lowest value was considered the low estimate and the highest value the high estimate. If estimates were available from a single source, the lower limit and upper limit of the 95% confidence intervals were used as low and high estimates, respectively.

The rest of the population who were not included in the HRG was lumped together with the general population. Estimates of the general population were obtained separately for females and males.

Estimation of HIV prevalence of risk groups

HIV prevalence estimates for the identified HRG were available mainly from ongoing IHBSS. The most recent HIV prevalence figures available was used and ensuring that sample sizes were sufficient. Since the number of MSMs tested annually in the IHBSS was small, data from 2003 to 2005 were combined. In the absence of data for HIV prevalence in male clients of FSWs, this was approximated by taking the HIV prevalence rates in male clients of STD clinics.

For the general population, the group made use of the results of the screening for HIV among blood donors in lieu of ANC women in order to arrive at more stable estimates of HIV prevalence. In the latter group, there were very few subjects tested for HIV in the recent years, while the numbers of blood donors tested were many.

Similar procedures in obtaining low and high estimates as in the population sizes of risk groups were employed for the low and high estimation of HIV prevalence. Table 14 below shows the source of data per risk group identified.

Table 14. Source of data and risk group

Source of data	Risk group
IDU	IHBSS 2005
MSM	IHBSS 2003-2005
Male clients of FSW	IHBSS 2005
Female Sex Workers	IHBSS 2005
Blood donors	NVBSP and SACCL (2002-2004)

Additional Assumptions

Population sizes were based on projections for 2005, since no census was done for 2005. The projections were based on medium assumptions of population growth. Population size per area (i.e. urban, rural) was based on NSO classification as of 2000 (NSO Report 2003).

For the LRG, Method B of the Workbook approach was used but modified since Method A required knowledge of size and HIV rates of LRG but which were not available. The modification in Method B came about when it was necessary to assume that there was no group in the population who had no HIV transmission (called 'No Risk Group' in the Workbook approach). Only one prevalence rate was applied to the entire general population. Subsumed in this decision was the additional assumption that the HIV prevalence in the urban general population was equal to the rural general population.

Results

Populations included in the High Risk Group (HRG) were: IDUs, MSM, male clients of female sex workers and FSWs.

The Workbook Method classified the partners of high-risk populations as members of the LRG. However, there were no data available on the number of sexual partners of persons who belong to the HRG, which was a requirement of Method A for estimating HIV prevalence in the LRG. Thus, the TWG decided to use Method B which uses HIV prevalence data from pregnant women. In the absence, of data from ANC women, HIV prevalence rates of blood donors were applied instead.

Two of the TWG members – Drs. Nerissa Dominguez of WHO/WPRO and Dr. Dorothy Agdamag of SACCL

With a total adult (15-49 years) population of **44,413,476 M**, where some **21,340,675 M** lived in urban areas, the prevalence of HIV infection using the Workbook Method are presented in Tables 15-16 for each risk group and for the overall population.

Table 15. Country estimates of the size and prevalence of HIV infection in the HRG

High Risk Population	Estimates				Ave. no. of adults LWHA	Assumptions/ Remarks
	Population Size		HIV Prevalence (%)			
	Low	High	Low	High		
IDUs	16,000	30,500	0.10	2.90	**349**	▪ population size used was based on percentage of injecting drug use among number of drug users in the country ▪ HIV prevalence used based on results of IHBSS 2005
MSM	379,799	804,280	0.00	0.39	**1,171**	▪ percentage of anal sex behavior among MSM applied to male adult population to compute for size of MSM ▪ HIV prevalence used based on results of IHBSS 2003-2005
Male Clients of FSW	280,604	438,444	0.00	0.63	**1,136**	▪ proportion of men who ever had sex were assumed to be "sexually active" ▪ percentage of "paid sex" used to compute for number of male clients ▪ calculated pop. size is for local clients only; foreigners are not included since said group is a transient pop. ▪ HIV prevalence used based on results of IHBSS 2003-2005
FSW	112,354	175,553	0.06	0.34	**286**	▪ number of male clients calculated was used ▪ demand of paid sex and estimated working weeks in a year of FSWs were used as factors ▪ proportion of local clients was applied ▪ HIV prevalence used based on results of IHBSS 2005
Total	**788,757**	**1,448,777**			**2,942**	total number of high-risk adults LWHA

Based on the above results, the Workbook Method also calculated for female statistics, i.e., the number and percentage of infected women. Among the 2,942 high-risk adults LWHA, 10.3% or 303 were women. On the other hand, the number and percentage of infected women among low-risk adults LWHA in the general population is 4192 or 51.0%.

Table 16. Country estimates of the size and prevalence of HIV infection in the LRG

General Population	Estimates				Ave. no. of adults LWHA	Assumptions
	Population Size		HIV Prevalence (%)			
	Low	High	Low	High		
Low Risk Group						
Female	22,029,660	22,093,584	0.01	0.03	**4,192**	▪ pop. size automatically calculated by the Workbook ▪ HIV prevalence in voluntary blood donors reflect that in general population ▪ in the absence of prevalence data for rural population, it was assumed that rate is the same in urban
Male	20,871,115	21,595,059	0.01	0.03	**4,034**	▪ pop. size automatically calculated by the Workbook ▪ HIV prevalence in voluntary blood donors reflect that in general population ▪ in the absence of prevalence data for rural population, it was assumed that rate is the same in urban population
Total	42,900,775	43,688,643			**8,226**	

Table 17. Estimates of Prevalent HIV Infections, Philippines 2005

Number of adults (15-49) LWHA	11,168
Proportion of LWHA that are IDU (%)	3.1%
Adult (15-49) prevalence (%)	0.03%
Percent of LWHA who are female (%)	40.2%

In general, partners involved in the 2005 consensus process agreed that the estimated number of HIV infections among people aged 15-49 years old was 11,168, giving an overall national prevalence of 0.03% among adults (Table 17).

Discussion

The use of the Workbook method facilitated the estimation of HIV/AIDS, including the consensus-building process. It allowed for the identification of specific information to be used in the estimation procedure. The members of the TWG were compelled to critically examine the data sources for the population sizes, the HIV prevalence estimates and the assumptions that go with their applications. The TWG group found the estimation procedure in the Workbook Method fairly straightforward and acceptable provided reliable data are entered into the spreadsheet.

Unfortunately, despite its facility, the application of the Workbook approach in this consensus did not result in a situation where reasonable confidence can be attached to the estimates. The TWG members felt that many of the data used were of dubious quality. One reason was the unavailability of the recommended data requirements for specific subgroups. This forced the TWG to use available data from surrogate subgroups. For instance, HIV prevalence in male clients of STD clinics was used instead of prevalence in male clients of FSWs. Similarly the prevalence of HIV infections among blood donors was used in lieu of the prevalence of HIV among women in ANC clinics, due to instability of the prevalence of HIV infection derived from small samples in the latter group. Moreover, no direct estimates of the number of FSWs were available. In its place, the group resorted to a suggested estimation procedure that required several key assumptions (Table 15).

The Workbook method allows the estimation of the number and prevalence of HIV infections in sub-regions of the population studied. It would have been desirable had estimates for HIV infections were derived for each region, province or city in the Philippines to provide a geographical distribution of the problem. The fact that the country's IHBSS is concentrated in large cities in the country reflects the general notion that the prevalence of HIV infections varies widely geographically. However, due to the unavailability of the regional, provincial or city sizes of the HRG and the corresponding HIV prevalence data, the consensus group was constrained to deriving only a national figure.

In this report's estimation procedure, the group deviated slightly from the recommended methodology. Using Method B of the Workbook method, it suggests that HIV is present in both female and male members of the general population, whereas in the Workbook default, only the women contributes to the number of HIV infections. Data from the blood donors, after screening out individuals with high-risk behaviors and other blood-related infections such as hepatitis and STDs, did not differentiate male and female blood donors. In fact, male donors were expected to far outnumber females; consequently, the HIV-positive individuals detected in the blood screening were most likely to be males.

The other assumption that was changed in the Workbook approach was the zero transmission/prevalence in the general population, other than ANC women. The TWG's contention becomes more appropriate since it had lumped together into the general population category all who did not qualify for membership in the selected HRGs. One should realize that certain other subgroups that are hidden in this general population might actually be conduits of HIV infection since these groups had been previously identified to contribute to the number of HIV infection. These included among others, OFWs (having worked abroad has been consistently identified as a risk factor for HIV); MSMs who had abstained from sex in the past 12 months but might have been sexually active before; and, regular partners of IDUs and male clients of FSWs, who could easily be infected by their HIV-positive sexual partners. Unfortunately, the required information was not available to segregate them in the Workbook method as distinct HRG or even as LRG wherein low-level transmission was definitely occurring, so Method A of the Workbook approach could be applied.

The use of the prevalence of HIV among blood donors was very critical in the estimation process since this was applied to the biggest chunk of the general population. According to the rules in blood donation, the base population in the denominator counted only those individuals who had no history of high-risk behaviors and were not positive for other blood-borne diseases. Using this base, the level of HIV prevalence will tend to go down, thus underestimating the total number of HIV infections in the general population. The advantage of using blood donor data was the stability of the estimates because of the large numbers tested.

Drs. Ofelia Saniel and Jesus Sarol, Jr. assisted the TWG in the 2005 HIV Estimation

Other critical factors in the estimation were the numbers of FSWs and MSMs. An estimate used in the 2002 HIV Consensus Workshop has tagged the number of FSWs at 500,000 whereas, in this report, an upper limit of 175,500 was used. Unfortunately, the justification for the bigger estimate in 2002 could not be found for review. On the other hand, the population estimate of 175,500 FSWs, although indirectly interpolated, was based on actual results of relevant studies. The check feature of the Workbook finds the 500,000 FSWs an unusually high estimate, while the 175,000 was considered within the expected range when compared to the situation in other countries.

The estimated number of MSMs included only those who had been sexually active during the past 12 months. In the MENSSA study, 13.8% of men have ever had bisexual/homosexual acts, compared to only 1.7% who had sex with other men in the past 12 months. As previously mentioned, the difference in these two subgroups of MSMs (i.e., males who admitted to having sex with other men but had done so more than 12 months ago --- 13.8% minus 1.7%) had been counted in the general population who definitely had a lower risk of infection than these groups of MSMs.

Available information on prevalence of HIV infections among the different subgroups still suggested a low prevalence situation for the Philippines in 2005. All of the estimated HIV rates, even for HRG were below 5%, with 95% confidence. However, in comparison with earlier estimates, this report indicated a higher number of HIV infections. More recent data

suggest that HIV infections were more prevalent in 2005 in all HRG and more significantly, in the general population, compared to those in 2002. For instance, in 2005 the estimated prevalence of HIV infection among the general population ranged from 0.008% to 0.03% whereas the prevalence used in 2002 was only 0.001%.

Conclusions

1. As of 2005, the prevalence of HIV infection among adult Filipinos was 0.03%. This estimate translates to some 11,200 Filipinos between 15-49 years old who are HIV infected.

2. Although the high risk groups account for only 3% of the total population of 15-49 years old, 26% (or about 3,000) of the HIV infected individuals are found in these high risk groups.

3. An estimated 4,200 women 15-49 years old are HIV infected. This number represents about 40% of the total number of HIV infections in the country.

4. Although the number of HIV infected injecting drug users was only 350 (or 3% of total infected persons), this number can increase quite fast since transmission of infection in this particular high risk group is the most efficient.

5. The Workbook Method is a useful and practical tool to estimate the magnitude of existing HIV infections in countries with low level and concentrated epidemics such as the Philippines. However, many of the data required for estimation, like reasonable estimates of population size of high risk groups and the HIV prevalence in these risk groups, are lacking or are outdated.

Recommendations

For policy/advocacy purposes:

- Results of the IHBSS indicate marked variations in the levels of HIV infection and the frequency of practice of risky behaviors among the various high-risk populations and among the sentinel sites. It would, therefore, be reasonable to assume that estimates of prevalent HIV infections will likewise vary. However, the paucity of data on the size of these HRG in smaller subdivisions of the country makes it impossible to derive estimates of prevalent HIV infections in sub-national levels of the country. Needless to say, these types of estimates can better inform the governments, both national and local, in responding to the local needs. Attempts should be made to obtain the required information to maximize use of sub-national information. With more and better data becoming available at the subnational levels, the quality of information that will be available for the entire country will also be improved.

- With minimum technical assistance from DOH, this exercise on estimating prevalence of HIV infection can be replicated in other smaller areas of the country and can be used as an IEC and advocacy strategy to local government officials to increase their awareness and appreciation of the gravity and urgency of the AIDS problem as a political, social and health issue.

For surveillance and research purposes:

- The absence of reliable data on the size of the HRG, especially of FSWs and their clients, casts doubt on the accuracy of the current estimates of prevalent HIV cases in the country. Thus, collecting more and better quality data required for estimation purposes should be given priority.

- Clients of sex workers should be among the high risk populations that should be included in the regular IHBSS so that data on infection prevalence would be made available for future estimation purposes.

- It appears from the results of the Workbook Estimation method that a population with a 'moderate' level of HIV risk (i.e., risk of infection is higher than the general population but lower than the known risk groups) may exist but hidden among the general population. The Workbook Method should allow for further segregation of the 'low risk population' to better reflect the differences in risk of HIV among this very heterogeneous group. Lumping relatively higher risk groups (e.g., partners of IDUs, occupational cohorts of men on extended out-of-town assignments like military men, and MSMs who have been sexually inactive in the last 12 months) with pregnant women, who have lower risk of HIV infection, seems inappropriate. It is important to determine how best to identify and access this 'moderate risk' group so that appropriate prevention strategies such as behavior change communication can be designed for them.

- Over the years, the HIV/AIDS Registry consistently recorded HIV seropositive cases among Overseas Contract Workers (OCW). Because the number of tests done in this population is unknown, it was not possible to compute for the prevalence of infection in this population. It may be prudent to include this group as a sentinel population to validate data obtained from the Registry.

For program planning/management:

- Wider dissemination of the results of the estimation should be coupled with a focused discussion of the implications of the estimates on policy, HIV prevention and control programs, care and support initiatives, as well as surveillance and research, should be initiated by the government and private agencies working on HIV/AIDS, women's and children's health and rights issues.

- Design and implementation of HIV prevention and control intervention programs as well as care and support initiatives will considerably benefit if data on size, composition and location of the infected individuals/groups will be taken into consideration. Design of behavioral change communication strategies, for instance, will be more appropriate.

ANNEXES

ANNEX A

Terms of Reference for a Local Consultant on HIV Estimation 2005, Philippines

Rationale:

Preparatory meeting on the 2005 HIV Estimate set the target date and activities until the Philippines will come up with its 2005 figure of HIV positive. A standard workbook method will be utilized in estimating the number of HIV positive in the Philippines. The whole process will be composed of at least two meetings and one consensus workshop.

Based on the agreement made during the preparatory meeting, members of the technical working group will be collecting data that will be used in the estimate. This will be spearheaded by the National Epidemiology Center – Department of Health. All the members will work on the estimate, come up with assumptions that will support the estimate obtained and present to the bigger body during the consensus for approval.

A local consultant will be hired to assist the National Epidemiology Center and the technical working group during the whole process. He/she will collate all the data assigned to the members of the TWG. Together with NEC staff, they will facilitate the rational use of data with the prescribed Workbook Method. They will help the whole group come up with assumptions that will justify the computed estimate. Final output will be presented during the Consensus Workshop. Local consultant will facilitate the discussion on the implications of the estimate done by the TWG during the Consensus Workshop. Final write up will be submitted to the National Epidemiology Center two weeks after the said workshop.

Objectives:

1. To identify data, data sources to be used in the estimation of HIV/AIDS in the Philippines
2. To assist TWG in setting up all assumptions to guide in the estimation process
3. To assist NEC and TWG in the estimation process using the Workbook Method
4. To write and document the whole estimation process including the final estimate output
5. To facilitate all meetings and workshop

Methodology:

1. Brainstorming
2. Group work/Workshop

Expected Outputs:

1. Meeting 1: list/inventory of data needed by the Workbook Method; process on how available data was utilized using the Workbook Method
2. Meeting 2: assumptions; final estimate; 2005 HIV Estimate for the country; process in coming up with the final estimate
3. Meeting 3: final consensus; implications of the 2005 HIV Estimate; workshop documentation
4. Write up of the whole process

ANNEX B

Members of the Technical Working Group

Name	Designation/Office
1. Dr. Enrique Tayag	OIC, NEC-DOH
2. Dr. Juan Lopez	Chief, SRAE-DOH
3. Dr. Aura Corpuz	Program Manager, NHSSS-DOH
4. Dr. Dorothy May Agdamag	Technical Advisor, SACCL
5. Dr. Ilya Tac-an	Epidemiologist, CHO-Cebu City
6. Dr. Ma. Consorcia Quizon	FHI Consultant
7. Dr. Loreto Roquero, Jr.	Country Director, FHI
8. Dr. Ricardo Mateo, Jr.	Senior Technical Officer, FHI
9. Dr. Ma. Elena Borromeo	Country Coordinator, UNAIDS
10. Dr. Ma. Nerissa Dominguez	Program Officer, WHO
11. Dr. Nguyen Thuy	Regional Epidemiologist, WHO-WPRO
12. Mr. Joel Atienza	National HIV Coordinator, NASPCP, DOH
13. Mr. Noel Palaypayon	HIV Surveillance Officer, NEC-DOH
14. Dr. Ofelia Saniel	Professor, UP-CPH
15. Dr. Jesus Sarol, Jr.	Professor, UP-CPH

Secretariat

1. Dr. Aura Corpuz	Point Person for DOH, 2005 Estimate
2. Dr. Ofelia Saniel	Consultant
3. Dr. Jesus Sarol, Jr.	Consultant
4. Ms. Paulyn Jean Claro	Research Associate, UP-CPH
5. Mr. Noel Palaypayon	Documentor
6. Ms. Shiela L. Obsequio	Research Assistant
7. Mr. Joel Jacob	Support Staff

ANNEX C

List of Workshop Participants: Actual and Invited

I. Actual participants

Name	Designation/Office
1. Dr. Jean-Marc Olivé	WHO Representative
2. Dr. Roderick Poblete	PNAC Secratariat
3. Dr. Rossana Ditangco	Research Chief, RITM
4. Dr. Rosario Abrenica	Head, H4 Pavillon, SLH
5. Dr. Gerard Belemac	Program Manger, NCDPC
6. Ms. Hazel Galang	Medical Technologist, RITM
7. Dr. Arlene Gutierrez	PSMID, Cebu City Chapter
8. Ms. Lourdes Jereza	President, USPF
9. Dr. Madeleine Salva	PNGOC
10. Dr. Ruth Sison	PNRC
11. Dr. Florence Tadiar	President, WHCF
12. Mr. Perfecto Uysinco	Executive Director, TriDev
13. Dr. Zelda Zablan	Deputy Project Director, HIV/AIDS Study
14. Mr. Jesus Ramirez	PAFPI
15. Mr. Joel Jacob	Administrative Assistant, FETPAFI
16. Ms. Arlene June Tabios	UNAIDS
17. Ms. Nenita Ortega	Remedios AIDS Foundation

II. Other invited participants who were not present during the workshop

1. Dr. Criselda Abesamis	Director IV, NCHFD-NVBSP-DOH
2. Dr. Cora Manaloto	Public Health Advisor, OPHN, USAID
3. Asec. Austere Panadero	DILG
4. Dr. Yolanda Oliveros	Director IV, NCDPC-DOH
5. Dr. Ernesto Villalon	STI Coordinator, NASPCP-DOH
6. Dr. Michael Tan	Professor, UP-Diliman, Quezon City
7. Dr. Jose Narciso Sescon	Executive Director, RAF
8. Mr. Noel Pascual	President, Pinoy Plus
9. Mr. Joshua Formentera	President, PAFPI
10. Hon. Marianito Roque	Administrator, OWWA
11. Dr. Michaelangelo Marquez	PNRC
12. Dr. Emily Bomasang	OIC, Virology Department
13. Dr. Corazon Raymundo	YAFS-UP-Diliman, Quezon City
14. Dr. Jaime Lagahid	Director III, Infectious Disease Office-DOH
15. Ms. Malou Marin	Executive Director, ACHIEVE
16. Dr. Rosita Cueto	Social Hygiene Clinic Physician, Davao City
17. Ms. Ruthy Libatique	Program Manager, PNGOC
18. Dr. Mario Baquilod	Chief, Infectious Disease Office-DOH
19. Dr. Evelyn Alesna	Infectious Disease Office, Cebu Medical

ANNEX D

D. Data Collection Tool (used during 1st TWG meeting)

HIV Consensus 2005:

Meeting 1: Nov. 10, 2005

Kindly provide the following information.

Title of Project/Program	
Dates Covered:	
Areas Covered:	
Population Surveyed:	
Inclusion/Exclusion Criteria:	
Sampling procedure: (Please provide a short description of sampling procedure used)	
HIV testing procedure: (if applicable)	
Results: (Please provide a short description of your study results. Include the following points in your discussion.) - HIV prevalence - Estimates in high-risk groups - Other significant points	
Limitations/Comments on usefulness of data	

Name: _____

Signature: _____