Follow-up to the Declaration of Commitment on HIV and AIDS
United Nations General Assembly Special Session (UNGASS)

Country Report of the Philippines
January 2006 to December 2007

Prepared by the
Philippine National AIDS Council (PNAC)

With support from the
UN Theme Group on HIV and AIDS

Manila, Philippines
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Table of Contents

ACRONYMS

ADB	Asian Development Bank
AFP	Armed Forces of the Philippines
AIDS	Acquired Immune Deficiency Syndrome
AMTP	AIDS Medium Term Plan
APCASO	Asia-Pacific Council of AIDS Service Organisations
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
ASEP	AIDS Surveillance and Education Project
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BSS	Behavioural Sentinel Surveillance
CFSW	Clients of Female Sex Workers
CHD	Centre for Health Development
CHOWs	Community Health Outreach Workers
CRIS	Country Response Information System
CUP	Condom Use Programme
DepEd	Department of Education
DFA	Department of Foreign Affairs
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOLE	Department of Labour and Employment
DSF	Deep-sea Fishermen
DSWD	Department of Social Welfare and Development
FHI	Family Health International
FSW	Female Sex Worker
FSI	Foreign Service Institute
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV and AIDS
GO	Government Organisation
GOP	Government of the Philippines
GSP	Girl Scouts of the Philippines

GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
GWHAN	Girls, Women, HIV and AIDS Network
HACT	HIV/AIDS Core Team
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
IHBSS	Integrated HIV Behavioural and Serologic Surveillance
JICA	Japan International Co-operation Agency
LAC	Local AIDS Council
LGU	Local Government Unit
MARPs	Most-at-risk populations
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MIS	Management Information System
MSM	Men who have Sex with Men
MTPDP	Medium Term Philippine Development Plan
NASA	National AIDS Spending Assessment
NASPCP	National AIDS and STI Prevention and Control Programme
NCHFD	National Centre for Health Facility Development
NCPI	National Composite Policy Index
NDHS	National Demographic Health Survey
NEC	National Epidemiology Centre
NEDA	National Economic and Development Authority
NGO	Non-Government Organisation
NHSSS	National HIV/AIDS Sentinel Surveillance System
NSO	National Statistics Office
NVBSP	National Voluntary Blood Services Programme
OFW	Overseas Filipino Worker
OI	Opportunistic Infection
OSHC	Occupational Safety and Health Centre
OUMWA	Office of the Undersecretary for Migrant Workers Affairs
OVC	Orphans and vulnerable children
OWWA	Overseas Workers Welfare Administration
PAF	Programme Acceleration Fund

PAFPI	Positive Action Foundation Philippines, Inc
PDEA	Philippine Drug Enforcement Agency
PDOS	Pre-Departure Orientation Seminar
PEOS	Pre-Employment Orientation Seminar
PE	Peer educator
PGH	Philippine General Hospital
PhilHealth	Philippine Health Insurance Corporation
PNGOC	Philippine NGO Council on Population, Health and Welfare
POEA	Philippine Overseas Employment Administration
PPA	Pinoy Plus Association
PIPs	People in Prostitution
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PNAC	Philippine National AIDS Council
PNP	Philippine National Police
PO	People's Organisation
POEA	Philippine Overseas Employment Administration
RA	Republic Act
RAATs	Regional AIDS Assistance Teams
RATF	Regional AIDS Task Force
RITM	Research Institute for Tropical Medicine
SACCL	STI/AIDS Co-operative Central Laboratory
SHC	Social Hygiene Clinic
SLH	San Lazaro Hospital
SSESS	Sentinel STI Etiologic Surveillance System
STI	Sexually Transmitted Infection
TB	Tuberculosis
TCS	Treatment, Care and Support
TDF	Tropical Disease Foundation
TESDA	Technical Education and Skills Development Authority
TISAKA	Tingog sa Kasanag

TWG	Technical Working Group
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USPF	University of Southern Philippines Foundation
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

I. status at a glance

A. Process of developing the Country UNGASS Report 2006-2007

The Philippines began planning for its Country UNGASS Report (January 2006 to December 2007) as early as June 2007 and earnestly begun preparation in July 2007 with the widest inclusion of various stakeholders from government, donors, civil society, and communities of most at risk populations and people living with HIV and AIDS. A total of 114 agencies and organisations were involved in a series of consultations (52 from the government agencies including some regional offices; 42 non-government organisations or NGOs; seven [7] donor agencies; seven [7] UN agencies; three [3] academic institutions; and three [3] organisations of the positive community.) In addition, three (3) individual AIDS experts were consulted.

Data were collected from all sectors involved in HIV and AIDS prevention and control programme across the country. The National Economic Development Authority (NEDA) collected, consolidated, and analysed data pertaining to the National AIDS Spending Assessment (NASA) over a period of two (2) months.

The National Composite Policy Index (NCPI) was consolidated through desk review, consultations, workshops, and self-administered questionnaires. *(see Annex 2 for complete list of participants)*

Prior to consultations, selection of participants to the NCPI was done in consultation with *Pinoy UNGASS,* the Philippine National AIDS Council (PNAC), the Principal Recipient and Sub-Recipient of the Global Fund for AIDS, TB and Malaria (GFATM) Project, and the UN Theme Group on HIV and AIDS. *Pinoy UNGASS* is an electronic discussion group that begun in 2003, aimed as an advocacy tool for wider participation of all sectors in the national response in general and UNGASS report in particular. Since then, it has become a national network of NGOs that monitors the implementation of UNGASS commitments.

The selection of participating NGOs to the NCPI workshop is based on criteria set in 2005 for UNGASS report, that is, an NGO should have existing programmes on HIV and AIDS and have been working on HIV and AIDS for at least three (3) years. The Philippine UNGASS Report 2008 Team also developed an *"NCPI Part B Facilitation Guide"* which proved to be significantly helpful in guiding the participants in understanding the NCPI questionnaire which was found to be subject to a wide variety of interpretations.

Majority of the multilateral/bilateral representatives who participated in the NCPI consultation process viewed the NCPI questionnaire as an evaluation of the country's policies which to them is a sensitive issue, prompting them to decline filling in the questionnaire. Instead, they suggested the following:

1. It would be easier for bilateral organisations if they would fill up a survey form instead of an evaluation form. However, if a survey would be conducted instead, the methodology should be changed. Instead of selecting a few focal organisations, there should be sufficient sampling of bilateral organisations to make the results credible.
2. Donors can answer questions on NASA, but the NCPI is a sensitive area that generates diplomatic/protocol issues. They noted that as foreign bilateral organisations, they really could not comment or judge a country's existing policies. One participant noted that answering the form might have diplomatic repercussions on the organisations involved.

The accuracy and veracity of the data and consensus on the overall report were confirmed in a vetting workshop held on November 23, 2007. Further vetting on the data reported was made by the multi-sectoral, multi-disciplinary Philippine UNGASS core team during a series of meetings in December 2007 to January 25, 2008.

The report was also circulated among the UN Theme Group on HIV and AIDS, the PNAC Executive Committee and the final approval by the PNAC members was done through a referendum.

B. Status of the epidemic

The Philippines is an HIV low prevalence country with cumulative registered cases of 3,061 from 1984 to the end of December 2007. Of this cumulative number, 2,754 are still living.

HIV affects Filipino adults during their peak economically productive years (58% of the registered cases were aged 25-39 years old). Current data indicate that young adults, men who have sex with men (MSMs), people in prostitution (PIPs), injecting drug users (IDUs), overseas Filipino workers (OFWs), and the partners of all these groups are particularly vulnerable to HIV infection.

Compared to the monthly average in the last five (5) years (2003-2007) which was 20 per month, the AIDS Registry showed an average of 29 new HIV cases per month for 2007. National adult HIV prevalence remains under 0.1%. [1]

HIV prevalence among the most-at-risk-populations (MARPs) remains at .08%. But the low prevalence is no reason to be complacent; behaviour change among the MARPs and vulnerable populations continues to be a challenge. All modes of transmission have already been reported but sexual means remain to be the most common (88%). Condom use among MARPs (e.g. FSW : 65%; MSM: 45%) is below universal access (UA) target and lower among the general population.

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[1] HIV and AIDS Country Profile Philippines 2005

C. Policy and programmatic response

The policy and programmatic anchor of the national response to HIV and AIDS is Republic Act 8504 or the Philippine AIDS Prevention and Control Act of 1998. Amendments have been proposed in the last 13th Congress of the House of Representatives to make it more suitable to the changing times and ever evolving dynamics of HIV prevention in the country.

The principle of "Three Ones" is in place in the country with the national response having:

1. **One co-ordinating authority** – The *Philippine National AIDS Council (PNAC)* was constituted in 1992 and has set the following policy directions in implementing AMTP IV:

a. Alignment with the vision, goals, and purposes of the Medium Term Philippine Development Plan (MTPDP), the Millennium Development Goals (MDG), UNGASS Declaration of Commitment on HIV and AIDS and the ASEAN Joint Ministerial Statement and other international commitments relevant to the country;
b. Ensure that measures and programmes are responsive to the identified needs of concerned sectors, individuals, and groups;
c. Give priority to the infected and affected and to existing and emergent highly vulnerable groups covered by AMTP IV;
d. Ensure quality improvement in the design and implementation of STI, HIV and AIDS interventions and put in place systems to monitor and measure quality of these interventions;
e. Scale up and expand effective intervention measures with corresponding ample resource support;
f. Ensure integration, harmony of purpose and direction of all on-going programmes and projects;
g. Establish mechanisms to ensure a protected level of funding support to achieve the goals and objectives of AMTP IV.

2. **One strategic plan** – The national response to the AIDS epidemic of the country is embodied in the *AIDS Medium Term Plan IV (2005-2010).* The goal of the AMTP IV is to prevent further spread of HIV infection and reduce the impact of AIDS on individuals, families, and communities. It is articulated in more detailed form with corresponding resource requirements in the Operational Plan (2007-2008). Under the leadership of PNAC, both documents came about after a series of consultations with various stakeholders. The Operational Plan reflects priority activities that need to be accomplished before 2010 from the AMTP IV.

Objectives of the AMTP IV:

a. Increase the proportion of population with risk-free practices;

b. Increase the access of people infected and affected by HIV and AIDS to quality information, treatment, care and support services;
c. Improve accepting attitudes towards people infected and affected by HV and AIDS; and
d. Improve efficiency and quality management of systems in support of HIV and AIDS programmes and services.

The two-year AIDS Operational Plan (2007 to 2008) spells out the priorities for 2007 to 2008 with corresponding cost requirements. The AMTP IV and the Operational Plan were developed from multi-sectoral inputs in a series of consultations and workshops among stakeholders. Aside from the above documents, the country also has developed its Roadmap to Universal Access to Prevention, Care, Treatment, and Support.

3. **One monitoring and evaluation framework** - The *Monitoring and Evaluation System of the Philippine AIDS Response* is discussed in detail in Sections IV and VII.

D. Achievement of UNGASS Indicators in the Philippines 2006-2007

The Integrated HIV Behavioural and Serologic Surveillance or IHBSS 2007 covered 10 sentinel sites in the country leaving out 29 cities and municipalities with HIV and AIDS programmes under the GFATM. HIV prevention activities in some of these sentinel sites have slowed down due to lack of funding.

Plans by the National Epidemiology Center (NEC) of the Department of Health (DOH) to include all sites to capture data outside of sentinel sites are underway.

UNGASS Indicators

Indicators	Main Data Source	Status: 2006-2007	Remarks
National Commitment and Action – Expenditures			
1. Domestic and international AIDS spending by categories and financing sources	National AIDS Spending Assessment (NASA 2005-2007, unpublished report)	2006: USD 8,561,155 2007: USD 4,829,217 (up to Sep 2007)	2005: USD 8,054,566 The national AIDS spending assessment tracks and profiles, by financing source and type of activity or action, HIV and AIDS spending in the Philippines from 2005 up to September 2007. NEDA collected data from government (national and some local government units), multilateral and bilateral organisations and NGOs. *Data limitations:* 1. non-disaggregation of data 2. some may have been budget data and not actual expenditures 3. limited LGU and NGO data, unaccounted spending items, estimated expenditure items The bulk of expenditure on *prevention and treatment* in 2005 and 2006 was supported by the GFATM.

Indicators	Main Data Source	Status: 2006-2007	Remarks
National Commitment and Action – Policy Development and Implementation Status			
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	NCPI Workshop Results	2006-2007: Index not computed anymore	2003: 85.00% 2005: 91.66% Please refer to Annex 2 for NCPI summary report
National Programmes			
3. Percentage of donated blood units screened for HIV in a quality assured manner	HIV and AIDS Registry 2007 as reported by National Voluntary Blood Services Programme (NVBSP) of National Centre for Health Facility Development (NCHFD)	No data available	Proxy data: 391 screened blood units were reactive to HIV and referred to the National Research Laboratory in Research Institute for Tropical Medicine (RITM). Of these, 30 were confirmed HIV + by Western Blot. Starting 2008, the DOH through the NEC and NVBSP will collect this data.
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Department of Health-National AIDS STI Prevention and Control Programme (DOH-NASPCP)	2006: 99% (170/172) 2007: 56% (336/600)	The current treatment policy of the country states that PLHIV with CD4 count of 200 or less are provided with free ARV. In 2007, the estimated number of adults and children with advanced HIV infection is higher than in 2006.

5. Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child transmission	HIV and AIDS Registry 2007	2006: 100% 2007: 50%	It should be noted that all known HIV+ pregnant women are provided with services. Two (2) cases were reported to have received PMTCT services in 2006 of the estimated 77 HIV positive women likely to get pregnant (15-45 years old). In 2007, one case was reported.
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	DOH - NASPCP; GFATM-TDF	2006-2007: 49% of all cases (99/201)	Since 2006, 99 of 201 estimated number of TB cases in PLHIV received TB and HIV treatment. Of the 201, 60% were female and 40% were male.
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	NDHS 2003 Table 11.6: HIV testing status of men	Partial Data available	The available data was the testing status of men - 2.4% (106/4428) who have reported that they had been tested and knew the results. No data is available on women because they are not covered in the survey for this particular question. Plan: NDHS is being reviewed and PNAC is ensuring the inclusion of women population for this question. This is to align NDHS data according to UNGASS requirements.
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	IHBSS 2007	FSW: 12% (618/5205) MSM: 16% (169/1059) IDU: 4% (33/752) Clients of FSWs: 6% (78/1275)	Plan: Additional data may be obtained from the 22 newly established VCT centres. However, no data from these centres can be established yet as of this time. Systems and mechanisms for reporting from VCT centres are currently being established to enable the country to monitor progress on this core indicator.

9. Percentage of most-at-risk populations reached with HIV prevention programmes	IHBSS 2007	• FSW: 14% (703/5205) • MSM: 19% (196/1059) • IDU: 14% (106/752) • Clients of FSWs: 6% (72/1275)	IHBSS 2007 covered 10 sentinel sites in the country leaving out 29 cities and municipalities with HIV and AIDS programmes under the GFATM. HIV prevention activities in some of these sentinel sites have slowed down due to lack of funding. Plans by NEC to include all sites to capture data outside of sentinel sites are underway.
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Lunduyan, et al. A Deafening Silence. UNICEF, 2005.	No data available	2005: 65% (59/90) In 2005, DSWD and UNICEF estimated that there are 2,000,000 orphans (0-17 yrs old) in the Philippines, not necessarily due to AIDS. A study made by Lunduyan, et al. in 2005 revealed that of the 90 infected and affected children, 59 (65%) were provided OVC services by the DSWD, Precious Jewels Ministry, and Lunduyan Foundation.
11. Percentage of schools that provided life skills-based HIV education within the last academic year	Department of Education (DepEd) http://www.deped.gov.ph/cpanel/uploads/issuanceImg/factsheet2007(Aug31).pdf (accessed January 17, 2008)	No data available	As of 2007, there are 42,140 elementary and 8,450 secondary schools in the country, both public and private under the supervision of the DepEd. The current life skills modules of DepEd do not have specific HIV topics. However, many NGOs implement adolescent sexual and reproductive health, including HIV projects in schools. The Girl Scouts of the Philippines (GSP) which is present in almost all public elementary and secondary schools also run Adolescent Sexual and Reproductive Health (ASRH) programme, including HIV and AIDS.

			The M & E System of the Philippine HIV and AIDS Response, once fully operational will enable the country to obtain data from DepEd, GSP, and other NGOs.
Knowledge and Behaviour			
12. Current school attendance among orphans and among non-orphans aged 10-14	DepEd: http://www.deped.gov.ph/cpanel/uploads/issuanceImg/Indicators0506.pdf *(accessed January 17, 2008)* http://www.unicef.org/infobycountry/philippines_statistics.html#25	Indicator not relevant to the Philippines	In 2005, the DSWD and UNICEF estimated that in the Philippines, there are 2,000,000 orphans (0-17 yrs old), not necessarily due to AIDS.
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NDHS 2003 Table 11.3.1/11.3.2 Beliefs about AIDS: Women and men age 15-49 years old correctly rejected local misconceptions about AIDS transmission or prevention	No data available	Actual questions in NDHS 2003: Q1: People can reduce the risk of having HIV by limiting sex to one uninfected partner - 72% (4709/6558) Q2: People can reduce the risk of having HIV by using condoms - 48% (3136/6558) Q3: AIDS cannot be transmitted by supernatural means (proxy for healthy-looking person can have HIV) - 79% (5188/6558) Q4: AIDS cannot be transmitted by mosquito bites - 59% (3899/6558)

			Q5: A person cannot become infected by sharing a food with person with AIDS – 49% (3190/6558) Plan: NDHS is being reviewed and PNAC is ensuring the inclusion of the indicator in the published report. This is to ensure that NDHS data are aligned according to UNGASS requirements.
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	IHBSS 2007	Correctly answered all 5 questions: • FSW: 2% (93/5205) • MSM: 10% (106/1059) • IDU: 26% (199/752) • Clients of SW: 19% (240/1275)	Actual questions used: 1. Having sex with only one faithful partner reduces the risk of HIV Transmission. 2. Using condom during vaginal sex prevents HIV transmission and using condom during anal intercourse prevents transmission. 3. In your opinion, can you tell if someone is infected with HIV just by looking him/her (proxy: Can a healthy looking person have HIV?) 4. Mosquitoes and other insect bites will transmit HIV 5.One can get HIV if one uses public toilets. In addition, the IHBSS showed higher results for the following: MARPs who correctly identified at least 3 ways of preventing sexual transmission of HIV: FSW: 53% (2753/5205) MSM: 49% (515/1059) IDU: 75% (566/752) Clients of FSWs: 66% (840/1275) MARPs who correctly identified at least 1 way of preventing sexual transmission of HIV: FSW: 92% (4797/5205) MSM: 49% (773/1059) IDU: 75% (653/752) Clients of FSWs: 97% (1234/1275)

			IHBSS 2007 only covered 10 sentinel sites in the country leaving out 29 cities and municipalities with HIV and AIDS programmes under the GFATM. HIV prevention activities in some of these sentinel sites have slowed down due to lack of funding. Plans by NEC to include all sites to capture data outside of sentinel sites are underway.
15. Percentage of young women and men who have had sexual intercourse before the age of 15	NDHS 2003 Table 6.5: Age at sexual intercourse	No data available for general population	The NDHS published report has no exact equivalent of the UNGASS question. Available data is on women only which indicates that 1% (70/4856) had sex at age 15.
16. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	NDHS 2003 Table 11.10: Multiple sex partners among young men IHBSS 2007	No data available for general population	In NDHS 2003, 6% (105/1703) of young men age 15-24 years old who have had sexual intercourse in the last 12 months. In IHBSS, the following MARPs had sexual intercourse with more than one partner in the past 30 days: MSM: 40% (410/1035) IDU: 30% (224/748) 32% male; 0% female Clients of FSWs: 44% (526/1187) all males Data on FSWs who had sex with client in the past 7 days and those who had sex other than the client in the month: 90% (4674/5187)

17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	NDHS 2003 IHBSS 2007	No data available for general population	No data available for general population. IHBSS 2007, the following MARPs who had more than one sexual partners and used a condom during their last intercourse: FSW: 48% (2250/4674) MSM: 49% (505/1035) IDU: 27% (61/224) – 27% male; 0% female Clients of FSWs: 65% (344/526) all males
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	IHBSS 2007	• FSW : 65% (3400/5205) • MSW among MSM: 50% (75/150)	Data on male sex workers (MSW) were generated from MSM who reported having been paid for sexual services. 150 have been paid for sexual services out of 1059 total MSM sample size reported
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	IHBSS 2007	32% (69/216)	IHBSS 2007 data on the percentage of men reported the use of condom the last they had anal sex with a male partner reveals that they have the following types of partners: 1. Condom use with consensual partner: 32% (69/216) 2. Condom use with paid partner: 30% (31/102) 3. Condom use with paying partner: 50% (75/150) For CRIS data, item 1 was submitted.

20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	IHBSS 2007	No data available	IHBSS 2007 asked the following questions. The results are given but cannot generate specific answer to the UNGASS indicator: 1. condom use during last sexual intercourse with wife – 14% (64/450) 2. condom use during the last sexual intercourse with sex worker – 27% (62/226) 3. condom use during last sexual intercourse who paid IDU – 30% (43/141) 4. condom use during last sexual intercourse with other partners – 30% (44/217) Plan: PNAC to ask NEC to align IHBSS questions to UNGASS requirement
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	IHBSS 2007	48% (359/752)	
Impact			
22. Percentage of young women and men aged 15–24 who are HIV infected	HIV and AIDS Registry 2007 Unicef Report	No data available for general population	AIDS Registry reveals that among young women and men aged 15–24: 2006: 44 (Females: 16; Males: 28) 2007: 41 (Females: 4; Males: 37) HIV screening as part of antenatal services for the general population is not yet in place in the country. The Philippines is piloting such in Davao Medical Centre and soon, the GFATM–supported Round 6 AIDS project will also pilot a similar service for pregnant women.

23. Percentage of most-at-risk populations who are HIV infected	IHBSS 2007	0.08% (7/8291)	FSW: 0.06% (3/5205) MSM: 0.28% (3/1059) IDU: 0.13% (1/752) Clients of FSW: 0% (0/1275) Data on age disaggregation is not available
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	DOH - NASPCP	Sep 1 2005 to Aug 31 2007: 96 % (163/170)	All patients are over 15 years old Male: 60% (98) Female: 40% (65)
25. Percentage of infants born to HIV-infected mothers who are infected	HIV and AIDS Registry 2007 Modelled c/o UNAIDS Geneva		The HIV and AIDS Registry reveals that: 2006: 4 perinatal transmissions ages ranging from 2 to 10 2007: 8 perinatal transmissions ages ranging from 2 to 8

II. overview of the AIDS epidemic

The first HIV and AIDS case in the Philippines was reported in 1984. The Philippine HIV and AIDS Registry carries a cumulative total of 3,061 from 1984 to December 2007. More than half (52%) were detected in the last seven (7) years (2001-2007). From a "low and slow" description of the status of HIV in the Philippines during the 1990s until the year 2004, local experts now look at the possibility that HIV is "hidden and growing."

PNAC reports that HIV infection in the country has been significantly picking up pace since 2000. With an average of 20 people being infected with HIV every month, the current rate of new case reports is at least twice that observed in the 1990s. [1] Sexual means of transmission remains to be the most common (87%). *(see table 3)*

Compared to the monthly average in the last five (5) years (2003-2007) which was 20 per month, the HIV and AIDS Registry showed an average of 29 new HIV cases per month for 2007. National adult HIV prevalence remains under 0.1%.[2] HIV prevalence among the MARPs remains at 0.08%.

Returning OFWs account for about 35% of the total reported cases. It should be noted, however, that HIV antibody testing is routinely conducted among OFWs as part of employment requirements of their employers and/or the host countries.

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[2] HIV and AIDS Country Profile Philippines 2005

[3] HIV and AIDS Country Profile Philippines 2005

Table 1: Reported number of people living with HIV and AIDS (PLHIV) in the Philippines, 984 to December 2007

Cumulative Number of HIV and AIDS cases	**Total**	**3,061**
	Male	2,027
	Female	1,023
	Unknown	11
Cumulative Number of AIDS cases	**Total**	**782**
Number of AIDS deaths	**Total**	**307**
Reported Cases in 2006	**Total**	**309**
	Male	219
	Female	90
Reported Cases in 2007	**Total**	**342**
	Male	279
	Female	63

Source: HIV and AIDS Registry 2007

Table 2: HIV seropositive cases by sex and age group as of December 2007

Age	Male	%	Female	%
<10	26	1.28	19	1.85
10 – 19	16	0.79	35	3.42
20 – 29	531	26.2	416	40.7
30 – 39	778	38.3	356	34.8
40 – 49	464	22.9	125	12.2
>50	176	8.68	44	4.30
No age reported	36	1.78	28	2.73
TOTAL	2,027	100	1,023	100

Notes:

a. *10 cases had no reported age and gender. (1 in 1991, 3 in 1993, 3 in 1994 and 3 in 2000)*
b. *1 case in 2003 had no reported gender*

Source: HIV and AIDS Registry 2007

Table 3: Reported Modes of Transmission as of December 2007

Reported Modes of Transmission	January 1984–December 2007	January to December 2006	January to December 2007
Unsafe Sexual Transmission			
• Heterosexual Contact	1,838	193	139
• Homosexual Contact	620	81	107
• Bisexual Contact	230	26	74
Contaminated Blood/Blood Products	19	0	0
Injecting Drug Use	7	0	0
Needle prick injuries	3	0	0
Perinatal transmission	45	4	8

Source: HIV and AIDS Registry 2007

It should be noted, however, that the HIV and AIDS Registry data is limited to reported cases. Out of lack of knowledge, fear or a strong belief that they can never get infected, (even among the most at risk and vulnerable groups), only few people get themselves tested for HIV. These limitations notwithstanding, the increasing number of cases seem to complement the 2005 estimate by the World Health Organization (WHO) and the DOH that the number of Filipinos infected with HIV is reaching 12,000 from just 6,000 in 2002. The estimated number of PLHIV in 2007, however is down to 7,490 which are mainly due to the change in the estimation methodology.

A. Estimates of population sizes

Most recent estimates of the most at risk and vulnerable populations were reached during a series of workshop from September to December 2007. Estimates of the number of PLHIVs were arrived at during a National Consensus Meeting held on November 22, 2007.

The AMTP IV puts the OFWs as vulnerable population. Of the 8 to 12 million OFWs, it is estimated that 883,897 are deemed at most at risk due to their work situation and behaviour.

Table 4: Estimates of MARPs and Vulnerable Population Size 2007

MARPs	Estimated population size 2007			
	Low	High	HIV prevalence Estimates %	
			Low	High
• Female sex workers	128,196	156,108	0.01	0.19
• Men who have sex with men	203,340	610,019	0.07	0.98
• Injecting drug users	7,239	14,478	0.00	0.73
• Male clients of female sex workers	813,359	1,423,378	0.01	0.09
VPs				
a. Migrant workers (OFWs: only those deemed vulnerable and returned to the country)				
• Current OFW	883,897	883,897	0.10	0.26
• Former OFW	1,700.000	1,700,000	0.05	0.13
Total	3,736,031	4,787,880		
b. Out of school youth	11.6 M *(source: 2003 Functional Literacy, Education and Mass Media Survey FLEMMS)*		No data	
c. Street children	224,417 *(source:http://www.streetchildren.org.uk/reports/southeastasia.pdf – 2003)*		No data	

Source: 2007 HIV Estimates in the Philippines. Unpublished.

Note: MARPs estimates are based on situations prevailing in the 10 sentinel sites: Cities of Pasay, Quezon, Baguio, Angeles, Cebu, Iloilo, Cagayan de Oro, Davao, General Santos, and Zamboanga.

Table 5: Estimates of PLHIV 2007

PLHIV	Estimated population size 2007	
	15-49 (M &F)	Women (23.9%)
• People living with HIV	7,490	1,788
Total	7,490	1,788

Source: 2007 HIV Estimates in the Philippines. Unpublished.

III. national response to the AIDS epidemic

Wary of the unfolding epidemic in neighbouring Thailand in the late 1980s, the Philippines was quick to recognise its own socio-cultural risks and vulnerabilities to AIDS and immediately responded to its threat. These responses included:

- Creation of the **National AIDS and STI Prevention and Control Programme (NASPCP)** within the DOH in 1988;
- Issuance of Executive Order No. 39 in 1992 that created the **PNAC,** a multi-sectoral body that advises the President of the Philippines on policy issues regarding AIDS. Members of PNAC are government agencies, non-government organisations, professional groups, and representatives of PLHIV;
- Establishment of the **HIV Surveillance System** to keep track of the infection, and guide planners and implementers;
- Enactment by Congress of **Republic Act 8504 or the Philippine AIDS Prevention and Control Act of 1998**. The law mandates the promulgation of policies and prescription of measures for HIV prevention and control in the Philippines, institutionalisation of a nationwide information and educational programme, establishment of a comprehensive AIDS monitoring system, and strengthening of PNAC;
- Development of **AIDS Medium Term Plans (AMTP)** to guide policy makers and programme planners to determine where resources for AIDS could make the most impact and what strategies and interventions were needed given the prevailing situation. The country is now on its fourth AMTP (2005-2010). A costed operational plan for 2007-2008 has been developed;
- Development of **DOLE National Workplace Policy.** A tripartite committee has been formed to issue guidelines for workplace policy makers and ensure full implementation of this policy. Some companies have now established their AIDS in the Workplace programmes;
- Development of AIDS **modules for integration in the school curricula** at all levels, including non-formal education. Training of trainers on the use of these modules have been conducted;
- Development of **guidelines, standards, and protocols** for HIV case reporting, media reporting, treatment, care, and support, including provision of anti-retroviral drugs;

- Implementation of **community-based interventions**, ranging from information dissemination to behaviour change strategies, targeted at vulnerable groups;
- **Capacity building of health care providers** and the creation of the **HIV and AIDS Core Team (HACT)**, made up of doctors, nurses, medical technologists, and social workers in government-retained hospitals, together with NGOs based in the community;
- Creation of **Local AIDS Councils (LACs)** in some cities and institutionalisation of LGU and NGO partnership at the city level. Local AIDS ordinances, including provision of budgetary allocations, were also enacted;
- Integration of **AIDS and Migration** in the **curriculum** of the **Foreign Service Institute** (FSI) of the Department of Foreign Affairs (DFA); and
- Establishment of a **national monitoring and evaluation system on AIDS** that is now lodged within the PNAC

Source: Snapshots 2007, UNAIDS

A. Expenditures

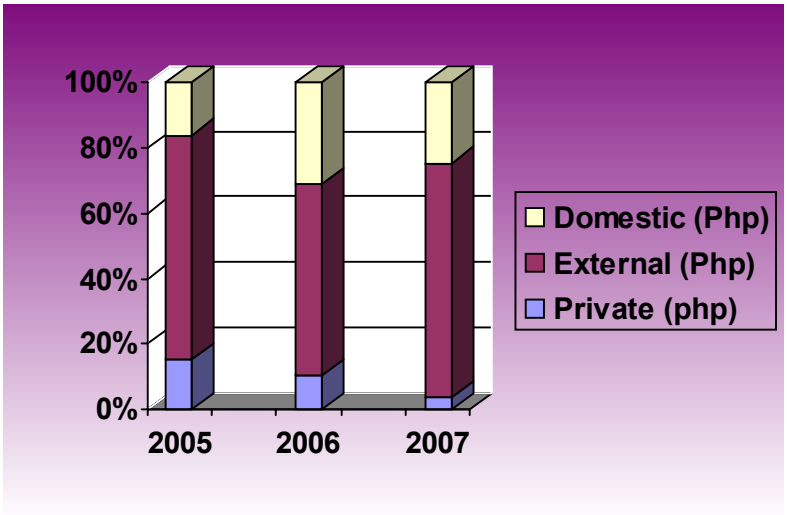
Historical AIDS Spending

From 2000 to 2007, the average total spending for AIDS is about Php311 million. Domestic spending averaged Php63 million per year, while spending from external source averaged Php223 million per year. More than half of total spending is from external sources. Table 6 shows AIDS spending by source from 2005 to 2007.

In terms of spending by activity, prevention initiatives remain the highest followed by programme support costs, and treatment and care activities. It should be noted that there are new spending categories and further disaggregation of items for 2005 to 2007. Hence, yearly expenditures by specific spending item may not be comparable.

Based on the Operational Plan of the AMTP-IV, the financial requirements for 2007 and 2008 is about Php849 million. Given the average total spending of about Php311 million per year, there is a funding gap of about Php227 million or Php113.5 million per year.
(Source: NASA Report 2005 and 2007)

Figure 1 AIDS Spending 2005 to 2007



	2005	2006	2007
Domestic	71,300,338	136,643,016	57,027,834
External	305,576,236	257,765,089	165,413,841
Private	66,813,198	44,901,547	8,242,799

Table 6: AIDS Spending by Year and Source, 2005-2007

SOURCE	2005	2006	2007	Total	%
Domestic (Php)	71,300,338	136,643,016	57,027,834	264,971,189	23.79%
(in US$)	1,294,358	2,662,864	1,193,838	5,151,060	
External (Php)	305,576,236	257,765,089	165,413,841	728,755,166	65.44%
(in US$)	5,547,308	5,023,260	3,462,823	14,033,391	
Private (Php)	66,813,198	44,901,547	8,242,799	119,957,545	10.77%
(in US$)	1,212,900	875,030	172,557	2,260,487	
Total (Php)	**443,689,772**	**439,309,653**	**230,684,475**	**1,113,683,899**	100.00%
(in US$)	**8,054,566**	**8,561,155**	**4,829,217**	**21,444,938**	
(exchange rate)	55.0855	51.3143	47.7685		

Notably, a lot of AIDS-related activities are being carried out by NGOs which usually source their funds from development partners and international NGOs. Private spending in this report includes private local donations (e.g. donations to NGOs) and internally generated funds.

Figure 2 shows the AIDS spending by function and by year. For the period 2005-2007, most of the resources (60%) went to prevention interventions, followed by programme support at (25%), treatment and care (5%), human resources (5%), enabling environment (4%), and research studies (1%).

Figure 2: AIDS Spending by Function, 2005-2007

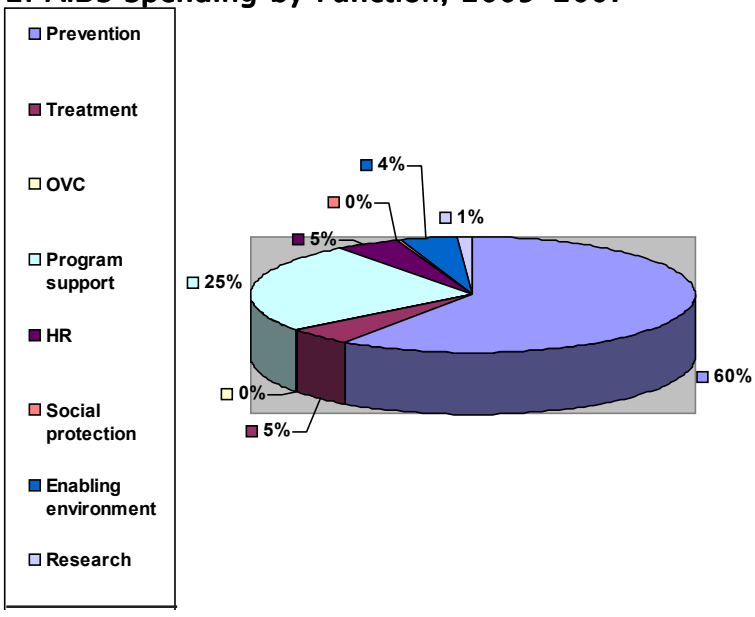


Table 7 shows the annual breakdown of resources by activity or function. Prevention programmes in the country include: mass media, condom social marketing, counselling and testing, improving management of STIs, interventions for vulnerable population, programmes for sex workers, among others. Resources were also spent on programme support costs (programme administration, monitoring and evaluation, etc.) treatment and care (anti-retroviral drugs, medicines for opportunistic infections, etc), enabling environment activities (advocacy communications), training, and research studies.

Table 7: AIDS Spending by Function and Year 2005 - 2007

	2005	2006	2007	Total	%
Prevention	235,929,088	295,107,649	126,422,566	657,459,303	59.03%
(in US$)	4,282,962	5,750,983	2,646,568		
Treatment	30,398,210	6,323,921	15,908,058	52,630,189	4.73%
(in US$)	551,837	123,239	333,024		
OVC	1,000,000	1,159,598	169,000	2,328,598	0.21%
(in US$)	18,154	22,598	3,538		
Programme Support	120,466,636	94,283,343	67,506,413	282,256,391	25.34%
(in US$)	2,186,903	1,837,370	1,413,199		
HR	30,018,623	19,189,009	6,268,200	55,475,832	4.98%
(in US$)	544,946	373,951	131,220		
Social Protection	0	0	1,841,000	1,841,000	0.17%
(in US$)	0	0	38,540		
Enabling Environment	19,520,877	18,357,783	9,879,438	47,758,098	4.29%
(in US$)	354,374	357,752	206,819		
Research	6,356,337	4,888,351	2,689,800	13,934,488	1.25%
(in US$)	115,390	95,263	56,309		
Total	**443,689,772**	**439,309,653**	**230,684,475**	**1,113,683,899**	100.00%
(in US$)	**8,054,566**	**8,561,155**	**4,829,217**	**21,444,938**	
exchange rate	55.0855	51.3143	47.7685		

B. Key accomplishments of the National Response in 2006 to 2007

The Philippines is now moving towards instituting mechanisms to sustain the initiatives of pilot and project based responses. Among these mechanisms are:

Governance and Health Systems Strengthening

PNAC is undergoing organisational development through a series of workshops designed to enable it to function more efficiently and coherently as a council and to harness the inherent roles and functions of the member-agencies and organisations maximally towards achieving the goal and objectives of the AIDS national response.

Strengthening health systems is essential for the delivery of quality services. Some health service providers, both at the local primary health facilities and hospitals have been trained in the management of sexually transmitted infections (STIs), HIV and AIDS cases (laboratory proficiency, diagnosis and treatment), voluntary counselling and testing, and surveillance. Anti-Retroviral Theraphy (ART) Guidelines have also been approved while Voluntary Counselling and Treatment (VCT) protocol is being popularised both in government and private clinic settings. Basic laboratory equipment for the social hygiene clinics located in identified "HIV risk zones" have been procured. In addition, Post-Exposure Prophylaxis (PEP) Guidelines have been drafted.

Table 8: Health Services Providers

Trainings conducted	Personnel trained
Behaviour Change Communication (Peer Educators and Community Health Outreach Workers)	265 • PEs - 104 • CHOWs - 161
HIV and AIDS Clinical Management Training	50 HACT Physicians, Social Workers, Nurses trained
Voluntary Counselling and Testing for HIV	88 (Social Hygiene Clinic Physicians - 58; Nurses - 30)
HIV Proficiency	34 Medical technologists trained
Electronic Medical Records for Treatment Hubs	33 HACT Physicians, Nurses and Pharmacists trained
Sentinel STI Etiologic Surveillance System	104 Social Hygiene Clinic Physicians and Regional Epidemiologists trained

The decentralised nature of the health and development delivery system in the Philippines necessitates the capacity building of local government units to establish local HIV and AIDS programmes. PNAC, with assistance from NGOs, are training Regional AIDS Assistance Teams (RAATs), to build

capacity of LGUs and LACs in planning, implementing and monitoring local HIV and AIDS responses. To date, 29 LGUs have enacted local AIDS ordinances, established local AIDS councils (LACs) similar in function to the PNAC.

While the participation of civil society in the national response has been consistently robust and pro-active, the support provided by the GFATM in 29 project sites also accelerated the participation of more civil society organisations from outside of Metro Manila in programme planning and implementation.

True to the principle of greater involvement of people living with HIV (GIPA) and meaningful involvement and participation of most at risk and vulnerable populations, some 412 people from affected families and community-based caregivers have been trained in care, support and treatment. More PLHIV and affected families are getting involved in promoting access to treatment. Leaders of the most at risk and vulnerable communities in 29 project sites are also continually being trained in prevention and advocacy.

Institutionalisation and strengthening of the Monitoring and Evaluation System of the Philippine AIDS Response is ongoing. The most challenging aspect is getting the national government organisations (e.g. DepEd, DOLE, DILG and others) as well as the LGUs on board the system to complete the HIV and AIDS response picture in the country.

Prevention

The year 2007 saw the geographic scaling up of HIV prevention interventions due to the advent of Round 5 AIDS project supported by the GFATM, in addition to the Round 3 project which has been included in the UNGASS 2005 report. Prevention intervention activities are focused among sex workers, MSM, IDUs and OFWs. Some 1,503 peer educators from the most at risk population sector have also been trained and doing volunteer work in 11 project sites (GFATM Round 3).

HIV and AIDS local responses are now in place in 39 LGUs, 100% Condom Use Programme (CUP) are in place in 15 sites – (10 sentinel sites, 4 WHO-assisted sites, and Aklan province).

There are now 32 public VCT centres with trained VCT counsellors and proficient medical technologists. Pilot implementation of prevention of mother to child transmission (PMTCT) at Davao Medical Centre is ongoing and has provided HIV testing to 927 pregnant women.

Almost 300 Foreign Service Officers. The training is conducted in collaboration with the Foreign Service Institute (FSI), the career development arm of DFA, Office of the Undersecretary for Migrant Workers Affairs (OUMWA) of the DFA and the Overseas Workers Welfare Administration (OWWA). Several participants who have been deployed reported that they had undertaken HIV education and outreach work with Filipino communities onsite.

A guidebook- "Positive Response: Guidebook on Handling Migration and HIV/AIDS Issues for Foreign Service Personnel", has been developed and distributed to all 89 foreign posts. A 33-minute HIV awareness video for OFWs has also been produced and distributed.

The newly started UN Joint Programme on HIV and Migration and the HIV programme support (MWs and IDUs) grant by the Asian Development Bank (ADB) also augmented current HIV initiatives in the country.

Low profile IDU harm reduction interventions are in place in nine (9) LGUs.

Another important partner being engaged by the national response is the faith-based sector. The "Training Manual on HIV and AIDS for Catholic Church Pastoral Workers," endorsed by the Catholic Bishops' Conference of the Philippines, Daughters of Charity of St. Vincent de Paul, and Mission Congregation of the Servants of the Holy Spirit, is now being printed. Faith-based organisation plan to pilot HIV prevention and care initiatives in three (3) dioceses in 2008.

Treatment, Care and Support

The advent of GFATM funding accelerated the implementation of treatment, care, and support embodied in AMTP IV. It also gave opportunity to strengthen aspects of the country's health systems to respond to the needs of PLHIVs.

Anti-retroviral treatment is given free to all indicated HIV patients in the 11 treatment hubs. To date, a total of 336 patients are under free ARV treatment under the auspices of GFATM.

Through the leadership of the NASPCP, 11 treatment hubs across the country are now in place where patients can access free ARVs with support from GFATM Rounds 3 and 5. HACTs of DOH hospitals and the University of the Philippines - Philippine General Hospital (UP-PGH), a hospital under the Office of the President, have been capacitated and updated on clinical management. These are:

Treatment hubs	Location
1.Ilocos Training Regional Medical Centre	San Fernando, La Union
2. Baguio General Hospital	Baguio
3. San Lazaro Hospital	Manila
4. Research Institute of Tropical Medicine	Manila
5. UP - Philippine General Hospital	Manila
6. Bicol Research and Training Regional Medical Centre	Legazpi City, Albay
7. Don Vicente Sotto Memorial Medical Centre	Cebu City
8. Corazon Locsin Medical Centre	Bacolod City
9. Western Visayas Medical Centre	Iloilo City
10. Davao Medical Centre	Davao City
11. Zamboanga City Medical Centre	Zamboanga City

Private hospitals are also being engaged to set up a private-public partnership for HIV and AIDS treatment, care, and support by setting up networking and referral system to enable patients to access the free ARVs.

In 2006, the Philippine Health Insurance Corporation (Philhealth) has passed board resolution number #921 "Approving the Outpatient Human Immunodeficiency Virus (HIV)-Acquired Immune Deficiency Syndrome (AIDS) benefit."

The positive community, members of some affected families, and the care and support NGOs are actively involved in TCS. Community-based caregivers are also very active in doing their role in the care continuum.

Ⅳ. good practices

To ensure the inclusion of good practices from organisations outside Metropolitan Manila, the Philippine UNGASS team developed criteria for the objective selection of good practices to be featured in this report. Call for submission of Good Practices was disseminated through pinoyungassdgroups@yahoo.com, letters and phone calls to all stakeholders. The announcement included the template or format and criteria for determining whether the practice can be considered "good practice." The criteria for selection were: pioneering effort, appropriateness of approaches, significant impact, sustained to date, and replicability. Organisations that had no capacity to write their practice were interviewed and provided assistance for the write-up. The submissions were also required to present proof or evidences of achievements. The final selection was categorised into the following:

A. Policy and infrastructure (3 good practices)
B. Community involvement in HIV and AIDS prevention among MARPs (4)
C. HIV prevention among the youth (1)
D. Greater involvement of PLHIV (1)

A. Policy and infrastructure

1. Monitoring and Evaluation System of the Philippine HIV and AIDS Response

Write-up: *Ms. Ruthy Libatique*

The development of the Monitoring and Evaluation (M&E) System of the Philippine HIV and AIDS Response is a story of continuing intensive consultation and collaboration among a wide sector of stakeholders (2003 to present).

The idea for a central AIDS information system to ascertain progress of the various HIV and AIDS initiatives in the country was planned during an NGO workshop on "Involving NGOs in the UNGASS Process" sponsored by the Asia-Pacific Council of AIDS Service Organisations (APCASO) in October 2003. The idea was addressed by PNAC and thus the institutionalisation of the M & E System of the Philippine HIV and AIDS Response began in 2003 through PNAC in collaboration with various stakeholders and with support from UNAIDS. Since then, the following have been accomplished (through three projects supported by UNAIDS Philippines):

1. Convened a Technical Working Group (TWG) to work on the setting up of the M & E System for HIV and AIDS;
2. Identified key or core indicators that could be compared across countries;
3. Identified country-specific indicators that would provide basis for consistent and appropriate strategies in the national response programmes;
4. Formed a data collection structure and information flow for the selected indicators;
5. Developed the *Monitoring and Evaluation Manual: Philippine Response to HIV and AIDS;*
6. Prepared the UNGASS Report 2005 as a validation of the M&E process;
7. Trained and oriented non-government organisations and Local AIDS Councils on M&E;
8. Installed Country Response Information System (CRIS) and trained its users at the national and local sites;
9. Pilot-tested the proposed M&E system;
10. Developed a webpage and blogsite for M&E.

In the process, both core and country-specific indicators were revalidated vis-à-vis the AMTP IV in conjunction with the Universal Access initiatives.

The manual was also revisited by the M&E Team to revalidate it vis-à-vis the learning experiences from pilot testing.

The National Consultation of the M&E pilot sites (December 3-4, 2006) brought together all those involved in the pilot test to share learning and experiences as well as determine what will work best in institutionalising M&E system at the local level. The consultation also sought to identify the next steps to forward a unified and rational M&E System in the Philippines.

As the institutionalisation of the M&E System progressed, the implementers realised the need to assess the M&E system to:

- describe the existing Philippine M&E System relative to the attributes of a fully functional M&E system;
- identify needs and gaps of the current M&E system; and
- plan activities to make the M&E system function.

Thus, such evaluation of the M&E system was conducted on February 26-27, 2007 in Manila. The results of the evaluation became the basis for the formulation of a plan (2007-2010) to resolve the issues and challenges identified.

A core group of stakeholders from both government and civil society remain active in the process of planning and implementation of the M & E System.

2. Local Responses to HIV and AIDS

Write-up: *Ms. Ruthy Libatique*

The devolved nature of health care delivery system in the Philippines puts the burden of prevention and control of STIs, HIV and AIDS in the hands of the local government units. Thus, the AMTP IV specifically looks at LGUs as key major partners in the national response. A number of local responses from key cities in the Philippines can be replicated by other LGUs. Shining examples are the STI/HIV and AIDS programmes of Laoag City in the north and Zamboanga City in the south.

a. Laoag City

Laoag City, almost 500 kilometres north of Manila, started its local response to HIV and AIDS in 2002. Shortly after an orientation on STI, HIV and AIDS attended by city officials, the Local AIDS Council (LAC) was established. A year later, the local AIDS ordinance was passed by the Legislative Council with a budget of PhP100,000 or $2,326 for production of educational materials. The ordinance is set for amendment to include laying down of sanctions to establishments who are not complying with the provisions of the ordinance.

The city has a functional LAC, which is directing and co-ordinating the local response. It is chaired by the City Mayor, with membership composed of all local agencies and institutions, representatives (owners and workers) of the entertainment industry, and NGOs. Continuing education of Council members is ongoing to keep them abreast of programmatic developments. The city also implements the 100% Condom Use Programme in all entertainment establishments.

Since 1983, the city has confined its entertainment zone in Barangay (village) 1 in order to facilitate health and sanitation monitoring. There are two (2) monitoring teams - one for hotels, motels, and restaurants and one for entertainment establishments, which are also required to maintain an HIV and AIDS IEC Corner.

Regular spiritual education and counselling are also part of the intervention, aside from STI case management services provided to the sex workers. Short trade courses are also offered by the city to sex workers who would like to retire from the industry.

b. Zamboanga City

Zamboanga City, is approximately 460 nautical miles south of Manila, 365 nautical miles northeast of Kota Kinabalu (Malaysia), and 345 nautical miles northeast of Menado (Indonesia). It is bounded to the west by Sulu Sea, on the east by the Moro Gulf, on the south by the Basilan Strait and Celebes Sea and by Zamboanga Del Norte and Zamboanga Sibugay on the north. Its distance from Cebu City is about 372.57 nautical miles, and it is also 340.17 nautical miles from Davao City. The proximity of the city to neighbouring countries and provinces provides an easy entry and exit point for mobile population, some of whom are undocumented.

Zamboanga City is a 2003 "Galing Pook"[1] awardee for its HIV and AIDS local response programme. The city's response started in 1999 with assistance from the DOH and the United States Agency for International Development (USAID) and culminated in 2001 into the enactment of City Ordinance 234, Zamboanga City AIDS Ordinance, which created the Zamboanga City Multisectoral AIDS Council. In 2004 the city sustained the local response when the assistance ended in 2003. The city's AIDS programme is multisectoral in approach and harnesses the expertise of NGOs and other sectors. Programme components include capacity building of service providers, public awareness thru Information Education and Communication (IEC), condom promotion, and monitoring and surveillance of target groups. Since then, the local government has released P5.3 million (approximately$101,920) for the programme.

The experiences of Laoag and Zamboanga cities prove that the ingredients required for a local AIDS response to thrive and be sustained are: strong political and legislative will, effective multi-sectoral partnership, sustained media advocacy, and community involvement and volunteerism. The practice model can be replicated by other local government units within the Philippines or other countries with similar situation as the Philippines.

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[1] *"Galing Pook" or* Good Governance Facility For Adoption and Replication" (GOFAR) in Local Governance Best Practice

3. *Institutionalising HIV and AIDS Responses in the Foreign Service*

Write-up: *Amara Quesada*

The Philippine economy depends highly on the remittances of overseas Filipino workers to keep it afloat. In fact, the current administration is openly promoting overseas migration as an option for employment. However, with this promotion for labour migration, the government needs to recognise its central role in keeping Filipino migrants safe and protected from HIV infection. It is on-site or at the receiving countries where migrant workers are most vulnerable to HIV infection. While Philippine embassies and consulates are tasked to address the needs of migrant workers and to provide them with needed assistance, Foreign Service personnel are often ill-equipped in handling HIV and AIDS-related cases.

The practice evolved from initial awareness-raising activities in Philippine Embassies and Consulates in countries with high concentrations of Filipino migrant workers. The main purpose of this was to reinforce the HIV awareness-raising component of the Pre-Departure Orientation Seminar. After a time, the stakeholders saw that building the capacity of the Embassies and Consulates to deliver HIV-related services on-site was more sustainable.

In 2003, through the Programme Acceleration Funds (PAF) of the UNAIDS, the Action for Health Initiatives (ACHIEVE, Inc.), the Foreign Service Institute (FSI), the PNAC, and the Philippine Overseas Employment Administration (POEA) hatched a project that aimed to train the trainers-FSI on HIV and AIDS, migration realities and counselling, and pilot a training among Foreign Service Officers who were about to be deployed.

The seminar and training aimed to strengthen perspectives and build capacity of Foreign Service personnel in handling HIV cases among migrant workers on-site. ACHIEVE also collaborated with the Office of the Undersecretary for Migrant Workers Affairs (OUMWA) of the DFA and the Overseas Workers Welfare Administration in the conduct of the seminars and trainings.

The participants (all departing Foreign Service personnel as well as locally-based personnel of OUMWA and OWWA) in the seminars represented different government agencies that dealt directly with overseas migration. This was a two-day activity that incorporated basic education, realities of

migration, foreign policy issue,s and basic HIV and AIDS counselling training. The participants were also asked to develop an action plan based on how they, as trainers, plan to apply the knowledge and skills they have learnt.

The training module (2-3 days) includes gender and sexuality component. Those who have undergone the training module are newly inducted Foreign Service officers. OFWs and female spouses living with HIV are involved in the training team as resource persons and trainers.

To further support the efforts of the foreign posts in delivering HIV services to OFWs, ACHIEVE produced a directory of HIV and AIDS service providers in foreign countries who have expressed willingness to assist the posts in providing HIV and AIDS services to OFWs. In addition, ACHIEVE also produced a guidebook, "Positive Response: Guidebook on Handling Migration and HIV/AIDS Issues for Foreign Service Personnel," which has been distributed to all 89 foreign posts. A 33-minute HIV awareness video for OFWs has also been produced and distributed.

Impact

- Since the practice started, ACHIEVE has conducted seminars for Foreign Service personnel/officers and trained almost 300 on HIV case handling. Several participants who have been deployed reported that they had undertaken HIV education and outreach work with Filipino communities on-site. They have also provided feedback about the usefulness of the guidebook.
- While the initial intent of the practice was focused on Foreign Service personnel, the practice spurred several follow-up actions, including the training of locally-based personnel of OUMWA and OWWA.
- With regard to the handling of repatriated HIV positive OFWs, new guidelines and proper referral systems, as well as the training of airport quarantine personnel in first-line handling of known cases of returning HIV positive OFWs, were developed.
- The practice allowed ACHIEVE and FSI to establish a stronger partnership. It has resulted in the integration of HIV education in the Pre-Departure Orientation Seminar (PDOS) for all Foreign Service personnel. In the 10-day training that they undergo, one whole day is devoted to discussion of HIV and AIDS and migration issues.
- One of the most important outcome of this project happened among the migrant workers and the spouses of migrant workers living with HIV and AIDS. In the process of their involvement, their own knowledge and skills were also enhanced.

Lessons Learnt

- It is crucial to build partnerships with stakeholders who have hands-on experience on the issues because they can provide vital information on the most feasible strategies that can be developed.
- In institutionalising a programme, choose an agency that would be able to maximise its impacts and ensure its sustainability. Lodging the project with the Foreign Service Institute (FSI) was logical since it is the career development arm of the Department of Foreign Affairs. Its tasks include the following: to serve as the centre for the development and professionalisation of the career foreign service corps; to serve as a research institution on issues and problems with foreign policy implications, global and regional strategies, and management of foreign affairs; and to serve as the institutional consultant of the Department on matters related to foreign policies and programmes as well as development management, planning, and review.

In institutionalising a programme, choose an agency that would be able to maximise its impacts and ensure its sustainability.

- By institutionalising the training within the DFA, the continuous training and capacity-building of embassy staff is assured. This would translate to a more responsive staff who can provide assistance to migrant workers working abroad.
- The meaningful involvement of the affected communities cannot be overstated. Without them, this project would not have been successful.

B. Community Involvement in HIV and AIDS prevention among MARPs

The principle of involving the community as part of the solution to development problems and not solely as beneficiaries is the overarching theme of the good practices described below.

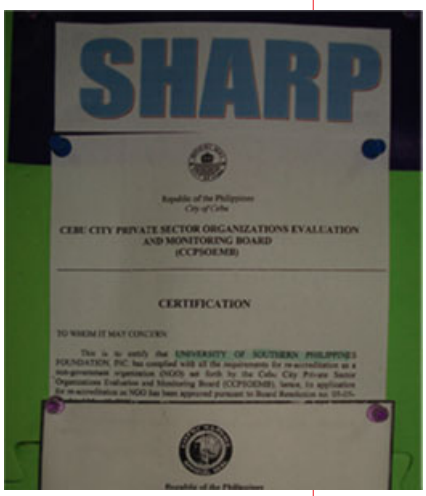
1. IDUs as Key Partners in Harm Reduction

Interviewee: Dr. Lourdes Jereza
Interviewers: Noemi Bayoneta – Leis & Ross Mayor

Among the most-at-risk populations, the injecting drug users (IDUs) are the hardest to reach. Because of their substance dependence, they tend to cluster underground. HIV and AIDS advocates are also wary of dealing with them because of the risks entailed in the community.

The first harm reduction project in the country was implemented in Cebu City as early as 1995 by the University of Southern Philippines Foundation (USPF) through the support of the AIDS Surveillance and Education Project (ASEP). The project aimed to:

- develop local capacity to institute a harm reduction programme that will provide assistance to IDUs and communities where IDU risk behaviour exists and constitutes a threat to public health; and
- take practical measures so that harm reduction resulting from injecting drug use can be minimised.



Strategies applied consist of:

- community outreach peer education on STI, HIV and AIDS, and drug use prevention;
- condom provision; and
- syringe exchange/ distribution in collaboration with the City Health Office and targetted barangays (village).

USPF practically dealt with the IDUs all by itself because initially, other NGOs were wary of working with the IDUs. USPF was even criticised by some sectors for its needle exchange programme. Such a programme, critics said, further encourages the addiction of IDUs. In addition, critics believed that the IDUs are a bane to society and do not deserve any assistance.

Despite the challenges, USPF proceeded with its programme. For years, it maintained a needle exchange programme and conducted advocacy campaigns against needle sharing.

When support from ASEP ended, short-term funding was provided by the International HIV/AIDS Alliance through the Philippine NGO Support Programme (PHANSUP). Today, the project is supported by the GFATM through the Philippine NGO Council on Population, Health and Welfare (PNGOC) and Tropical Disease Foundation (TDF). Through GFATM's support, the programme embarked on a two-prong approach: first is the training of selected IDUs as harm reduction advocates, and second is the building of alliances with local government officials and other organisations.

Aside from providing clean needles and condoms, the project trained a core group of IDUs as peer educators who were envisioned to run a programme for IDUs on their own. Their effort has already led to the establishment of SHARP, a peer educator group composed of IDUs. By empowering them and giving them a higher stake in the programme, USPF is slowly succeeding in taking the IDUs out of the shadow. SHARP has already been established and there are efforts to establish AIDS councils at the village level.

Selected IDUs were given trainings, after which, they had to sign an agreement that they would help implement the project.

Instead of training other IDUs in their own localities, the advocates are assigned to other areas so they do not have to expose themselves in their own villages. The advocates are divided into sub-groups, which are based on the different personalities and/or hobbies of IDUs (e.g. punk, dancing).

Dividing the sector into sub-groups allows advocators who share the same interests with their target group to immediately establish a rapport. To keep tract of their progresses, the advocates are required to submit journals. IDUs also help in developing information materials such as ways on how to prevent the spread of HIV and AIDS and how to use a condom. These materials are included in the needles, which are distributed for free.

Through the foundation's earlier programmes, other organisations and local government offices were able to understand the situation of IDUs. They became more receptive to the idea of working for and with the sector. The more active participation of local government offices in the project is the main difference from its earlier programme. Currently, the police orient the IDUs on the different anti-drugs laws. Village leaders are also given trainings on how to incorporate HIV and AIDS programmes for high-risk

groups. The City Health Service, on the other hand, handles the pretest-counselling and blood testing. Village health workers are also included in the campaign. Their purpose is to encourage IDU in their villages to join the project. Once convinced, the new IDU would also encourage other users. As incentive to health workers, they are given modest stipend.

Challenges and pitfalls

Although the society is more cognizant of IDUs, people working with IDUs also experience discrimination. Because of the anti-drugs laws, individuals working with the sector are also apprehended by the police if they are caught carrying needles for the exchange programme. Through dialogues with the police and other law enforcement officials, this particular challenge is now being addressed.

Some government officials are hesitant on working with IDUs and HIV and AIDS prevention because of its seemingly low prevalence in the sector. To counter this, the implementers presented data showing that cases of Hepatitis C infection among IDUs are on the rise. They argued that since Hepatitis C has the same mode of transmission as HIV and AIDS, there is an urgent need to address this infection.

Results of the project

From 70 shooting galleries (places where IDUs meet and inject drugs) in Cebu, the number of galleries went down to eight.

The journals submitted by the advocates serve as tools in monitoring their progress, as well as the number of IDUs they have reached. Quantitative data are still limited, but the behavioural changes among IDUs and even the society may well serve as indicators.

Provinces like Davao have sent representatives to Cebu to see how the practice works and how it can be adapted.

Impact

Barely a year in its implementation, the practice has already achieved one of its main goals of empowering the IDUs through the formation of SHARP IDUs. Instead of being mere recipients, the sector is now becoming more involved in HIV and AIDS advocacy programme. Another goal of the project, which they hope to achieve in the near future, is the inclusion of the sector in the province's LAC.

Prior to the project implementation, IDUs did not allow or want their photos to be taken but that has been changed. Now, they even conduct dialogues with local government agencies.

Another impact of the project is the more welcoming attitude of some local government officials towards the IDUs. The change in attitudes is more evident among the police, who have since tied up with the implementers. The police now engage the sector after realising that their tough stance merely drives IDUs further underground.

Critical lessons learnt

- Earning the trust and respect of the IDUs is crucial in the success of any project. Learning to speak their language was helpful.
- The involvement of local government units will further ensure the success of a project. Their involvement should not be limited to the provision of any resources available; rather, meaningful dialogues between the government and IDUs should be initiated to clear the air of mistrust and suspicion.
- Providing a modest stipend to volunteers will further boost their morale.
- Stress debriefing for volunteers and development workers must be conducted to avoid burn outs. Even simple activities like holding parties can be an effective stress reliever.

2. Metamorphosis – From Beneficiaries to Implementers

Write-up: ***Butterfly Brigade***

The Butterfly Brigade is a self-help group of MSM established in Aklan in 2001. It was tapped by the local government to become the Provincial Peer Educators' Council of Aklan to provide trainings and seminars on reproductive health. It has managed to genuinely empower itself and consequently was able to get support from donors like the UNFPA to implement reproductive health project, including HIV prevention among MSM. Instead of being mere beneficiaries, they have taken an active role in project implementation. It also capitalises on the talent and creativity of its members in staging events and activities that would attract more participants.

From a group that was solely focused on the unmet health needs of the MSM, the Butterfly Brigade now caters to the needs of heterosexual males, women, and children.

In 2000, the municipality of Malay passed an ordinance against prostitution. According to the gay community, the said ordinance effectively banned *"what looks like sex work, who looks like sex workers"* in bars and clubs in Boracay. Hardest hit by the ordinance were the transgenders who were barred from entering entertainment establishments in Boracay on allegations that they would engage in sex work. This galvanized the MSM community into forming a group to protest against the ordinance.

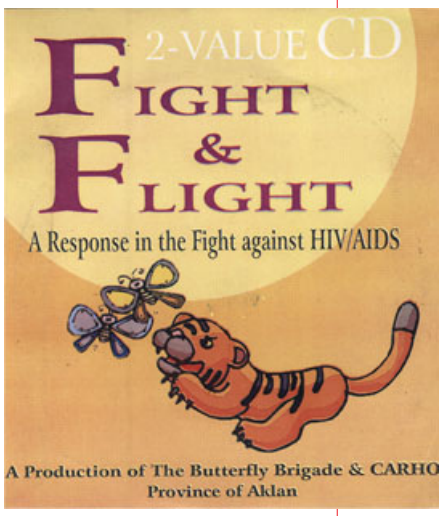
The gay groups in Kalibo conducted informal meetings and solicited funds so they could mobilise more gay men. From these meetings, they realised that the ordinance was just one of the issues confronting them, but that discrimination and access to health information and services were bigger concerns. With this realisation, they organised themselves and formed SUB-EAK which means "sunrise" in local term.

They submitted proposals and in 2001, the UNFPA gave them a grant for two trainings on "Peer Education for Safer Sex". To echo the trainings, the group tried a different approach. Instead of conducting trainings in the morning, these were conducted from 8pm to 2 am to accommodate other gay men who would be cruising for sex. Rapport with the target audience was established with the use of gay lingo. Other non-traditional

ways of teaching were utilised, such as holding beauty contests, to deliver the message. Aside from various advocacy projects, the brigade also spearheaded a social marketing for condoms, in partnership with DKT Philippines.

It was also during this period when they collaborated with the provincial health department, as well as with the other private and public agencies where the members were connected. The trainings were not only about safe sex; these were anchored on reproductive health, with a focus on sexuality and sexual health. Encouraged by the success of the trainings, the provincial health department and the UNFPA funded more training. After the sixth training, trained peer educators from all over the province were convened for the Strategic Planning on STI, HIV and AIDS Prevention and Control. The planning resulted in the following:

- Systematised information dissemination; and
- Development of the 2-way "follow-thru" user-friendly referral system, established with the help of the different municipal health departments.



The Butterfly Brigade underwent a series of organisational strengthening, including strategic planning and capacity building activities, to be able to deliver effective services and manage their own organisation. The Department of the Interior and Local Government (DILG) assisted the group in identifying their strengths and weaknesses, as well as the threats and opportunities that the group might encounter. To address the problem of low and/or waning enthusiasm of members, incentives like hospitalisation package for active members were provided by the provincial health office. Networking with local, national, and international organisations also help in strengthening the brigade.

The practice demonstrates the effectiveness of involving and empowering the stakeholders in ensuring the success of projects. Without prodding from a community organiser, the gay community of Aklan initiated the formation of the brigade in response to their unmet needs for health services. Without the backing of an established organisation, they themselves initiated informal group discussions. From these informal meetings, they saw the need to form a group that would respond to the health needs of the MSM community.

Through its advocacy campaigns, the brigade has improved the health-seeking behaviour of the gay community in the province. The number of MSM accessing services at the social hygiene clinic has improved dramatically.It was also slowly breaking down the wall of discrimination.

Critical lessons learnt

Ownership of the project and the genuine empowerment of the target community ensure the success of any project. It is essential to harness the potential of the target communities because they know their own culture and dynamics and can use this understanding for strategizing.

3. Integrating Community Organising with Scaling Up of Prevention and Care of Sexually Transmitted Infections (STI) and HIV Among Men who have Sex with Men (MSM)

Write-up: Glenn Cruz

Since 1991, members of TLF Sexuality, Health and Rights Educators Collective (or TLF SHARE Collective) have been at the forefront of pioneering STI and HIV prevention among gay and bisexual men as volunteer peer educators and trainers under the former The Library Foundation. It is also one of the civil society representative-members in the Philippine National AIDS Council. Towards the close of the decade, members have come into a consensus that other grassroots MSM communities have the capacity to "share" in STI and HIV prevention and care efforts – only that capacity-building activities need to be initiated.

The opportunity to actualise the theory arose during the implementation of the third round HIV and AIDS grant of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The MSM component of the project aimed to improve behaviour change communication and STI management. It was hoped that in addition to the achievement of project targets – such as increased reach and improved awareness among at-risk populations – genuine and competent involvement of grassroots communities would facilitate sustainability of the project's initiatives.

This practice made "meaningful community participation" a consistent principle in all levels of intervention. This included ensuring spaces within the project's activities for development of community capacity to engage in participatory processes and the addressing of MSM-related sexual health and rights issues. This practice is intended for volunteer peer educators (in particular, those who come from being informal leaders and influencers among MSM peer groups) to co-perform as "change agents" or facilitators in the development of organised MSM communities. In developing the skills of these participants as educators, trainers and advocates, it was also intended that the organised communities become valuable resources in the strengthening of local STI and HIV prevention and care responses.

The projects in TLF SHARE Collective's sites started off with consultation processes that included a comprehensive training-seminar on STI and HIV, safer sex skills, and assessment of life and community situations. It was also during the consultations that many peer educators were identified. Invitation in the process ensured the participation of leaders from diverse peer groups. It was crucial for the process that participants be able to

reflect the project's significance with their life situations, the project to gain acceptability, and generate interest for voluntary participation. Participatory processes with the community also ensured important assessment checkpoints in monitoring and evaluation.

There were also additional skills development sessions for participatory learning and action such as risk mapping and other qualitative baseline information gathering. Dialogues and forums that put MSM sexual health and rights agenda were conducted to complement with wider sector awareness-raising campaigns for STI and HIV prevention and care, including activities lined up together with AIDS Candlelight Memorial and World AIDS Day. To thoroughly pursue decision-making towards consolidating the organised communities, periodic meetings were held, which culminated with the determination of core groups.

Members of core groups attended community-organising workshops to aid the development of mission, vision, goals, organisational structures, and immediate action plans to fortify their constitution. Several members of the core groups were also participating as peer educators and counsellors in the project to enhance their roles in the communities. Peer educator skills development not only included interpersonal communication skills, but also group process facilitation. Eventually, peer educators' prevention activities included interest building in the community organising efforts. This further reinforced the message that peer support can facilitate behavioral change, which leads to the prevention of transmission of STI and HIV.

In preparation for the likely scenario of the project into its second phase, select peer educators and community leaders underwent a Training of Trainers programme. This is meant to ensure the availability of local resources in the development of local HIV and AIDS responses. Other activities that contributed to the processes included staff development training (to prepare in implementing the integrated approach), participatory development of IEC materials and outreach and education planning, quarterly and annual programmatic monitoring, and participatory assessments.

Challenges Met in Implementing the Practice

The fast, intense nature of delivery of the project was a formidable challenge in integrating community organising; requiring a faster pace in preparations, decision-making, and planning towards organisational development. Local situations in Lucena and Gumaca became difficult: existing divisiveness within groups have almost always threatened the continuation of processes.

Some local governments have not also kept up with the momentum. Community organisations that have sufficiently prepared for multisector local response have found themselves stalled. In sustaining support for the self-help groups formed during the GFATM's second phase of implementation, re-organising became an important, ongoing agenda despite the absence of allocation for further capacity building activities for community development.

Results of the Practice

Out of the six MSM communities TLF SHARE Collective worked in this project, four have successfully developed into organisations – Bahaghari ng San Pablo (Rainbow Association of San Pablo), HEARS Gumaca (Health Educators Advocating for Rights and Sexuality), Gay Association of Legazpi, and Tabak Sangre (True, Red-bloods of Tabaco). An existing gay organisation in Daraga, the Alternative Movement for Integrated Gays' Advancement (or AMIGA, meaning "Friend"), was able to develop their policies on sexual health and rights, including STI and HIV prevention and care.

Immediately, while communities were consolidating towards organising, peer educators' performance in outreach and education also improved. At the second half of the first phase, outreach targets have been surpassed. Motivation to reach a wider network to establish the legitimacy of collective, organised action also helped in increasing the reach of STI and HIV prevention services. At the initiation of GFATM's second phase, it was also realised that it was easier to maintain a pool of volunteer peer educators. Because of the continuing organisational relations among members, enrolment in peer education work is now being facilitated by the organisations.

Some of the MSM community organisations gained inroads in participatory governance: they have become members of the local AIDS councils (LAC); helped organise LAC-initiated educational campaigns; and some, after participating in the project, have gained "political clout." AMIGA was able to continue working with the local government through a participatory governance development project. Tabak Sangre was able to help place candidates, who committed prioritising sexual health and rights, HIV and AIDS, into public office. Some beneficiaries of the project's capacity building activities also ran in the barangay (village) elections.

4. From prostituted women to empowered Women – Tingog Sa Kasanag (TISAKA) experience

Interviewees: Ms. Inday Monding, Sr. Carmen Dianne Cabasagan, and Lalae P. Garcia
Interviewers: Noemi Bayoneta – Leis & Ross Mayor

Prostituted women in the Philippines are traditionally looked upon as sinners. On top of the social censure they have to endure, prostituted women are also often arrested. Because of the stigma and the risk of being jailed, they are passive participants in national AIDS programmes. For instance, only a handful of local AIDS councils have prostituted women as members even though the sector is entitled to a representation. There have been efforts in the past to seek the sector's active participation, but the women themselves were hesitant.

TISAKA was formed in 1998 with 30 prostituted women as initial members through the efforts of Talikala, a women advocacy NGO based in Davao City. TISAKA aims to empower and mobilise prostituted women through its advocacy campaigns. Its end goal is to provide the women with alternative sources of income through its livelihood programmes. TISAKA's approach in dealing with the issue of prostitution can best be described as militant. It does not see prostitution as a mere economic choice; rather, it also analyses socio-economic and political factors that contribute to the further exploitation of women.

The organisation was able to organise more than 350 women from 55 establishments. It conducted education drives among prostituted women to make them aware of the issues confronting them and to mobilise them in dealing with these issues. In 2001, the group was formally registered at the Securities and Exchange Commission as a people's organisation. Until 2006, TISAKA was operating under the guidance of Talikala.

TISAKA started to operate on its own this year and its projects are all ongoing, although they are still hampered by the lack of funds. It relies on its pool of volunteers and is involved as implementer in the GFATM-supported HIV and AIDS prevention project in Cagayan de Oro City. As of now, TISAKA does not provide health services to the prostituted women. It focuses on organising, advocacy, and education. Although it does not provide direct medical and legal services, it maintains a referral system that allows prostituted women to seek medical and legal help.

It maintains a good working relationship with the local government, as well as with the local press club. The latter helps ensure that their advocacy gets enough press coverage. TISAKA is also a member of Alliance Against

AIDS in Mindanao (ALAGAD Mindanao), a network of NGOs working on HIV and AIDS in Mindanao, south of Philippines. It hopes to win a representation in the LAC in the future.

TISAKA is able to slowly strengthen its organisation through partnerships with the Religious of the Good Shepherd (RGS), the local government unit, and other organisations. Funding remains to be a problem, but the organisation is able to augment its meager resources by maintaining a small canteen in its rented office.

Impact

The most visible impact can be seen from the empowerment of the women themselves. Before being organised, the women would rather stay in the background. Today, the women are taking charge, spearheading different advocacy campaigns. In staging street plays, for instance, the women are very much involved. Aside from acting on the plays, the women themselves write the scripts based on their individual experiences as prostituted women.

The women, too, become more vocal in asserting their rights. When a rumour circulated that one of the women who have had her regular exam at the local health centre tested positive for HIV, the police immediately rounded up the prostituted women and jailed them. When TISAKA intervened and asked the police to release the women, they were told that the women were not really arrested but were merely 'rescued.' TISAKA pointed out that if the women were indeed 'rescued,' they should not have been thrown in jail. TISAKA threatened to bring the matter to the attention of the media, prompting the police chief to release the women.

Constant dialogues with the local government have resulted in small victories for the prostituted women. The local government has passed a resolution declaring October 5 as a "Day of No Prostitution." Even the women's relationship with the police has improved. After the 'rescue' incident, the police chief asked TISAKA to include them in their dialogues with the mayor to clarify how the laws and policies concerning prostituted women should be implemented. As a compromise, the police asked TISAKA to tell its members to stay inside establishments to avoid arrest. Otherwise, the police would be constrained to arrest the women who are loitering outside.

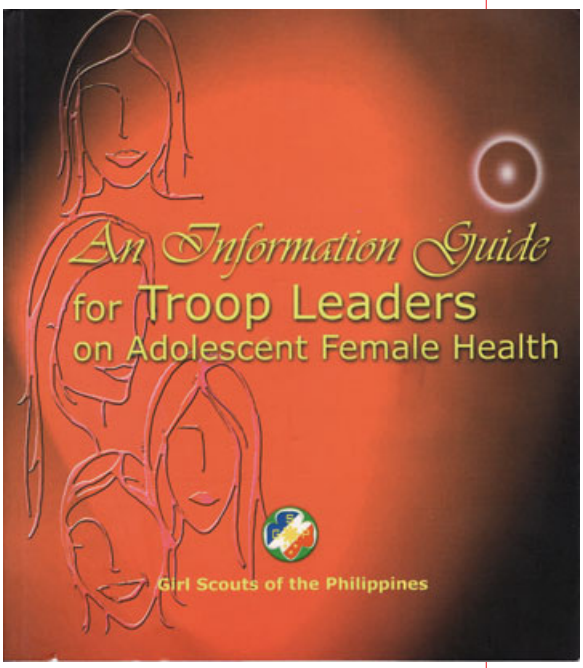
The women are also able to gain acceptance by involving the society in its advocacy campaigns and projects.

C. HIV Prevention among the Youth

Mainstreaming HIV and AIDS prevention in the Girl Scouts of the Philippines Programme

Interviewee: Ginnie W. Oribiana, OIC
Interviewers: Emily Magharing & Ross Mayor

The Girl Scouts of the Philippines (GSP) was formally chartered on May 26, 1940 under Commonwealth Act No, 542. At present, 95 GSP councils operate in six (6) regions, with a membership of more than 1 million Filipino girls and young adults.



In 2002, with funding assistance from UNAIDS, the Philippine NGO Support Programme (PHANSuP) in collaboration with the Philippine National AIDS Council (PNAC) and other youth-oriented NGO partners of the former as well as with the active participation of the GSP and the Boy Scouts of the Philippines (BSP), some 80 Boy Scouts and Girl Scouts joined a week-long ARH and HIV and AIDS Camp in Cebu City. The camp aimed at equipping the scouts with knowledge and skills on responsible adolescent reproductive health and HIV and AIDS.

Adolescent Reproductive Health (ARH) was included in the GSP training curriculum in 2002, under its 8-point challenge programme; one of which is the "Challenge to be Prepared." The decision to include ARH was borne out of the realisation that young girls need to be equipped with the right knowledge and attitude on sex and sexuality in general to help them deal with the issues in a more responsible manner and to respond to the need of young people for reliable ARH information, including related issues like violence against women and children, and HIV and AIDS.

The activities under this programme are trainings, training the trainers workshops, and publications of IEC materials. Given the sensitivity of the issues discussed, the ARH training is given to juniors, seniors, and cadet scouts. The programme is also being implemented in public schools, complementing the DepEd's life skills programme.

The GSP is keen to develop its own pool of trainers who can teach ARH and HIV and AIDS concepts to the younger scouts. The GSP taps adult scouts and troop leaders as trainers. To achieve this goal, the GSP, (with funding support from the David and Lucille Packard Foundation through PHANSUP) produced a training manual, "An Information Guide for Troop Leaders on Adolescent Female Health." Consultation workshops were held with experts from the DOH, various NGOs, and volunteer doctors. In April 2007, a one-day training on how to use the manual was held, participated by adult scouts and troop leaders.

Since the integration of ARH in the curriculum, young girls who have participated in the activities become more comfortable in discussing ARH and other related issues. Their initial biases and misconceptions concerning HIV and AIDS have been dispelled.

Girl scouts also participate in various activities conducted during World AIDS Day.

To further encourage the scouts' active participation, they are given an ARH badge when they do at least four of the suggested activities listed in their ARH manual.

To the GSP's credit, the gains of the HIV and AIDS Camp were continued and became a regular programme. To get it rolling, the GSP co-ordinated with the DOH and other non-government organisations, such as the Remedios AIDS Foundation, as well as with its own pool of volunteer doctors. Until now, the GSP maintains a close co-ordination with the said organisations.

The programme continues to this day; in the words of a GSP official, HIV and AIDS will always be a pressing issue. The GSP will use its own fund to maintain the programme's viability by seeing to it that the following resources required to implement it are sustained:

- *Human resources.* Resource persons, some of whom are either volunteer doctors or persons referred by the DOH, who conduct ARH trainings. The GSP is currently developing its own pool of trainers composed of troop leaders and adult scouts.
- *IEC materials.* Brochures, pamphlets, and manuals need to be reprinted to replenish the GSP's stocks. The GSP is also utilising its newsletter and website for its ARH and HIV and AIDS advocacy.
- *Skills.* Troop leaders and adult scouts need to develop their skills so they could conduct the trainings on their own. The publication of a guide manual is an initial step towards upgrading the trainers' skills.

In the future, the GSP will develop its own sets of indicators to measure the success of the programme.

Challenges and pitfalls

One of the initial challenges faced by the GSP is the hesitance of young girls in discussing sex and sexuality. To overcome this challenge, ARH was slowly integrated in the programme. When it was just starting, discussions would only last for ten to 15 minutes. As the young girls became more comfortable, the discussions were lengthened. In time, they have become more comfortable in expressing themselves.

Initially, the implementers found out that the girls thought that HIV and AIDS was highly contagious (e.g.; a person sitting next to a PLHIV could be infected). Through the discussions, misconceptions about HIV and AIDS were dispelled, resulting in a greater understanding of people living with HIV and AIDS.

Other observations regarding the programme implementation are the following:

- Philippine society generally frowns on discussions concerning sex and sexuality. However, the ARH programme does not encounter any objections from school administrators and parents.
- Troop leaders themselves are still not comfortable discussing ARH. For instance, they still use euphemisms like flowers and birds to refer to female and male genitals. To improve the trainers' skills, a manual has already been published, which they can use as a guide. Also, there is a plan to conduct a two- to three-day workshop next year.

Impact

In a conservative society like the Philippines, discussing sex and sexuality among adolescents may cause a public uproar. The DepEd is mandated by the RA8504 to provide ARH, HIV and AIDS education but cannot adequately do so because of negative public opinion fanned by the Catholic Church. The GSP, which is the largest association of girls and young women in the Philippines with a membership of more than a million – responds to this gap.

The GSP's ARH programme has not met any resistance. This may be attributed to the positive impression the Philippine society has on GSP. Through the years, the organisation is known for its meaningful and socially-relevant activities. Another factor that contributed to the acceptance of the project is that it was launched without any fanfare, thus avoiding negative publicity.

D. Greater involvement of people living with HIV and AIDS (GIPA)

Institutionalisation of Access to Treatment in the Philippines (2005 to 2006)

Write-up: *Roberto Ruiz*

The participation of the positive community in promoting and working towards access to treatment of PLHIV has significantly increased the number of those accessing ARVs. Few had access to ART, more or less 25 PLHIVs, due to the prices of these drugs from 1995 to 2001. Some were enrolled in clinical trials (which ended in 2000) and a few who had the means bought their own ARV.

In 2001, the Union National Le SIDA (UNALS) and Solidarite' SIDA, AIDS organisations in France, funded the generic ARV for 30 PLHIV volunteers from the different HIV and AIDS groups through Positive Action Foundation Philippines, Inc. (PAFPI). Their inclusion in the programme list was recommended by Research Institute for Tropical Medicines (RITM). The treatment regimen included CD4 test and other health monitoring diagnostics. In return, the volunteers agreed to advocate and lobby for HIV and AIDS as part of GIPA in response advocacy programmes in the country. As a result, they joined a pro-active team called Treatment Action Group of the Philippines (TAGOP).

TAGOP Four spearhead the achievement of the following goals:

- Advocacy – lobbying for policies supporting sustainable access to treatment at national to local level;
- Information, education, and capability building – enhancing awareness and acceptance of PLWHIVs on treatment;
- Monitoring and testing – encouraging PLHIV, affected families (AF), and significant others (SO) to treatment adherence;
- Income generation – initiating activities to generate logistical support for the sustainability of TAGOP efforts.

Significant Changes

- From 120 PLHIV accessing ARV in 2005, it increased to more than 300 PLHIV in 2000; a remarkable increase of more than 100% in one year's time.
- More PLHIV are joining the PLHIV groups (Pinoy Plus and PAFPI) and are active in the various HIV and AIDS activities.

- Mortality rate decreased based on the records of RITM and San Lazaro Hospital.
- More PLHIV are empowered and are now taking the lead in HIV and AIDS awareness campaign in terms of prevention and control.

Now that access to treatment has been institutionalised, more PLHIV are coming out to access the services being offered. Their participation in the different HIV and AIDS prevention and control activities is a reflection of the strong and effective programmes being implemented by the different organisations. Their success stories proved their important role in the improvement of health care delivery system being implemented in the different health care facilities and institutions.

V. major challenges & remedial actions

The overall challenge for the Philippines is to prevent the further spread of HIV and to ***act ahead*** of the epidemic. Thus the National Response is geared towards accelerating and scaling up current initiatives by various stakeholders with assistance from donors like the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and multilateral and bilateral development partners.

The IHBSS 2007 results showed low reach of MARPs. The results were from the 10 sentinel sites where AIDS prevention have either stagnated due to lack of funds or in some cases, stopped. The ongoing initiatives in the 11 project sites of GFATM Round 3 AIDS project and the 18 sites of the GFATM Round 5 AIDS project were not part of the IHBSS.

The IHBSS results in the 10 sentinel sites serve as a wake up call for the national response in general and the local responses in the sentinel sites in particular.

Among FSWs, only 14% were reached by both prevention programmes (HIV testing and condom) and even lower among younger FSWs, at only 11%. However, looking at each prevention programme, percentage of those reached is higher:

- Those who we reached and know where to have an HIV test – 35%
- Those who we reached and received a condom – 28%

Among MSM, both prevention programmes reached only 19% while even lower among younger MSM at 15%. However, looking at each prevention programme, percentage of those reached is higher:

- Those who we reached and know where to have an HIV test – 31%
- Those who we reached and received a condom – 46% (much higher)

Among the IDUs, only 14% were reached by all three (3) prevention programmes (HIV testing and condom, needles and syringes). Among younger IDUs, result is only 11%, and among male IDUs, only 13%. The results were brought down by the very low results obtained in General Santos City, where the harm reduction intervention has barely started. However, looking at each prevention programme, percentage of those reached is higher:

- Those who we reached and know where to have an HIV test – 38% (up to 60% among female IDUs)
- Those who we reached and received a condom – 48% (higher, or up to 58% among female IDUs)
- Those who were reached and given needles – 30% (up to 45% among female IDUs)

Among clients of FSWs, only 6% were reached by all three (3) prevention programmes. However, looking at each prevention programme, percentage of those reached is higher

- Those who we reached and know where to have an HIV test – 24%.
- Those who we reached and received a condom – 11%

The above data pose a formidable challenge to the 10 sentinel sites to rejuvenate and/or strengthen the local responses begun in early 2000s. It also beams a strong signal to the National Response leadership to advocate to these LGUs and/or provide assistance to revive these local responses.

Despite the significant accomplishments that were realised in 2006 to 2007, achieving the objectives of Universal Access to prevention, treatment, care and support continues to be the major challenge to the country.

Policy, political support and governance – a crosscutting concern

Issues	Progress made in 2006-2007	Continuing challenges in the years to come
• RA 8504 not widely circulated • Harmonising laws governing drug users with RA 8504	Unknown to many is that amendments have been proposed in the last 13th Congress of the House of Representatives to make it more suitable to the changing times and ever evolving dynamics of HIV prevention in the country. While the law has been in place since 1998, its operationalisation has yet to reach 90% of all geographic locales and sectors of Philippine society.	• While NGOs were aware of the existence of a law on HIV and AIDS, information on and specific provisions of RA 8504 are not widely circulated nor popularised. Some NGOs also said that some of the law's provisions were not clear. Many NGO representatives, government officials, and local government officials were not familiar with specific provisions. • Results of the NCPI A showed that more GO-members of PNAC are not aware of the law – signifying serious problem in advocacy. • The need to harmonise laws governing drug users with RA 8504 to implement harm-reduction programme
Political leadership	• National political leadership can hardly be seen. Only a handful of officials, such as Congresspersons Nerissa Soon-Ruiz, Antonio Yapha, Jr., and Satur Ocampo, publicly support the National Response. • Political leadership is best manifested in some local government units (LGUs) that have institutionalised STI, HIV and AIDS prevention and control programmes into their local development plans. Some 29 LGUs have passed local ordinances with corresponding budgetary allocations (although small) and have functional LACs that direct and oversee the local response.	• Advocacy to high government officials for articulation of support to the HIV and AIDS national response • Articulation of support from the highest political leaders with accompanying budgetary allocation to enable implementers to achieve programme targets and eventually, universal access targets by 2015.

Sustaining PNAC and the PNAC Secretariat	• PNAC organisational assessment and organisational development plan in place, but need to be implemented in a speedier manner; • PNAC Secretariat: team building conducted but "fit" of personnel within PNAC secretariat needs review; placement of appropriate staffing of PNAC secretariat is a concern	• Advocacy to high level officials of member-government organisations to take an active part need to be heightened; • Contribution of other member-government organisations to PNAC budget is zero except for DOH. • Secondment to PNAC secretariat of appropriate personnel from other member-organisations to augment manpower remains a challenge • Frequent change in head of PNAC secretariat aggravated by inadequate or lack of turnover of functions and work at hand continue to hound PNAC
Funding *(Source: 2007 NASA Report)*	Total AIDS spending from 2005 to 2007 is estimated at PhP1.113 billion (Figure 1) or USD21,444,938. The bulk of spending is from external sources , the biggest contributors of which are GFATM (Php107 million in 2005, Php31 million in 2006, and Php52 million in 2007) and USAID (Php71 million in 2005, Php98 million in 2006, and Php22 million in 2007). The GFATM support accelerated prevention and treatment and care and support activities in 2006 to 2007. The USAID funds supported the systems strengthening.	The 2005-20007 AIDS spending assessment results point to the following concerns: • the need to further mobilise resources to finance AIDS interventions - It is imperative that resources be mobilised in order to finance all the interventions outlined in the AMTP-IV. • the need to effectively and efficiently use available resources - Given the uncertainty of continuing funds from external sources and in light of the need to use aid effectively (Paris Declaration 2005), harmonization of procedures and processes of development partners is

		important so that funds can be managed easily by implementing agencies. Moreover, managing for results and mutual accountability has to be given importance. Limited resources should be used to finance priority activities that will result in greater impact and halt and reverse the spread of HIV. The right mix of interventions will have to be determined and good practices will have to be replicated. • The need to work towards sustainability of initiatives - At present, more investments are needed so that programmes will be able cover all target groups, especially the most at risk groups (female sex workers, injecting drug users, and males having sex with males) including migrant workers. • Treatment, care and support services need to be further expanded to increase access. In addition, institution-based prevention (school-based and workplace) activities and general public interventions will have to be accelerated to curb AIDS. It is important to work towards institutionalising essential activities (e.g., surveillance, ARV procurement, etc.) and to allocate sufficient funds for AIDS interventions in the regular budget. • It may also be worthwhile to look into alternative sources of financing. It should, however, be noted that sustainability is more than having adequate financial resources. It also involved other elements that contribute to the successful implementation and/or expansion of initiatives.

Lack of policy guidelines on: HIV counselling and testing in diagnostic centres for OFWs	A number of policy guidelines have been approved – namely; ARV guidelines, VCT, PEP	Many guidelines still need to be written and approved to facilitate institution of interventions specifically among the IDUs and vulnerable sectors like the OFWs. The country needs to continue efforts for policy guidelines on: • IDU harm reduction • Proper HIV testing protocol for OFWs (pre and post test counselling at the diagnostics clinic level) • Philhealth's Outpatient HIV and AIDS benefit
Strengthening monitoring of human rights	In 2005, the challenge was strengthening the monitoring of human rights issues in HIV and AIDS by establishing enforcement mechanisms for the promotion and protection of human rights, and providing legal assistance and access to justice mechanisms for PLWHA, most-at-risk populations, and vulnerable populations. Still a challenge; no change from 2005. While a Human Rights Commission exists, it is neither pro-active nor reactive towards HIV- and AIDS-related cases.	• Continues to be a challenge in the coming years
Setting up and strengthening M & E System	• National M & E System development completed and pilot-tested; • Developing and maintaining data bases for MARPs and VPs for more effective policy making and programming and HIV and AIDS	• Nationwide, multisectoral, multi-organisational implementation of the National M&E System; • Getting the national government organisations (e.g. DepEd, DOLE, DILG and others) as well as the LGUs on board the system to complete the HIV AND AIDS response picture in the country. • Alignment of indicators of donors and NGOs with the indicators in the M & E System of the National response to HIV and AIDS

Increasing civil society involvement and participation	• CSO participation in UA process • CSO participation in strategic planning • CSO participation in operational planning and budgeting • Significant involvement of CSOs in GFATM AIDS project implementation	• Capacity building of other NGOs and POs to be able to participate meaningfully in the fight against AIDS
Establishing local responses to HIV and AIDS	To date, 29 LGUs have local AIDS ordinances and functional LACs	• Capacity building of LGUs in various aspects to establish/sustain local responses

Prevention

Issues	Progress Made in 2006-2007	Continuing Challenges in the years to come
Strengthening VCT: Ensuring quality assurance in HIV testing	Significant efforts in improving quality of HIV testing being made by government	• Logistical and manpower sustainability at the LGU level
Strengthening HIV and AIDS education	• The advent of monetary support from the GFATM accelerated the engagement of LGUs and NGOs in 27 new project sites. Being a low HIV prevalence country, prevention activities are focused and scaled up on the MARPs and VPs. Prevention interventions include outreach and education, condom distribution, and needle and syringe distribution to IDUs. • There is an ongoing HIV and AIDS prevention programme for uniformed personnel, particularly in the Armed Forces of the Philippines (AFP).	• Scaling up of HIV and AIDS education among MARPs and VPs in other sites in the country. FSW coverage is high, but low coverage in clients of FSW who are in fact, the vectors of the infection. The clients are part of the general population. • Prevention among the general population is virtually absent. Per NSO projection, there are 17,532,162 young women and men aged 15-24 in 2007. The national response need to establish an HIV education programme for the general population to capture this sector. In addition, we do not know the status of the programme. • HIV and AIDS education in schools is still very limited; teachers not yet trained in life skills education on HIV and AIDS. As of 2007, there are 42,140 elementary and 8,450 secondary schools in the country, with a combined enrolment of 11 million (both public and private) under the supervision of the DepEd. This represents 11 million missed opportunities for life skills education.

Strengthening of correct and consistent condom use and ensuring supplies are available	100% Condom Use Programme (CUP) have been implemented in 15 LGUs; Condom promotion and distribution in 29 GFATM project sites	The programme needs to intensify promotion of correct and consistent condom use among the MARPs, vulnerable and general population. Prevention among general population remains to be a challenge. • Sustaining 100% CUP in LGUs where it had been implemented; • Introduction and acceptance of 100% CUP by other LGUs
Institutionalising AIDS in the workplace programmes		Limited AIDS in the workplace programmes; Monitoring and technical assistance to workplaces
Expanding and sustaining local responses	There are 37 LGUs with local responses to HIV and AIDS	Sustainability challenges for LGUs: While prevention, treat-ment, care and support have scaled up due to GFATM support, more efforts still need to be undertaken, co-ordinated and sustained at the national and local levels by the national government, the local government units, civil society and other stakeholders.

Treatment, Care and Support

Issues	Progress Made in 2006-2007	Continuing Challenges in the years to come
Improving access to treatment, care, and support	• Significant improvement – 11 treatment hubs across the country • ARV available and accessible, free from GFATM • Access to OI drugs • Referral mechanism in place	• Some PLHIV not accessing ARV; • Support for laboratory work – ups inadequate • Expansion of referral system • OFW living with HIV access to care, support and treatment

VI. support from the country's development partners

Key support from the country's development partners range from funding interventions and programmes to AIDS technical assistance. Among the external agencies that support the National Response are: USAID; GTZ; KfW (Government of Germany); AusAID; European Commission (EC); UN organisations such as the WHO, UNFPA, UNICEF, and the UNAIDS; GFATM and other international foundations like the Ford Foundation and the Rockefeller Foundation.

GTZ provided funding support to the Philippines in the development of its Rounds 3, 5 and 6 AIDS proposals to the GFATM. The UN agencies provided technical support in the development of all rounds of application of the Philippines to the GFATM.

The Joint UN Theme Programme in the Philippines supported the Development and Strengthening of National M & E System of the Philippine HIV and AIDS Response.

Below is a summary of key support (monetary or technical) provided by various development partners: (*Note: Bilateral: USAID, KfW, EC; Multilateral: UN Agencies- WHO, UNICEF, UNFPA, UNAIDS; Other International: Ford Foundation, Rockefeller Foundation. Rows in grey denote no support received at all*)

Key Support Extended	Bilateral	UN Agencies	GFATM	Other international Foundations
I. Prevention-related activities	✓	✓	✓	✓
1. Mass media	✓	✓	✓	✓
2. Community mobilisation	✓	✓	✓	✓
3. Voluntary counselling and testing (VCT)		✓	✓	
4. Programmes for vulnerable and special populations		✓	✓	✓
5. Youth in school		✓		✓
6. Prevention programmes for PLHIV	✓	✓	✓	✓
7. Programmes for sex workers and their clients	✓	✓	✓	
8. Programmes for MSM	✓		✓	
9. Harm reduction programmes for IDUs	✓		✓	
10. Workplace activities		✓		
11. Condom social marketing	✓	✓	✓	
12. Public and commercial sector condom provision			✓	
13. Female condom				
14. Microbicides				

Key Support Extended	Bilateral	UN Agencies	GFATM	Other international Foundations
15. Improving management of STIs	✓	✓	✓	
16. Prevention of mother-to-child transmission (PMTCT)		✓		
17. Blood safety		✓		
18. Post exposure prophylaxis (health care setting, rape)		✓	✓	
19. Safe medical injections				
II. Treatment and care components		✓	✓	✓
1. Palliative care		✓	✓	✓
2. Provider-initiated testing		✓	✓	
3. OI treatment		✓	✓	
4. OI prophylaxis		✓	✓	
5. Anti-retroviral therapy		✓	✓	
6. Specific HIV laboratory monitoring			✓	
7. Home-based care		✓	✓	✓
8. Psychological care			✓	
9. Nutritional support				
10. Dental care				
11. Additional/informal providers				
12. Hospital care			✓	
13. Outpatient care			✓	
14. Others		✓	✓	
III. Orphan and vulnerable children (OVC)		✓		✓
1. Education		✓		✓
2. Basic health care support		✓		✓
3. Family/home support		✓		✓
4. Community support				
5. Administrative costs				
6. Others				
IV. AIDS programme support costs	✓	✓	✓	✓
1. Programme management	✓	✓	✓	✓
2. Planning and co-ordination	✓	✓	✓	✓
3.Monitoring and evaluation	✓	✓	✓	✓
4. Operations research (research and development)	✓	✓	✓	
5. Sero-surveillance	✓	✓	✓	
6. HIV drug resistance surveillance		✓		

Key Support Extended	Bilateral	UN Agencies	GFATM	Other international Foundations
7. Information technology		✓	✓	
8. Supervision of personnel	✓		✓	
9. Upgrading laboratory infrastructure		✓	✓	
10. Construction of new health centres				
11. Drug supply systems	✓	✓	✓	✓
12. Others	✓	✓	✓	
V. Incentives for human resources	✓	✓	✓	✓
1. Monetary incentive for physician			✓	
2. Monetary incentive for other staff			✓	
3. Formative education and build-up of AIDS workforce			✓	
4. Monetary incentive for nurse				
5. Training	✓	✓	✓	
6. Others				✓
VI. Social protection and social services (excluding orphans)		✓		
1. Monetary benefits				
2. In-kind benefits				
3. Social services		✓		
4. Income generation		✓		
5. Others				
VII. Enabling environment and development	✓	✓	✓	✓
1. Advocacy and strategic communication	✓	✓	✓	✓
2. Human rights		✓	✓	
3. AIDS-specific institutional development	✓	✓	✓	
4. AIDS-specific programmes involving women		✓		
5. Others		✓	✓	
VIII. Research excluding operations research		✓	✓	
1. Biomedical research				
2. Clinical research				
3. Epidemiological research		✓	✓	
4. Social science research		✓		
5. Behavioural research		✓		
6. Research in economics				
7. Research in capacity strengthening				
8. Vaccine-related research				
9. Others		✓	✓	

Many key development partners, with the exception of the GFATM, have their own priority programmes which sometimes do not synchronise with the requirements of the country's AIDS strategic plan. The AMTP IV has a costed operational plan where key development partners could take their cue. The country can achieve all its objectives in the current plan if the development partners could align their support with the AMTP demands namely:

- Support for management systems strengthening;
- Support for implementation of research agenda;
- Support to harmonise local M & E systems vis-à-vis national M & E system and across sectors
- Alignment of donors' indicators with the indicators in the M & E system of the National Response to HIV and AIDS

VII.

monitoring & evaluation environment

Deliberate efforts to set up a national HIV and AIDS M & E system earnestly begun in 2003 and is still continuing. A remarkable feature of the development of the M & E System is the fact that it is truly an exercise involving the participation of different sectors. The on-going institutionalisation of the system at various levels is marked by challenges- be it technological, structural, manpower and sometimes political- at almost every level.

So far, the following have been accomplished:

1. Developed the *Monitoring and Evaluation Manual: Philippine Response to HIV and AIDS;*
2. Prepared the UNGASS Report 2005 and 2008 as a validation of the M&E process;
3. Trained and oriented NGOs and LACs on M&E;
4. Installed CRIS and trained its users at the national and local sites;
5. Pilot-tested the proposed M&E system; and
6. Developed a webpage and blogsite for M&E.

The Monitoring and Evaluation System of the Philippine HIV and AIDS Response is lodged at PNAC. The DOH-NEC collects and validates STI and HIV reports from social hygiene clinics and hospitals, conducts passive HIV and AIDS surveillance (IHBSS), and furnishes the same to PNAC. Reports emanating from other government agencies go directly to PNAC while reports submitted by civil society are collected by a designated NGO focal point for M&E and submitted to PNAC.

The UNGASS report development for this reporting period served as a test drive of the newly established National Monitoring and Evaluation System for HIV and AIDS. The reality that during the collection of data, the Philippine UNGASS team had to go through channels perceived to facilitate submission of data from various levels of the reporting hierarchy pointed to the fact that the M & E system still needs considerable fine tuning at all levels of the M & E structure.

The institutionalisation of the M&E system up to the level of the LGU looks promising despite the challenges, and is estimated to finally be in place at all levels of the M & E structure by 2010.

A core group of stakeholders from both government and civil society remains active in the process of planning and implementation of the M&E System.

Figure 3. M and E Framework

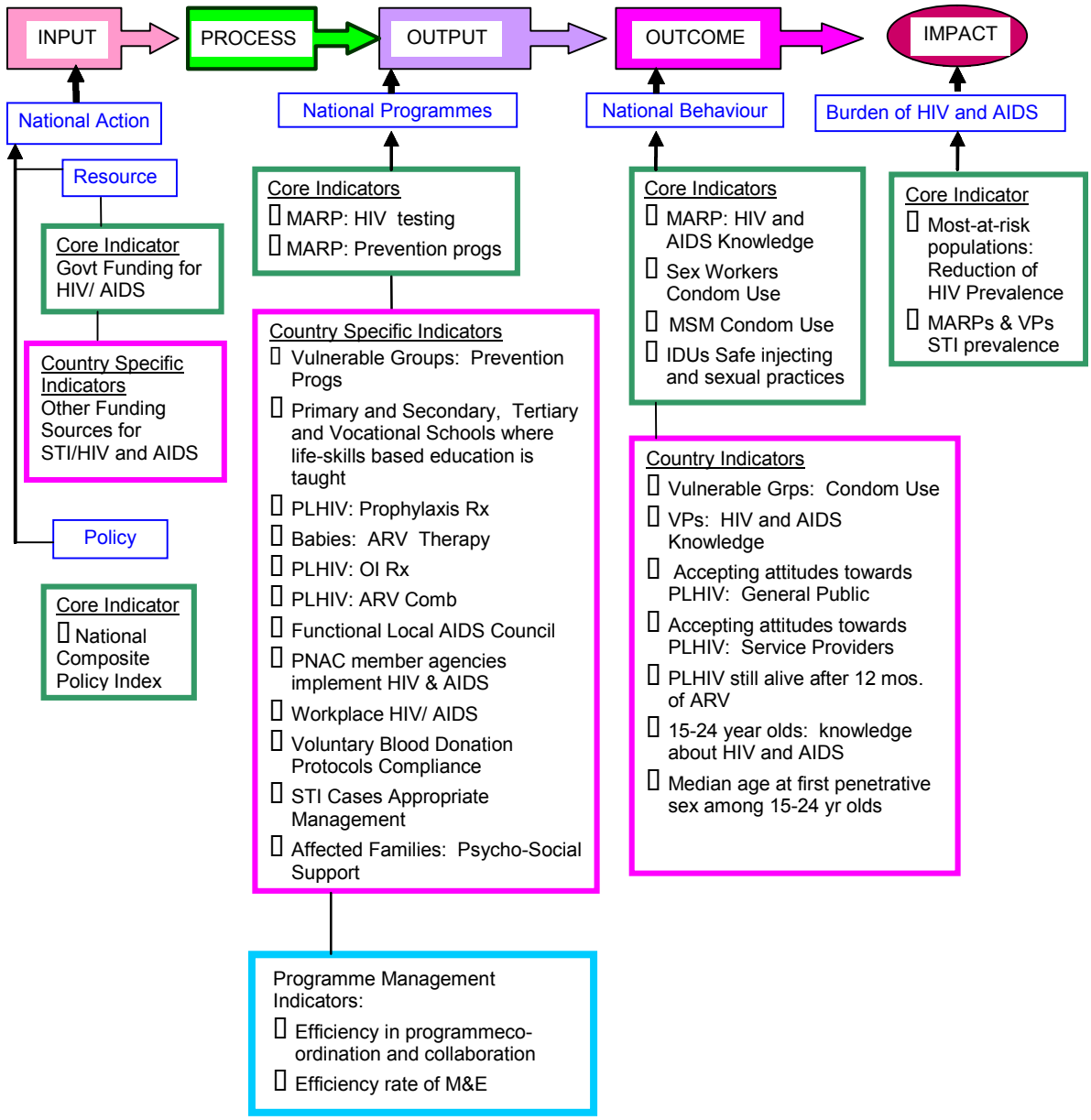
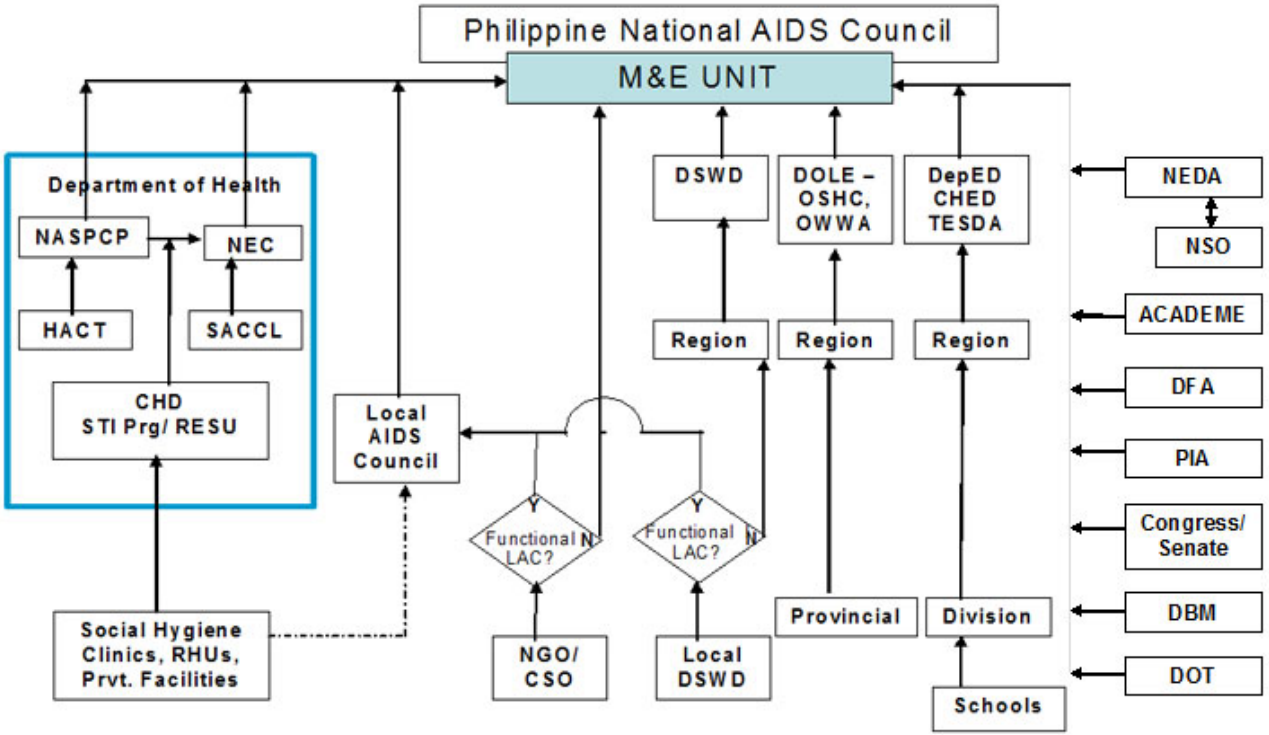


Figure 4: M and E System Structure



Active and passive surveillance systems in place

Part of the M & E system is the Active and Passive Surveillance. Since 1987, the DOH, through the NEC, has put in place both passive and active surveillance systems in order to keep track of how the epidemic progresses.

Included in the active surveillance are most-at-risk populations: People in Prostitution (PIP), Men Having Sex with Men (MSM), and Injecting Drug Users (IDU). Included in the PIP are Registered Female Sex Workers (RFSW), Freelance Female Sex Workers (FLSW), and clients of FSWs.

Overseas Filipino Workers (OFW), due to their risky behaviours while abroad and back home, have been classified as a vulnerable group and have been included in the passive surveillance surveys (AIDS Registry). OFW include seafarers, domestic helpers, and medical and health personnel.

The three (3)) types of surveillance systems in place are the following:

1. *HIV and AIDS Registry* – a passive surveillance system established in 1987, it continuously logs Western Blot-confirmed HIV cases reported by DOH-accredited hospitals, laboratories, blood banks, and clinics.

2. *Integrated HIV Behavioural and Serologic Surveillance (IHBSS)* – started in 2004 to serve as an early warning for increases in HIV seroprevalence. IHBSS consistently monitors what it considers as High Risk Groups (HRG) for HIV – Registered Female Sex Workers (RFSW), Freelance Female Sex Workers (FFSW), Men Having Sex with Men (MSM), clients of FSWs and Injecting Drug Users (IDU).

3. *Sentinel STI Etiologic Surveillance System (SSESS)* – set up in December 2001 and made operational in 2003. Since sexually transmitted infections (STI) have been identified as co-factors for HIV transmission, monitoring STI trend could guide programme intervention to prevent transmission of HIV.

Challenges of the M & E System

An assessment of the M&E system conducted in February 2007 yielded a collection of challenges:

1. Lack of personnel/focal persons to do M&E at almost all levels – from the PNAC secretariat to the LGUs and civil society. Fast turnover of manpower makes it difficult to identify people to be trained. Often, people who were trained previously leave the institution for better opportunities.
2. Inadequate/lack of funds to implement the M&E system
3. Inadequate or lack of capacity to do M&E
4. Technology problems – from lack of computers and/or incompatibility of hardware with software. Many LGUs use old computers (many are still running on Pentium II processing systems). In two (2) pilot sites where CRIS was implemented, electronic reporting was not successful.
5. Compatibility of data remains a challenge. Indicators of NGOs are frequently project-based and thus incompatible with the national indicators. Programme indicators of donors are not aligned with the indicators in the M&E System of the National Response to HIV and AIDS.
6. Difficulty on data collection both from government agencies and civil society organisations
7. Difficulty in communication and/or co-ordination with local sites
8. Lack of a unified documentation system

Finally, in terms of data collection for spending assessment, there remains a need to advocate the importance of the spending assessment exercise and ensure the submission of accurate data among stakeholders. It may also be necessary to upgrade the skills of those in charge of monitoring and evaluation and to improve reporting and recording systems to ensure quality and timeliness of data.

While some of the challenges cannot be overcome in the short term, the Philippines identified the following remedies or stopgap measures to facilitate institutionalisation of the M&E system:

1. Development of a handbook of indicators that are comparable over time and comparable with other countries
2. Provision of computers to selected LGUs
3. Development of data collection and analysis plan
4. Training of personnel on M&E

VIII.

annexes

Annex 1. Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV and AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes ✓	No
b) NAP	Yes	No
c) Others (please specify)	Yes	No

2) With inputs from

Ministries:		
Education	Yes✓	No
Health	Yes✓	No
Labour	Yes✓	No
Foreign Affairs	Yes	No✓
Others (please specify)	Yes	No
Civil society organisations	Yes✓	No
People living with HIV	Yes✓	No
Private sector	Yes✓	No
United Nations organisations	Yes✓	No
Bilaterals	Yes✓	No
International NGOs	Yes	No✓
Others	Yes✓	No

(please specify): Faith-based organisations

3) Was the report discussed in a large forum? Yes✓ No

4) Are the survey results stored centrally? Yes✓ No

5) Are data available for public consultation? Yes✓ No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report? (Name / title)

Dr. Jessie F. Fantone
Office-in-Charge
Philippine National AIDS Council Secretariat

Date: January 31, 2008

I. Non-government organisations

ORGANISATION	NAME	LEVEL OF PARTICIPATION				
		UNGASS Core Team	PINOY UNGASS D Group	NCPI-B Consultation Workshop	Vetting Forum	Others
Action for Health Initiative **(ACHIEVE)**	Malou Marin Amara Quesada	–	✓	✓	✓	✓ (Best Practice)
AIDS Society of the Philippines **(ASP)**	Dr. Nelia Salazar Dr. J.N.M. Sescon	✓	✓	✓	✓	X (NASA)
Alliance against AIDS in Mindanao **(Alagad Mindanao)**	Michael Jesus Mahinay	–	✓ (Alma Mondragon)	✓	✓	–
Alternative Law Research and Development Centre **(ALTERLAW)**	Atty. Gilda Guillermo	–	✓	✓	–	–
Apostleship of the Sea-Manila **(AOS)**	Sr. Aida Virtuez, SJBP	–	✓	✓	✓	–
Asilo de San Vicente de Paul	Sr. Mae Alere, DC	–	✓	✓	✓	–
Babae Plus	Maureen Colambo	–	✓	–	–	–
BIDLISIW	Nelly Majadillas	–	✓	–	–	–
Bicol Reproductive Health Information Network Inc. **(BRHIN)**	Ramon Moran Dr. Ferchito Avelino	–	✓ (Ramon Moran)	✓	–	–
Butterfly Brigade	Joseph Carlo Carillo	–	✓	✓	✓	✓ (Best Practice)

Convergence for Sustainable Human Development Inc. **(CSHDI)**	Menardo Futalan Maria Juvy Madrinan	–	✓ (Menardo Futalan)	✓	–	–
DKT International Philippines	Terry L. Scott Cristy Fuentes	–	✓	–	–	✓ (NASA)
Demographic Research and Development Foundation	Dr. Grace Cruz	–	–	–	–	–
Employers Confederation of the Philippines **(ECOP)**	Manuel Sid	–	–	–	–	–
Family Planning Organisation of the Philippines **(FPOP)**	Janina Narvaez Deborah Cabanag Lucia Lagda	–	✓ (Editha Geguna, & Lou)	✓	✓ J. Narvaez D. Cabanag	–
Free Rehabilitation, Economic, Education and Legal Assistance Volunteers Association, Inc. **(FREELAVA)**	Antonio Auditor	–	✓	–	–	–
Girls Scout of the Philippines **(GSP)**	Ma. Dolores T. Santiago Ginnie W. Oribiana	–	–	–	–	✓ (Best Practice)
Health Action Information Network **(HAIN)**	Edelina Dela Paz Noemi Bayoneta-Leis Emilyne De Vera Emily C. Magharing Ricky Trinidad	✓	✓ (Delen dela Paz, Emie De Vera, Nilda De Vera-Nazri, Noemi Bayoneta-Leis, Joyce Valbuena,Rosalyn Canolo)	✓	✓	✓ (Best Practice, NASA)

Human Development Empowerment Services **(HDES)**	Ma. Lourdes Lim Junpicar Dalus	–	✓ (Junpicar Dalus)	✓	✓	–
Health and Development Initiatives Institute **(HDII)**	Gladys Malayang	✓ (Arnold Vega)	✓	✓	✓	–
HOPE Volunteers Foundation	Julio Labayen III					
Institute of Social Studies and Action **(ISSA)**	Florence Tadiar Marlon Lacsamana	–	✓ (Florence Tadiar)	✓	✓	–
KABALAKA Reproductive Health Centre	Marian Virgie Gumayan	–	–	–	–	–
Kabataang Gabay sa Positibong Pamumuhay **(KGPP)**	John Piermont Montilla	–	✓ (John Piermont Montilla)	✓	✓ (Josel Cardinal)	–
Leyte Family Development Organisation **(LEFADO)**	Betty Garrido Kathleen Macawili	–	X (Betty Garrido)	✓	✓	–
Lunduyan para sa Pagpapalaganap, Pagpapatupad at Pagtatanggol ng Karapatang Pambata **(Lunduyan)**	Irene Fonacier-Fellizar Ramil Esguerra	–	✓ (Irene Fonacier-Fellizar)	✓	–	✓ (NASA)
Mayon Integrated Development Alternatives and Services **(MIDAS)**	Crieteta Triunfante	–	–	✓	–	–
National Catholic Churches of the Philippines **(NCCP)**	Grace Aoanan Lesley Capus	–	–	–	–	–

Philippines HIV/AIDS NGO Support Program **(Phansup)**	Roberto Nebrida	–	✓ (R. Nebrida)	✓	✓ (Xerxes Nebrida)	–
Philippine NGO Council on Population, Health and Welfare, Inc. **(PNGOC)**	Eden Divinagracia Ruthy Libatique	✓	✓ (R. Libatique, E. Divinagracia)	✓	✓	✓ Principal writer: RLibatique
Pinoy Plus Association **(Pinoy Plus)**	Jun Quinto Eddy Razon Noel Pascual	✓	✓ (N. Pascual)	✓	✓ (N. Pascual)	✓ (Best Practice)
Positive Action Foundation Phil., Inc **(PAFPI)**	Roberto Ruiz Lorna Garcia Michelle Navarro	✓	✓ (Joshua Formentera)	✓	✓	✓ (Best Practice, NASA)
Religious of the Good Shepherd	Sr. Carmen Dianne T. Cabasacan Ms. Lalae P. Garcia					✓ (Best Practice)
Remedios AIDS Foundation **(RAF)**	Dr. Jose Narciso Melchor Sescon	–	✓ (JNM Sescon)	✓	✓	✓ (NASA)
Salvation Army	Col. Malcolm Induruwage	–	–	–	–	–
Social Health, Environment and Development Foundation **(SHED)**	Domingo Non	–	–	✓	✓	–
TALIKALA	Eunice Casiple Jeanette Laurel	–	✓ (E. Casiple)	✓	–	–

The Library Foundation Share Collective **(TLF)**	Glenn Cruz Ferdinand Buenviaje	✓	✓ (G. Cruz)	✓	✓ (Ovidio Encelan Jr.)	✓ (Best Practice, NASA)
Tingog sa Kasanag (TISAKA)	Inday Monding					✓ (Best Practice)
TriDev Specialists Foundation Inc. **(Tridev)**	Perfecto "Toti" Uysingo	–	✓ (T. Uysingco)	✓	✓	–
Trade Union Congress of the Philippines **(TUCP)**	Ariel Castro Rola Reyes	–	✓ (A. Castro)	✓	✓	–
Tropical Disease Foundation **(TDF)**	Tina Ignacio Dr. Dorothy Agdamag	–	✓ (T. Ignacio)	✓ (Janie Rose Ilustre)	✓ (Mary Joy Morin)	✓ (NASA)
Visayas Primary Health Care Services, Inc **(VPHCSI)**	Pettty Orbeta-de Castro Mark Chito Molina	–	–	✓	–	–
Women /Men's Access to Vital Education and Services **(WAVES)** International, Inc	Juan Roxas	–	✓ (Maria Angelina Sondon)	✓	–	–
Women's Health Care Foundation, Inc. **(WHCF)**	Dr. Mirriam Fernando	–	✓ Dr. M. Fernando	–	–	✓ (NASA)

ORGANISATION	NAME	LEVEL OF PARTICIPATION				
		UNGASS Core Team	PINOY UNGASS D Group	NCPI-B Consultation Workshop	Vetting Forum	Others
Aklan State University **(ASU)**	Carol Joy Palma Remaneses	-	✓	✓	✓	-
University of the Southern Philippines Foundation **(USPF)**	Dr. Lourdes Jereza	-	✓	✓	-	✓ (Best Practice)
Siliman University Extension Programme	Dr. Nick Elman Dr. Fe Sycip-Wale					
University of the Philippines - Manila	Dr. Ofelia Saniel	✓	✓	✓	✓	

III. Government agencies

ORGANISATION	NAME	LEVEL OF PARTICIPATION								
		UNGASS Core Team	UNGASS D Group	NCPI A Respondent					Vetting Forum	Others
				Strategic Plan	Political Support	Prevention	Treatment, Care and Support	Monitoring and Evaluation		
Department of Health–Centre for Health and Development **(DOH–CHD Bicol)**		–	–	✓	✓	✓	✓	✓	–	–
Department of Social Welfare and Development **(DSWD–Bicol)**		–	–	✓	✓	✓	✓	✓	–	–
Department of Interior and Local Government **(DILG Bicol)**		–	–	✓	✓	✓	✓	✓	–	–
Department of Education **(DepEd Bicol)**		–	–	✓	✓	✓	✓	✓	–	–
Reproductive Tract and Health Clinics (Legazpi City, Bicol)		–	–	✓	✓	✓	✓	✓	–	–

National Economic Development Authority **(NEDA)**	Arlene Ruiz Dune Aranjuez	✓	–	✓	✓	✓	✓	✓	✓	–
Department of Education **(DepEd)**	Thelma Santos	–	–	✓	✓	✓	✓	✓	–	✓ (NASA)
Philippine National AIDS Council Secretariat **(PNAC)**	Dr. Jessie Fantone, Rench Chanliongco, Virginia Lily Evangelista	✓	✓	✓	✓	✓	✓	✓	✓	✓ (NASA)
Department of Tourism **(DOT)**	Dr. Ma. Amparo Cabrera	–	–	✓	–	–	–	–	–	✓ (NASA)
San Lazaro Hospital	Dr. Rosario Abrenica, Dr. Arturo Cabanban	–	✓	✓	✓	✓	✓	✓	–	✓ (NASA)
Department of Health-National AIDS/STD Prevention and Control Programme **(NASPCP)**	Dr. Yolanda Oliveros, Dr. Gerard Belimac, Joel Atienza	–	✓	✓	✓	✓	✓	✓	–	✓ (NASA)
League of Cities and Municipalities	Atty. Gil Cruz	–	–	✓	✓	✓	✓	✓	–	–
Department of Health -Centre for Health and Development (Western Visayas)	Ms. Charity Perea	–	–	✓	✓	✓	✓	✓	✓	–

Baguio AIDS Council **(Baguio AWAC)**	Dr. Celia Brillantes Dr. Charles Cheng	–	–	✓	✓	✓	✓	✓	✓	–
League of Provinces	Gov. Ben Evardone Veronica Hitosis	–	–	✓	✓	✓	✓	✓	–	–
Department of Interior and Local Government **(DILG)**	Usec. Austere Panadero Cesar Montances	✓		✓	✓	✓	✓	–	✓	–
Reproductive Tract and Health Clinics (Tabaco City, Bicol)		–	–	✓	✓	✓	✓	✓	–	–
Reproductive Tract and Health Clinics (Sorsogon City, Bicol)		–	–	✓	✓	✓	✓	✓	–	–
Reproductive Tract and Health Clinics (Municipality of Daraga, Bicol)		–	–	✓	✓	✓	✓	✓	–	–
Reproductive Tract and Health Clinics (Municipality of Matnog, Bicol)		–	–	✓	✓	✓	✓	✓	–	–
Department of Labour and Employment–Occupational Safety and Health Centre **(DOLE–OSHC)**	Dr. Dulce Estrella Gust Dr. Maria Pureza Fontelera	–	–	✓	✓	✓	✓	✓	✓	✓ (NASA)

Commission on Higher Education **(CHED)**	Sec. Romulo Neri Rose Castano	–	–	–	–	–	–	–	–	–
League of Provinces	Gov. Ben Evardone, Veronica Hitosis	–	–	✓	✓	✓	✓	✓	–	–
Technical Education and Skills Development Authority **(TESDA)**	Augusto Syjuco, Deputy Director Roger Peyuan	–	–	–	–		–	–	–	–
Department of Social Welfare and Development **(DSWD)**	Usec. Alicia Bala, Helen Suzara, Marlene Moral	–	–	–	–	–	–	–	–	✓ (NASA)
House of Representatives- Committee on Health **(HOR)**	Rep. Arthur Pingoy	–	–	–	–	–	–	–	–	–
House of Representatives- Committee on Millennium Development Goals	Rep. Nerissa Soon-Ruiz	–	–	–	✓	–	–	–	–	–
House of Representatives- Bayan Muna Partylist	Rep. Satur Ocampo	–	–	–	–	–	–	–	–	–
Senate of the Philippines- Committee on Health and Demography **(SENATE)**	Sen. Pia Cayetano	–	–	–	–	–	–	–	–	–
Philippine Hospitals Association **(PHA)**	Dr. Tibucio Masias	–	–	–	–	–	–	–	–	–
Department of Budget and Management **(DBM)**	Mr. Arthuro Bumatay	–	–	–	–	–	–	–	–	–

Department of Foreign Affairs-Office of the United Nations and International Organisations **(DFA)**	Grace Princesa	–	–	–	–	–	–	–	–	–
Philippine Information Agency **(PIA)**	Emelyn Quintos Libunao	–	–	–	–	–	–	–	✓ (Lyndon Planrum)	✓ (NASA)
Research Institute for Tropical Medicine **(RITM)**	Dr. Remigio Olveda	–	–	–	–	–	–	–	–	✓ (NASA)
Department of Health (DOH) – National Epidemiology Centre **(NEC)**	Dr. Enrique Tayag Dr. Aura Corpuz Dr. Genesis Samonte Mr. Noel Palaypayon	–	–	–	–	–	–	–	–	✓ (NASA)
National Statistics Office **(NSO)**	Bernadita Yabut	–	–	–	–	–	–	–	✓ (B. Yabut)	
Legazpi City Health Office	Dr. Fulbert Alec Gillego	–	–	–	–	–	–	–	–	–
Davao City Health Office	Dr. Josephine Villafuerte	–	–	–	–	–	–	–	–	–
Department of Health-Centre for Health and Development Region XI	Dr. Paulyn Jean Rosell-Ubial Dr. Renee Faldas	–	–	–	–	–	–	–	–	–

Committee on Health and Hospital Services	Hon. Christopher Alix Dr. Ilya Tac-an	–	–	–	–	–	–	–	–	–
Department of Health-Centre for Health and Development Region III	Dr. Rio Magpantay Dr. Eloisa Pineda	–	–	–	–	–	–	–	–	–
City Government of Iloilo	Mayor Jerry Trenas Dr. Urminico Baronda	–	–	–	–	–	–	–	–	✓ (NASA)
Provincial Government of Aklan	Dr. Emma Cortez	–	–	–	–	–	–	–	–	✓ (NASA)
City Government of Zamboanga City	Mayor Celso Lobregat Dr. Rodelyn Agbulos Dr. Kibtiya Uddin	–	–	–	–	–	–	–	–	✓ (NASA
City Government of Cagayan de Oro		–	–	–	–	–	–	–	–	✓ (NASA)
City Government of San Fernando		–	–	–	–	–	–	–	–	✓ (NASA)
City Government of Urdaneta		–	–	–	–	–	–	–	–	✓ (NASA)
City Government of Puerto Princesa		–	–	–	–	–	–	–	–	✓ (NASA)
City Government of General Santos		–	–	–	–	–	–	–	–	✓ (NASA)
City Government of Quezon City		–	–	–	–	–	–	–	–	✓ (NASA)
Commission on Human Rights **(CHR)**	Hon. Purificacion Quisumbing Dr. Joseph Jimenez	–	–	–	–	–	–	–	–	–
Department of Justice **(DOJ)**	Atty. Teresita Domingo Fiscal Rosalinda Aquino	–	–	–	–	–	–	–	–	–

ORGANISATION	NAME	LEVEL OF PARTIPATION				
		UNGASS Core Team	UNGASS D Group	NCPI B Consultation Workshop	Vetting Forum	Others
United Nations Children's Fund (UNICEF)	Philip Castro, Mr. Nicholas Alipui	-	✓	✓	✓	✓ (NASA)
Joint United Nations Programme on HIV/AIDS (UNAIDS)	Ma. Lourdes Quintos, Merceditas Apilado, Zimmbodilion Mosende, Dr. Elena Borromeo	✓	✓	✓	✓	✓ (NASA)
Health Policy Development Programme- United States Agency for International Development (HPDP-USAID)	Lloyd Norella, Cora Manaloto, Dr. Aye Aye Thwin	-	-	✓	✓	✓ (NASA)
World Health Organisation (WHO)	Madeline Salva Dr. Soe-Nyunt-U	-	-	✓	✓	✓ (NASA)
United Nations Development Programme (UNDP)	Ms. Nileema Noble	-	✓	✓	-	-
Australian Agency for International Development (AUSAID)	Jimmy Loro	-	-	✓	-	-
International Labour Organisation (ILO)	Jess Macasil	-	-	✓	-	-

United Nations Population Fund (UNFPA)	Ms. Suneeta Mukherjee Dr. Jovanni Templonuevo Rhona Montebon	–	–	✓	–	✓ (NASA)
Asian Development Bank (ADB)	Thomas Crouch Donna Lacuna Ms. Shireen Lateef Ms. Emi Masaki	–	–	–	–	✓ (NASA)
United Nations Development Programme (UNDP)	Ms. Nileema Noble	–	✓	✓	–	–
German Technical Co-operation (GTZ)	Dr. Michael Adelhardt	–	–	–	–	–
European Commission (EC)	Roger de Backer Ms. Romina Sta. Clara	–	–	–	–	✓ (NASA)
Japan International Co-operation Agency (JICA)	Mr. Shozo Matsuura	–	–	–	–	✓ (NASA)
The Global Fund to Fight AIDS, Tuberculosis and Malaria	c/o Tropical Disease Foundation	–	✓	–	✓	✓ (NASA)
German Development Bank	Ms. Olga Caday	–	–	–	–	✓ (NASA)

V. Other contributors

Name	Contribution
1. Rowena Alvarez	Consultant (former writer of UNGASS Report 20 Member, UNGASS Core Team Facilitator, Vetting Forum
2. Merle Pimentel	Facilitator, NCPI B Workshop for NGOs
3. Ma. Rosalyn Mesina	Co-documenter, NCPI B Workshop for NGOs Documenter, Vetting Forum
4. Ma. Rosario Mayor	Co-documenter, NCPI B Workshop B for NGOs Documenter, NCPI B Workshop for UN and Bilateral organisations Documenter, Best Practice interviews Copy Editor and Lay-out artist

National Composite Policy Index Questionnaire Part A (Administered to government officials)

Note: The NCPI A Questionnaire was distributed to PNAC members from the government agencies as well as to key government officials (Cong. Nerissa Soon-Ruiz and Satur Ocampo, Commissioner Purificacion Quisumbing of Commission on Human Rights).

Regional data was also gathered from Regions 5 & 6 and from the province of Aklan through the Aklan Provincial AIDS Council (APAC). Baguio City's AIDS Watch Council (AWAC) administered the questionnaire as well. Returned questionnaires from APAC and AWAC are not considered for this reporting because they cover local policy environment instead of national. However, data gathered from these two local AIDS councils will be used to further strengthen local response.

Data gathering was originally planned through Key Informant Interview but due to difficulties in setting an interview date, the respondents agreed to administer it themselves. Majority of the respondents filled up all sections of the questionnaire. As of Dec 19, the following agencies have returned the accomplished questionnaire through e-mail and by post:

1. Regional offices from Region 5 (Bicol Region)
2. NEDA
3. Department of Education
4. PNAC Secretariat
5. Department of Tourism
6. San Lazaro Hospital
7. National AIDS/STI Control Programme (NASPCP)
8. DOH Region 6 (Western Visayas RMMSHAPC)
9. League of Cities of the Philippines
10. Department of Interior and Local Government
11. Occupational Safety and Health Centre - DOLE
12. House of Representatives - Cong. Nerissa Soon-Ruiz (section on Political Support)

Organisation	Name	NCPI A Respondent				
		Strategic Plan	Political Support	Prevention	Treatment, Care and Support	Monitoring and Evaluation
Department of Health–Centre for Health and Development **(DOH–CHD Bicol)**		✓	✓	✓	✓	✓
Department of Social Welfare and Development **(DSWD–Bicol)**		✓	✓	✓	✓	✓
Department of Interior and Local Government **(DILG Bicol)**		✓	✓	✓	✓	✓
Department of Education **(DepEd Bicol)**		✓	✓	✓	✓	✓
Reproductive Tract and Health Clinics (Legazpi City, Bicol)		✓	✓	✓	✓	✓
National Economic Development Authority **(NEDA)**	Erlinda Capones (Director IV, Social Development)	✓	✓	✓	✓	✓
Department of Education **(DepEd)**	Thelma Santos (Director)	✓	✓	✓	✓	✓

Philippine National AIDS Council Secretariat **(PNAC)**	Dr. Jessie Fantone (Officer-in-Charge)	✓	✓	✓	✓	✓
Department of Tourism **(DOT)**	Dr. Ma. Amparo Cabrera (Medical Officer)	✓	-	-	-	-
San Lazaro Hospital	Dr. Rosario Abrenica MS III, Head HIV AIDS Pavilion	✓	✓	✓	✓	✓
Department of Health-National AIDS/STD Prevention and Control Programme **(NASPCP)**	Dr. Gerard Belimac (Programme Manager)	✓	✓	✓	✓	✓
League of Cities and Municipalities	Atty. Gil Cruz (Executive Director)	✓	✓	✓	✓	✓
Department of Health -Centre for Health and Development (Western Visayas)	Dr. Charity Perea (STI/HIV/AIDS Co-ordinator)	✓	✓	✓	✓	✓
Baguio AIDS Council **(Baguio AWAC)**	Dr. Celia Brillantes (Head Secretariat AWAC, Social Hygiene Clinic Physician)	✓	✓	✓	✓	✓
League of Provinces	Gov. Ben Evardone (Secretary General) Veronica Hotosis	✓	✓	✓	✓	✓
Department of Interior and Local Government **(DILG)**	Austere Panadero (Undersecretary) Cesar Montances (Chief Administrative Officer)	✓	✓	✓	✓	-

Reproductive Tract and Health Clinics (Tabaco City, Bicol)		✓	✓	✓	✓	✓
Reproductive Tract and Health Clinics (Sorsogon City, Bicol)		✓	✓	✓	✓	✓
Reproductive Tract and Health Clinics (Municipality of Daraga, Bicol)		✓	✓	✓	✓	✓
Reproductive Tract and Health Clinics (Municipality of Matnog, Bicol)		✓	✓	✓	✓	✓
Department of Labour and Employment-Occupational Safety and Health Centre **(DOLE-OSHC)**	Dr. Dulce Estrella Gust (Executive Director)	✓	✓	✓	✓	✓
House of Representatives-Committee on Millennium Development Goals	Rep. Nerissa Soon-Ruiz (Chairperson)	-	✓	-	-	-

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy/action framework to combat HIV/AIDS?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.3)

Yes ✓ No N/A

Period covered: AMTP4 2005-2010 [write in]

IF NO or N/A, briefly explain why

IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multi-sectoral strategy/ action framework?

Number of Years: 20 [write in]

1.2 Which sectors are included in the multi-sectoral strategy/ action framework with a specific HIV budget for their activities?

Sectors included	Strategy / Action framework		Earmarked budget	
Health	Yes ✓	No	Yes ✓	No
Education	Yes ✓	No	Yes ✓	No
Labour	Yes✓	No	Yes ✓	No
Transportation	Yes ✓	No	Yes	No ✓
Military/Police	Yes ✓	No	Yes ✓	No
Women	Yes ✓	No	Yes ✓	No
Young people	Yes ✓	No	Yes ✓	No
Other*: [write in] Children, OSY, Migrant workers PIP, PLHIV, MSM	Yes ✓	No	Yes ✓	No

*Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget, how is the money allocated?
1. Through external assistance – NEDA
2. Spending for HIV and AIDS is taken from other line items where the money is embedded or hidden
3. Sub-allotted from the Department of Health
4. Some agencies with no earmarked budget get their money for HIV and AIDS prevention from the Gender and Development budget/ fund which has an allocated budget
5. Other agencies do not have specific budget allocation for HIV and AIDS prevention but their funding is integrated in Human Resource Development and Training Program funds

1.3 Does the multi-sectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes ✓ No
b. Young women/young men	b. Yes ✓ No
c. Specific vulnerable sub- populations[1]	c. Yes ✓ No
d. Orphans and other vulnerable children	d. Yes ✓ No
Settings	
e. Workplace	e. Yes ✓ No
f. Schools	f. Yes ✓ No
g. Prisons	g. Yes No ✓
Cross-cutting issues	
h. HIV/AIDS and poverty	h. Yes ✓ No
i. Human rights protection	i Yes ✓ No
j. PLHIV involvement	j. Yes ✓ No
k. Addressing stigma and discrimination	k. Yes ✓ No
l. Gender empowerment and/or gender equality	l. Yes ✓ No

[1] Sub-populations that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes ✓ No

IF YES, when was this needs assessment /analysis conducted?

Year: 2004 [write in]

IF NO, how were target populations identified?

1.5What are the target populations in the country?

PIP (SW and clients)
Health workers
MSM
Young men/youth
Students
Travellers/migrant workers
Rape victims
Government employees
IDU
Children
PLHIV
Women

1.6 Does the multisectoral strategy/action framework include an operational plan?

Yes ✓ No

1.7 Does the multi-sectoral strategy/action framework or operational plan include:

a. Formal programme goals?	Yes ✓	No
b. Clear targets and/or milestones?	Yes ✓	No
c. Detailed budget of costs per programmatic area?	Yes ✓	No
d. Indications of funding sources?	Yes ✓	No
e. Monitoring and Evaluation framework?	Yes ✓	No

1.8 Has the country ensured "full involvement and participation" of civil society[2] in the development of the multi-sectoral strategy/ action framework?

Active involvement ✓	Moderate involvement	No involvement

IF active involvement, briefly explain how this was done:
1. Civil society members are represented in the Philippine National AIDS Council. Consultation meetings are conducted regularly.
2. PNAC gathered stakeholders for a strategic planning workshop
3. No activity is conducted without civil society involvement. Civil society membership in the national AIDS Council is 30%.
4. Civil society and NGOs are included in the consultation-meetings.
5. Civil societies as partners/members of the national AIDS Council involved in the development/planning of the strategic framework
6. Advocacy. Let all sector know the situation, the threat that HIV and AIDS brings to all sectors, the role that everyone has to play and the importance of their involvement.
7.Through active membership in the PNAC, the central advisory, policy-making and planning body
8. The AIDS Medium Term Plan of the country was developed through a national consultation with multisectoral participation co-ordinated by the Philippine National AIDS Council.

IF NO or MODERATE involvement, briefly explain :

1.9 Has the multi-sectoral strategy/action framework been endorsed by most external Development Partners (bilaterals; multilaterals)?

Yes	No ✓

1.10 Have external Development Partners (bilaterals, multilaterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes, all partners	Yes, some partners ✓	No

[2]Civil society includes among others: Networks of people living with HIV; women's organisations; young people's organisations; faith-based organisations; AIDS service organisations; Community-based organisations; organisations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organisations, human rights organisations; etc. For the purpose of the NCPI, the private sector is considered separately.

2. **Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?**

Yes ✓ No N/A

2.1 **IF YES,** in which development plans is policy support for HIV and AIDS integrated?

a)✓ b)✓ c)✓ d)✓ e) Other [write in]

2.2 **IF YES,** which policy areas below are included in these development plans?

✓ Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	✓	✓	✓	✓	
Treatment for opportunistic infections	✓	✓	✓	✓	
ART	✓	✓	✓	✓	
Care and support (including social security or other schemes)	✓	✓	✓	✓	
HIV/AIDS impact alleviation	✓	✓	✓	✓	
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	✓	✓	✓	✓	
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	✓	✓	✓	✓	
Reduction of stigma and discrimination	✓	✓	✓	✓	
Women's economic empowerment (e.g. access to credit, access to land, training)	✓	✓	✓	✓	
Other: [write in]					

3. **Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?**

Yes ✓ No N/A

3.1 **IF YES**, to what extent has it informed resource allocation decisions?

Low					High
0	1	2✓	3	4	5

4. **Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?**

Yes ✓ No

Behavioural change communication	Yes ✓ No
Condom provision	Yes No
HIV testing and counselling*	Yes ✓ No
STI services	Yes ✓ No
Treatment	Yes ✓ No
Care and support	Yes No
Others: [write in]	Yes No

* What is the approach taken to HIV testing and counselling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:

1. Voluntary based on RA 8504
2. Voluntary, because it is written in the law (RA8504) that all HIV testing in the Philippines is voluntary with accompanying counselling
3. Voluntary. We educate people especially those MARP
4. Voluntary. Except for OFWs. HIV testing is mandatory.
5. HIV antibody testing is non-mandatory to all Filipinos as prescribed by the IRR of RA 8504, though it is encouraged as long there is appropriate counselling

5. **Has the country followed up on commitments towards Universal Access made during the High-Level AIDS Review in June 2006?**

Yes ✓ No

5.1 Has the National Strategic Plan/operational plan and national HIV/AIDS budget been revised accordingly?

Yes ✓ No

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes ✓ No

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and projected needs ✓ Estimates only No

5.4 Is HIV and AIDS programme coverage being monitored?

Yes ✓No

(a) IF YES, is coverage monitored by sex (male, female)?

Yes ✓No

(b) IF YES, is coverage monitored by population sub-groups?

Yes ✓ No

IF YES, which population sub-groups?

1. PIP (Clients and Sex Workers)
2. MSM
3. Migrant workers
4. Youth
5. IDU
6. Children
7. Women

(c) Is coverage monitored by geographical area?

Yes ✓ No

IF YES, at which levels (provincial, district, other)? Identified risk zones

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?
Poor 0 1 2 3 4 5 6 7✓ 8 9 10 Good
Poor 0 1 2 3 4 5 ✓ 6 7 8 9 10 Good

Comments on progress made since 2005:

1. Due to the M&E effort, there is now a more concerted effort in all aspects of strategic planning.
2. We now have the AMTP4 to guide our activities. We now have an organised group of PLHIV in Western Visayas. The involvement of all sectors dramatically increased access to medical services and ARV for PLHIV. There are now two treatment hubs in Western Visayas.
3. The 2007 Strategy planning efforts are more promising as compared to 2005 .
4. There was an improvement since the 4th AIDS Medium Term Plan became operational; it also addressed gaps that were not addressed in the 3rd MTP.
5. Development of Costed Operational Plan

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organisations and processes to support effective AIDS programmes.

1. **Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?**

President/Head of government	Yes	No ✓
Other high officials	Yes ✓	No
Other officials in regions and/or districts	Yes ✓	No

2. **Does the country have an officially recognised national multi-sectoral HIV/AIDS management / co-ordination body? (National AIDS Council or equivalent)?**

Yes ✓ No

IF NO, briefly explain:

2.1 **IF YES,** when was it created?

Year: 1992 [write in]

2.2 **IF YES,** who is the Chair?

Francisco T. Duque III, Secretary of Health and Chair, Philippine National AIDS Council [write in name and title/function]

2.3 **IF YES,** does it:

have terms of reference?	Yes ✓ No
have active Government leadership and participation?	Yes ✓ No
have a defined membership? include civil society representatives? IF YES, what percentage? 27 % [write in] include people living with HIV? include the private sector?	Yes ✓ No Yes ✓ No Yes ✓ No Yes ✓ No
have an action plan?	Yes ✓ No
have a functional Secretariat?	Yes ✓ No
meet at least quarterly? review actions on policy decisions regularly? actively promote policy decisions? provide opportunity for civil society to influence decision-making? strengthen donor co-ordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes ✓ No Yes ✓ No Yes ✓ No Yes ✓ No Yes ✓ No

3. **Does the country have a national HIV/AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?**

Yes ✓ No N/A

Terms of reference	Yes ✓ No
Defined membership	Yes ✓ No
Action plan	Yes ✓ No
Functional Secretariat	Yes ✓ No
Regular meetings	Yes ✓ No Frequency of meetings: Quarterly

IF YES,

What are the main achievements?

1. Formulation of 4TH AIDS Medium Term Plan
2. AMPT4 Operational Plan 2007-2008
3. Created supportive environment for PLHIV
4. M&E System of the Philippine HIV and AIDS Response

What are the main challenges for the work of this body?

1. Budget for PNAC Secretariat
2. Waning motivation/interest of members over the years
3. Stronger commitment is needed
4. Waning interest of members due to low prevalence status of the country
5. Budget not clearly defined for some member-agencies
6. Strengthen M&E by reaching out & involvement people in the grassroots
7. Political support
8. Lack of human resource
9. Strengthening the national response on the HIV and AIDS epidemic; increase budget for HIV and AIDS intervention such as information and education, creating Local AIDS Councils.
10. Not all members are clear about their roles and responsibilities
11. Organisation Development of PNAC

Comment: PNAC Sec suffers from fast turn over of staff; needs capacity building, at the basic, AIDS 101.

4. **What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?**

Percentage: *no answer* [write in]

5. **What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organisations?**

a. Information on priority needs and services	Yes ✓ No
b. Technical guidance/materials	Yes ✓ No
c. Drugs/supplies procurement and distribution	Yes No ✓
d. Co-ordination with other implementing partners	Yes ✓ No
e. Capacity-building	Yes No ✓
Other: [write in]	

6. **Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?**

Yes ✓ No

6.1 **IF YES,** were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes No ✓

6.2 **IF YES,** which policies and legislation were amended and when?
Policy/Law: RA 8504; RA 9165 – amendments are ongoing
Year: [write in]

Overall, how would you rate the political support for the HIV/AIDS programme in 2007 and in 2005?
Poor Good 0 1 2 3 4 5 6 7 8 ✓ 9 10 Poor Good 0 1 2 3 4 5 6 7 ✓ 8 9 10
Comments on progress made since 2005: 1. 2007 political support is more promising than 2005 2. Leadership in PNAC is more visibly felt

III. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?

Yes ✓ No N/A

1.1. **IF YES**, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent
Delay sexual debut
Be faithful
Reduce the number of sexual partners
Use condoms consistently
Engage in safe(r) sex
Avoid commercial sex
Abstain from injecting drugs
Use clean needles and syringes
Fight against violence against women
Greater acceptance and involvement of people living with HIV
Greater involvement of men in reproductive health programmes
Other: [write in]

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV and AIDS by the media?

Yes	✓	No

2. Does the country have a policy or strategy promoting HIV/AIDS-related reproductive and sexual health education for young people?

Yes	No ✓	N/A

2.1 Is HIV education part of the curriculum in

primary schools?	Yes	No✓
secondary schools?	Yes	No✓
teacher training?	Yes	No✓

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No ✓

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No ✓

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes	✓	No

IF NO, briefly explain:

3.1 **IF YES**, which sub-populations and what elements of HIV prevention do the policy/strategy address?

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations* [write in]
Targeted information on risk reduction and HIV education	✓	✓	✓	✓	✓	OFW
Stigma & discrimination reduction	✓	✓	✓	✓	✓	Youth; public
Condom promotion	✓	✓	✓	✓	✓	Marine students
HIV testing & counselling	✓	✓	✓	✓	✓	OFW
Reproductive health, including STI prevention & treatment	✓	✓	✓	✓	✓	Secondary students
Vulnerability reduction (e.g., income generation)	N/A	N/A	✓	N/A	N/A	OFW
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle & syringe exchange	✓	N/A	N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005?												
2007	Poor											Good
	0	1	2	3	4	5	6	7 ✓	8	9	10	
2005	Poor											Good
	0	1	2	3	4	5	6✓	7	8	9	10	
Comments on progress made since 2005: Policy efforts are visible through the 4th AIDS Medium Term Plan												

4. Has the country identified the districts (or equivalent geographical/ decentralised level) in need of HIV prevention programmes?

Yes ✓ No

IF NO, how are HIV prevention programmes being scaled-up?

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts* in need	most districts* in need	some districts* in need
Blood safety		✓	
Universal precautions in health care settings		✓	
Prevention of mother-to-child transmission of HIV			✓
IEC on risk reduction		✓	
IEC on stigma and discrimination reduction		✓	
Condom promotion		✓	
HIV testing & counselling		✓	
Harm reduction for injecting drug users			✓

Risk reduction for men who have sex with men		✓	
Risk reduction for sex workers		✓	
Programmes for other vulnerable sub-populations			✓
Reproductive health services including STI prevention & treatment		✓	
School-based AIDS education for young people			✓
Programmes for out-of-school young people			✓
HIV prevention in the workplace			✓
Other [write in]			

*Districts or equivalent geographical/de-centralized level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

Poor Good

0 1 2 3 4 5 6 7 ✓ 8 9 10

Poor Good

0 1 2 3 4 5 ✓ 6 7 8 9 10

Comments on progress made since 2005:

1. Constraints in condom promotion
2. Constraints in the school-based AIDS education
3. Advocacy has been intensified
4. More high risk LGUs identified
5. The implementation of Blood Safety programme, Strengthening and Implementation of HIV and AIDS Prevention, Scaling-Up of Treatment, Care and Support, brought forth changes in HIV prevention programme.

IV. TREATMENT, CARE AND SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV/AIDS treatment, care and support?** (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes ✓ No

1.1 **IF YES,** does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes ✓ No

2. **Has the country identified the districts (or equivalent geographical/ decentralised level) in need of HIV and AIDS treatment, care and support services?**

Yes ✓ No

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	all districts* in need	most districts* in need	some districts* in need
a. Antiretroviral therapy		✓	
b. Nutritional care			✓
c. Paediatric AIDS treatment		✓	
d. Sexually transmitted infection management		✓	

e. Psychosocial support for people living with HIV and their families		✓	
f. Home-based care			✓
g. Palliative care and treatment of common HIV-related infections			✓
h. HIV testing and counselling for TB patients			✓
i. TB screening for HIV-infected people			✓
j. TB preventive therapy for HIV-infected people			✓
k. TB infection control in HIV treatment and care facilities			✓
l. Cotrimoxazole prophylaxis in HIV-infected people			✓
m. Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape)			✓
n. HIV treatment services in the workplace or treatment referral systems through the workplace			✓
o. HIV care and support in the workplace (including alternative working arrangements)			✓
p. Other programmes: [write in]			

*Districts or equivalent decentralised governmental level in urban and rural areas

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV/AIDS?**

Yes ✓ No

4. **Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

Yes No ✓

1.1IF YES, for which commodities?: [write in]

5. Does the country have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes No ✓ N/A

5.1 **IF YES,** is there an operational definition for OVC in the country?

Yes No

5.2 **IF YES,** does the country have a national action plan specifically for OVC?

Yes No

5.3 **IF YES,** does the country have an estimate of OVC being reached by existing interventions?

Yes No

IF YES, what percentage of OVC is being reached? % [write in]

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?
Poor Good 0 1 2 3 4 ✓ 5 6 7 8 9 10
Poor Good 0 1 2 3 ✓ 4 5 6 7 8 9 10
Comments on progress made since 2005: There is no specific policy for children orphaned because of HIV and AIDS. However, needs of children orphaned by AIDS are being provided by the Department of Social Welfare and Development with help from NGOs

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes ✓ Years covered:2006-2007, In progress No

1.1. IF YES, was the M&E plan endorsed by key partners in M&E?

Yes ✓ No

1.2. Was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes ✓ No

1.3. Have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners Yes, most partners ✓
Yes, but only some partners No

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes ✓ No
behavioural surveillance	Yes ✓ No
HIV surveillance	Yes ✓ No
a well-defined standardised set of indicators	Yes ✓ No
guidelines on tools for data collection	Yes ✓ No
a strategy for assessing quality and accuracy of data	Yes ✓ No
a data dissemination and use strategy	Yes ✓ No

3. Is there a budget for the M&E plan?

Yes	ü	Years covered: 2006-2007,	In progress	No

3.1 IF YES, has funding been secured?

Yes	ü	No

4. Is there a functional M&E Unit or Department?

Yes	In progress	ü	No

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

4.1 IF YES, is the M&E Unit/Department based

in the NAC (or equivalent)?	Yes	ü	No
in the Ministry of Health?	Yes	ü	No
elsewhere?			[write in]

4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:	0		
Position:	[write in]	Full time / Part time?	Since when?
Position:	[write in]	Full time / Part time?	Since when?
Etc.			
Number of temporary staff:	1		

4.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/ Department for review and consideration in the country's national reports?

Yes	✓	No

IF YES, does this mechanism work? What are the major challenges?
1. Timely submission of reports
2. Limited budget
3. Since it started, M&E reporting has come in trickles but with active collection, more data has been collected. Institutionalising M&E Units in different partner organisations
4. The mechanism works but needs more budget and human resource

4.4 **IF YES,** to what degree do UN, bilaterals, and other institutions share their M&E results?

Low					High
0	1	2	3	4✓	5

5. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No Yes, but meets irregularly
Yes, meets regularly ✓

IF YES, Date of last meeting: January 21, 2007 [write in]

5.1 Does it include representation from civil society, including people living with HIV?

Yes ✓ No

IF YES, describe the role of civil society representatives and people living with HIV in the working group?
1. Technical resource person
2. Data for the M&E is also submitted by Civil Society Organisations working with PLHIV. Organisations of PLHIV are actively involved in M&E
3. Serve as a link for those hard to reach population
4. Civil Society has a role in the development and popularisation of indicators and providing links to other implementing organisations in the dissemination of the importance of data/information collection for the M&E

6. Does the M&E Unit/Department manage a central national database?

Yes No ✓

6.1 **IF YES,** what type is it?

6.2 **IF YES,** does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?
Yes No

6.3Is there a functional* Health Information System?

National level	Yes ✓ No
Sub-national level **IF YES,** at what level(s)? City and regional and provincial	Yes ✓ No

6.4 Does the country publish at least once a year an M&E report on HIV/AIDS, including HIV surveillance data?

Yes ✓No

7. To what extent is M&E data used in planning and implementation?

Low					High
0	1	2	3	4	5 ✓

What are examples of data use?

1. Planning and budgeting
2. Policy formulation
3. Identification of funding gaps in the program
4. Identification of research gaps
5. Number of HIV/AIDS cases in the country
6. Modes of transmission
7. For program implementation, advocacy, prevention (condom use and other information and education activities), treatment, care and support
8. For policy redirection – amendment of Republic Act 8504 and other relevant legislation and standards

What are the main challenges to data use?

1. Validity, reliability
2. Timely submission/reporting
3. Assuring regular submission and validity of the data
4. These are aggregate data. No data at the local government unit level
5. Without LGU data, it is hard to entic LGUs to scale up efforts in combating HIV/AIDS in the locality
6. Not all information collected are useful or the information collected may not be the ones we need

8. In the last year, was training in M&E conducted

- At national level? Yes ✓ No
  IF YES, Number trained:

- At sub-national level? Yes ✓ No
  IF YES, Number trained:

- Including civil society? Yes ✓ No
  IF YES, Number trained:

Overall, how would you rate the M&E efforts of the HIV/AIDS programme in 2007 and in 2005?

Poor											Good
0	1	2	3	4	5	6 ✓	7	8	9	10	
Poor											Good
0	1	2	3	4	5 ✓	6	7	8	9	10	

Comments on progress made since 2005:

1. M&E Activities are more visible this year, with more output
2. Progress has been made because of the development of the M&E System, pilot testing of the system was done and there was involvement of multisectoral groups since the development of the M&E Plan

National Composite Policy Index Questionnaire Part B (Administered to non-government organisations, bilateral agencies and UN organisations)

Note:

Two workshops were conducted to administer the NCPI B. One workshop was conducted among UN agencies and bilateral organisations last October 16, 2007 and with non-government organisations on October 25, 2007. Both results are included in this report. In the workshop conducted for NGOs, there were some questions that generated polarised answers. In such case, both narrative answers are reflected.

Results of the Workshop with UN and Bilateral Organisations

Eight participants representing eight bilateral donor organisations attended the meeting. According to Dr. Jessie Fantone of PNAC, bilateral organisations were asked to give their inputs to make the 2008 UNGASS report more comprehensive. He added that "the inclusion of bilateral organisations is to get another viewpoint; from the side of donors."

The facilitators reiterated to the group that there would also be inputs coming from government agencies and non-government organisations. The inputs will be collated and will undergo a vetting process before it will be submitted. Ms. Ced Apilado said that the bilateral groups being consulted are the same for all countries so there will be uniformity in the process. She added that this would also allow for easy comparison of results across countries.

Majority of the participants, however, declined to fill up the questionnaires due to the following reasons:

1. Diplomatic/protocol issues. They noted that as foreign bilateral organisations, they really could not comment or judge a country's existing policies. One participant noted that answering the form may have diplomatic repercussions on the organisations involved.
2. Other bilateral organisations have priority regional policies, and these may not necessarily be appropriate or applicable to the country
3. Most of the representatives said that they would need to obtain the approval of their respective executive directors before they could issue an official evaluation. Otherwise, they said, what they would share would only be their own opinions and experiences and these are not reflective of the official stand of the organisations they represent.

Nevertheless, the meeting proceeded and the group gave a number of comments and suggestions:

On filling up the form

- In the next workshops, present the 2005 report first. The previous report can be used as a baseline to determine if progress has been achieved for each indicator. For example, if the answer to question # 1 was yes, the participants can then check if there has been any development in that particular indicator.

On the inclusion of bilateral organisations

1. There should be a separate questionnaire for donor agencies. Some participants noted that some of the questions are quite sensitive.
2. The donors are somehow represented since some of the NGOs they support are included.
3. It would be easier for bilateral organisations if they would fill up a survey form instead of an evaluation form. However, if a survey will be conducted instead, the methodology should be changed. Instead of selecting a few focal organisations, there should be sufficient sampling of bilateral organisations to make the results credible.
4. Donors can answer questions on NASA, but the NCPI is a sensitive area.

"There should be a separate questionnaire for donor agencies...some of the questions are quite sensitive."

On the questionnaire

1. The questionnaire does not reflect the issue of enforcement.
2. Talking about policies is different from talking about the level of awareness. What if there is an existing policy but the participants are unaware of this? This could be a problem when the answers are consolidated.
3. Another issue is how can the progress be measured? Can there be additional indicators or questions to track the changes?
4. In answering question # 6 (Should the government, through political and financial support, involved most-at-risk population in governmental HIV policy design and programme implementation?), NGOs should provide ample evidence to support their answer.

5. For question # 7, does policy refer to a *signed* policy? Maybe government representatives can answer this.
6. Some of the questions are complex (e.g., question # 8). The answers to the two questions may be different.
7. The PLHA community should answer question #11.
8. For question # 12, Mr. Peter Mosende of UNAIDS will check if the indicator is included in the list of M&E.

A. List of participants (UN and bilateral organisations)

ORGANISATION	NAME
1. UNICEF	Philip Castro
2. UNAIDS	Merceditas Apilado Zimmbodilion Mosende
3. HPDP-USAID	Cora Manaloto
4. WHO	Madeline Salva
5. AUSAID	Jimmy Loro
6. ILO	Jess Macasil
7. UNFPA	Rhona Montebon, Giovanni Templonuevo
The following were invited but were not able to attend:	
8. ADB	Thomas Crouch, Donna Lacuna
9. German Technical Co-operation (GTZ)	Dr. Michael Adelhardt
10. European Commission (EC)	Roger de Backer

Organisation	Name	NCPI B Sections			
		Human Rights	Civil Society Participation	Prevention	Treatment, Care and Support
Action for Health Initiative **(ACHIEVE)**	Amara Quesada (Programme Officer)	✓	✓	✓	✓
AIDS Society of the Philippines **(ASP)**	Dr. Nelia Salazar (President)	✓	✓	✓	✓
Alliance against AIDS in Mindanao **(Alagad Mindanao)**	Michael Jesus Mahinay (Program Co-ordinator)	✓	✓	✓	✓
Alternative Law Research and Development Centre **(ALTERLAW)**	Atty. Gilda Guillermo (Executive Director)	✓	✓	✓	✓
Apostleship of the Sea-Manila **(AOS)**	Sr. Aida Virtuez, SJBP (Staff)	✓	✓	✓	✓
Asilo de San Vicente de Paul	Sr. Mae Alere, DC (Sister-in-Charge, Lakbay Kapatid-SLM PLWA)	✓	✓	✓	✓
Bicol Reproductive Health Information Network Inc. **(BRHIN)**	Ramon Moran (Programme and Development Office)Dr. Ferchito Avelino (Chairperson, Board of Trustees)	✓	✓	✓	✓

Butterfly Brigade	Joseph Carlo Carillo (Project Co-ordinator)	✓	✓	✓	✓
Convergence for Sustainable Human Development Inc. **(CSHDI)**	Maria Juvy Madrinan (Community Health Development Worker)	✓	✓	✓	✓
Family Planning Organisation of the Philippines **(FPOP)**	Lucia Lagda (Chapter Programme Manager)	✓	✓	✓	✓
Health Action Information Network **(HAIN)**	Ricky Trinidad (Research Associate)	✓	✓	✓	✓
Human Development Empowerment Services **(HDES)**	Junpicar Dalus (Programme Manager on Treatment, Care and Support)	✓	✓	✓	✓
Institute of Social Studies and Action **(ISSA)**	Marlon Lacsamana (Programme Officer)	✓	✓	✓	✓
Kabataang Gabay sa Positibong Pamumuhay **(KGPP)**	John Piermont Montilla (Chief Executive Officer)	✓	✓	✓	✓
Leyte Family Development Organisation **(LEFADO)**	Betty Garrido (Executive Director)	✓	✓	✓	✓
Lunduyan para sa Pagpapalaganap, Pagpapatupad at Pagtatanggol ng Karapatang Pambata **(Lunduyan)**	Ramil Esguerra (Programme Officer)	✓	✓	✓	✓
Mayon Integrated Development Alternatives and Services **(MIDAS)**	Cristeta Triunfante (Executive Director)	✓	✓	✓	✓

Philippines HIV/AIDS NGO Support Programme **(Phansup)**	Roberto Nebrida (Executive Director)	✓	✓	✓	✓
Philippine NGO Council on Population, Health and Welfare, Inc. **(PNGOC)**	Ruthy Libatique (Project Manager, GFATM Round 3)	✓	✓	✓	✓
Pinoy Plus Association **(Pinoy Plus)**	Eddy Razon (President)	✓	✓	✓	✓
Positive Action Foundation Phil., Inc **(PAFPI)**	Roberto Ruiz (Board Member)	✓	✓	✓	✓
Remedios AIDS Foundation **(RAF)**	Dr. Jose Narciso Melchor Sescon (Executive Director)	✓	✓	✓	✓
Social Health, Environment and Development Foundation **(SHED)**	Domingo Non (Executive Director)	✓	✓	✓	✓
TALIKALA	Jeanette Laurel (Executive Director)	✓	✓	✓	✓
The Library Foundation Share Collective **(TLF)**	Glenn Cruz (Executive Director)	✓	✓	✓	✓
TriDev Specialists Foundation Inc. **(Tridev)**	Perfecto "Toti" Uysingo (Executive Director)	✓	✓	✓	✓
Trade Union Congress of the Philippines **(TUCP)**	Rola Reyes (Project Co-ordinator)	✓	✓	✓	✓
Visayas Primary Health Care Services, Inc **(VPHCSI)**	Mark Chito Molina (Project Co-ordinator)	✓	✓	✓	✓
Women /Men's Access to Vital Education and Services **(WAVES)** International, Inc	Juan Roxas II (Executive Director)	✓	✓	✓	

ORGANISATION	NAME	NCPI B Sections			
		Human Rights	Civil Society Participation	Prevention	Treatment, Care and Support
Aklan State University **(ASU)**	Carol Joy Palma –Remaneses (Instructress)	✓	✓	✓	✓
University of the Southern Philippines Foundation **(USPF)**	Dr. Lourdes Jereza (VP External Relations Programme)	✓	✓	✓	✓
University of the Philippines – Manila	Dr. Ofelia Saniel	✓	✓	✓	✓

I. HUMAN RIGHTS

1. **Does the country have laws and regulations that protect people living with HIV/AIDS against discrimination?** (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes ✓ *No*

1.1 ***IF YES,*** *specify:*

There are laws, like RA 8504 or the Philippine AIDS Prevention and Control Act of 1998, but these are not properly implemented. For example, RA 8504 has no mechanism for a grievance body. Also, there is low awareness about this law among the general public, as well as among local government officials who are supposed to implement it. On the part of the PLHIV community, they are hesitant to seek redress because of the stigma attached to being HIV+. There are already insurance packages for HIV+ but the premium is higher. Talks to include ARVs in the Philhealth package is ongoing.

2. **Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?**

Yes *No ✓*

Note:

The two groups have polarised answers – 17 answered no, 14 answered yes. For purposes of presenting both side, please see narratives below:

1. Group 1 explained that in voting No, they based their answer on the fact that RA8504 provides protection for the general population and not to specific sectors. In addition, the law's component on non-discrimination refers to people who are already positive, and not to the vulnerable sub-population, as referred to in the question. Group 1 also did not include local ordinances and policies because they interpreted the question as national in scope.

2. Group 2 answered Yes because they based their answer on other existing laws and local policies/ordinances. The group used a list of laws and policies, which was included in the kit as a reference. The group later agreed not to refer to the list and based their answers on what they know.

2.1 ***IF YES,*** for which sub-populations?

a) Women	*Yes ✓*	*No*
b) Young people	*Yes ✓*	*No*
c) IDU	*Yes*	*No ✓*
d) MSM	*Yes*	*No ✓*
e) Sex Workers	*Yes*	*No ✓*
f) Prison inmates	*Yes*	*No✓*
g) Migrants/mobile populations	*Yes ✓*	*No*
h) Other:	*[write in]*	

IF YES,
Briefly explain what mechanisms are in place to ensure these laws are implemented:

1. Judicial system from national to barangay (village) levels, including Juvenile Justice System
2. Establishment of multisectoral councils (PNAC, Council for the Welfare of Children, National Commission on the Role of Filipino Women, National Youth Commission, Gender and Development Councils)

Describe any systems of redress put in place to ensure the laws are having their desired effect:

1. Women's, youth's, children's desks in the workplace, police stations, National Bureau of Investigation, universities
2. Issuance of local ordinances
3. Overseas Workers Welfare Administration (OWWA)
4. Department of Foreign Affairs mission-based desks

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes ✓ No

3.1 ***IF YES,*** for which sub-populations?

a) Women	*Yes ✓*	*No*
b) Young people	*Yes ✓*	*No*
c) IDU	*Yes ✓*	*No*
d) MSM	*Yes ✓*	*No*
e) Sex Workers	*Yes ✓*	*No*
f) Prison inmates	*Yes*	*No✓*
g) Migrants/mobile populations	*Yes ✓*	*No*

h) Other: *[write in]*

Health care personnel, drivers, uniformed men, streetchildren, partners of OFWs – Yes

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

1. Administrative Order 003 of City of Manila – prevents access to condoms
2. Parental consent requirement for STI screening/VCT
3. Dangerous Drugs Act or Anti-Drugs Law criminalizes drug users.
4. Election code of the Commission on Election does not officially recognise MSM (as evidenced by the refusal to accredit a party list group on the ground that the LGTB sector it represents is not recognised).
5. Anti-vagrancy law criminalizes prostituted women.
6. POEA (Philippine Overseas Employment Administration), a member of PNAC, issued a ruling requiring compulsory HIV testing for applicants in clear contradiction to RA 8504.
7. Testing centres send test results direct to the recruitment agency/employers, violating violates the confidentiality provisions in the law.
8. Government's policy favouring Natural Family Planning is an obstacle which limits access to condom.
9. For Health Care Personnel, compulsory HIV testing is required prior to licensure exam.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy or strategy?

Yes ✓ *No*

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

Yes *No* ✓

Group 1 No; For group 2, 14 voted Yes, and 2 voted No. This implies 18 voted for No, and 14 voted for Yes. To explain:

1. *The No group said that there are some NGOs doing these, but at the national level, there is no policy regarding these. It was pointed out that if there was any national policy, cases should have been filed in courts.*
2. *Group 2 cited RA 8504, Art. 8, Sec. 46 as basis for their Yes answer. Other laws and policies they cited were the IRR of RA 8504, sec 46-52; creation and development of a mechanism*

by PNAC, by virtue of RA 8504. The mechanisms include reporting to DOLE for the private sector and the CSC for the government/public sector, as well as the interventions of NGOs. However, the group said that although there is a mechanism, it does not really address the issue. They cited three reasons: it is not properly implemented, cases are documented but there are no follow-ups, and there is no special court for positive persons.

IF YES, briefly describe this mechanism.

6. **Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?**

Yes ✓ *No* *N/A*

IF YES, describe some examples
1. MARPs have minimal involvement, e.g., project implementation
2. Although MSM sits in PNAC, it is not officially recognised [in some agencies] and their participation is limited
3. MARPs actively participated in the drafting of AMTP4
4. PNAC has budget indications in the AMTP4 Operational Plan
5. MARPs are included in some Local AIDS Council

7. **Does the country have a policy of free services for the following:**

(a) HIV prevention services	*Yes ✓*	*No*
(b) Anti-retroviral treatment	*Yes ✓*	*No*
(c) HIV-related care and support interventions	*Yes ✓*	*No*

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:
1. HIV prevention is a part of government service, but for private institutions, these services are not free
2. There are free ARVs and halfway houses for PLHIV
3. There is networking, referral, and partnership between NGOs, POs, and GOs. NGOs maximise the social service programmes of partner-LGUs
4. GFATM through DOH
5. CSOs rely on external funding to provide the above-mentioned services for free

6. Some NGOs charge fees to ensure continuity of services
7. Accessing the LAC funds
8. Resource mobilisation through multisectoral partnership
9. Fund raising projects
10. Tapping community resources

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes *No✓*

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Yes *No ✓*

9.1 Are there differences in approaches for different most-at-risk populations?

Yes✓ *No*

IF YES, briefly explain the differences:
1. Harm reduction approach is used to reach IDUs. Intervention is done underground because they are hidden population
2. PLHIV provision of TCS through home-based care, counselling, referral, hospitalization, patient & family enablers
3. Sex workers, IDUs, & MSMs are reached through peers and in their watering holes

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes✓ *No*

11. Does the country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes ✓ *No*

11.1 ***IF YES,*** does the ethical review committee include representatives of civil society and people living with HIV?

Yes✓ *No*

IF YES*, describe the effectiveness of this review committee*

1. The system is ineffective. Many NGOs are still unaware that all researches must pass through ethical review committee of PNAC.
2. Both the Philippine Centre for Health Research and Development and the Philippine National AIDS Council have guidelines on researches involving human subjects. The guidelines are practically the same.
3. In response to a question raised by another participant, one participant clarified that the ethical review applies to *both* general and clinical researches.

12.Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV and AIDS-related issues within their work

  Yes ✓ *No*

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

  Yes *No ✓*

- Performance indicators or benchmarks for

  a) compliance with human rights standards in the context of HIV/ AIDS efforts

  Yes *No✓*

  b) reduction of HIV-related stigma and discrimination

  Yes *No✓*

IF YES on any of the above questions, describe some examples:

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes *No✓*

14. Are the following legal support services available in the country?

- Legal aid systems for HIV and AIDS casework

  Yes *No ✓*

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

  Yes *No ✓*

- Programmes to educate, raise awareness among people living with HIV concerning their rights

  Yes ✓ *No*

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes✓ *No*

IF YES, what types of programmes?

- Media — *Yes✓* *No*
- School education — *Yes ✓* *No*
- Personalities regularly speaking out — *Yes✓* *No*
- Other *[write in]*

Community-based initiatives, work-based initiatives, Pre-departure orientation Seminar for OFWs, Faith-based organisations

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5✓	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5✓	6	7	8	9	10

Comments on progress made since 2005:

1. There were significant issues in the 2005 reports that were not addressed this year.
2. There was no significant change. If there were any changes, it was in the area of enforcement and not in policies.
3. The rate for this year is going up because of the initiatives at the local level, such as ordinances and resolutions.
4. There is a meaningful involvement of some PLHIV.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3✓	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4✓	5	6	7	8	9	10

Comments on progress made since 2005:

1. There is an improvement in mortality rate.
2. Some sections of the law are observed, but not fully implemented.
3. RA 8504 need to be revised and amended to address the present AIDS situation in the country.
4. There should be more effort to bring RA 8504 offenders to court.
5. Enforcement/focus is affected by political bickering, power struggle, and change in leadership.
6. There is no significant improvement at the national level.
7. Human rights issues and other major concerns were not intensely addressed.

II. CIVIL SOCIETY[1] PARTICIPATION

1. **To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?**

Low					*High*
0	1	2	3	4✓	5

2. **To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV/AIDS or for the current activity plan (e.g., attending planning meetings and reviewing drafts)?**

Low					*High*
0	1	2	3✓	4	5

3. **To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included**
   a. in both the National Strategic plans and national reports?

Low					*High*
0	1	2	3✓	4	5

   b. in the national budget?

Low					*High*
0	1	2✓	3	4	5

4. **Has the country included civil society in a National Review of the National Strategic Plan?**

Yes ✓ No N/A

IF YES, when was the Review conducted? *[write in]*

Year: 2004, drafting of AMTP4

[1]Civil society includes, among others: Networks of people living with HIV; women's organisations; young people 's organisations; faith-based organisations; AIDS service organisations; Community-based organisations; organisations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organisations; human rights organisations; etc. For the purpose of the NCPI, the private sector is considered separately.

5. **To what extent is the civil society sector representation in HIV/ AIDS efforts inclusive of its diversity?**

Low					*High*
0	1	2	3	4✓	5

List the types of organisations representing civil society in HIV and AIDS efforts:

- Local AIDS Council, LGUs
- HIV and AIDS NGOs
- People's Organisations (Pos)
- Faith-based organisations
- Business
- Professional health organisations, trade unions, NGOs representing MARPs

6. **To what extent is civil society able to access**

a. adequate financial support to implement its HIV activities?

Low					*High*
0	1	2✓	3	4	5

b. adequate technical support to implement its HIV activities?

Low					*High*
0	1	2✓	3	4	5

Overall, how would you rate the efforts to increase <u>civil society participation</u> in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6✓	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7✓	8	9	10

Comments on progress made since 2005:

1. Government effort may be low but it is counteracted by the pro-active efforts of CSOs.
2. More NGOs are implementing HIV and AIDS programmes.
3. Recognition on the works of GO, NGO, faith-based groups, civil society organisation for more collaboration, linkages, and referral system, sharing of resources to provide comprehensive care, support and treatment to PLHIV.

III. PREVENTION

1. Has the country identified the districts (or equivalent geographical/ decentralised level) in need of HIV prevention programmes?

Yes ✓ *No*

***IF NO**, how are HIV prevention programmes being scaled-up?*

***IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts* in need	most districts* in need	some districts* in need
Blood safety		✓	
Universal precautions in health care settings		✓	
Prevention of mother-to-child transmission of HIV			✓
IEC on risk reduction		✓	
IEC on stigma and discrimination reduction		✓	
Condom promotion		✓	
HIV testing & counselling		✓	
Harm reduction for injecting drug users		✓	
Risk reduction for men who have sex with men		✓	
Risk reduction for sex workers		✓	
Programmes for other most-at-risk populations			✓
Reproductive health services including STI prevention & treatment		✓	
School-based AIDS education for young people			✓
Programmes for out-of-school young people			✓
HIV prevention in the workplace			✓
Other [write in]			

**Districts or equivalent geographical/decentralised level in urban and rural areas*

Overall, how would you rate the efforts in the <u>implementation</u> of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6✓	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7✓	8	9	10
Comments on progress made since 2005:											

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the districts (or equivalent geographical/ decentralised level) in need of HIV and AIDS treatment, care and support services?

Yes ✓ *No*

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

***IF YES,* To what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	<u>all</u> districts* in need	<u>most</u> districts* in need	<u>some</u> districts* in need
a. Anti-retroviral therapy		✓	
b. Nutritional care			✓
c. Paediatric AIDS treatment		✓	
d. Sexually transmitted infection management		✓	
e. Psychosocial support for people living with HIV and their families		✓	
f. Home-based care			✓
g. Palliative care and treatment of common HIV-related infections			✓

h. HIV testing and counselling for TB patients			✓
i. TB screening for HIV-infected people			✓
j. TB preventive therapy for HIV-infected people			✓
k. TB infection control in HIV treatment and care facilities			✓
l. Cotrimoxazole prophylaxis in HIV-infected people			✓
m. Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape)			✓
n. HIV treatment services in the workplace or treatment referral systems through the workplace			✓
o. HIV care and support in the workplace (including alternative working arrangements)			✓
p. Other programmes: [write in]			

**Districts or equivalent decentralised governmental level in urban and rural areas*

Overall, how would you rate the efforts in the implementation of HIV and AIDS treatment, care and support programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5✓	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005:

1. No rating done in 2005.
2. More families learn to accept their sick members
3. More PLHIV came out for treatments
4. More PLHIV turn to their families for care & support
5. More families share their concern, support, & care to their sick members, a good number of them died in the arms of family member or relatives
6. ARVs was for sale in 2005 and was given for free to all PLHIV in 2006 through involvement of some AIDS activists

2. What percentage of the following HIV and AIDS programmes/ services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	50-75%	>75%
Prevention for vulnerable sub-populations				
- IDU	<25%	25-50%	50-75%	✓ >75%
- MSM	<25%	25-50%	50-75%	✓ >75%
- Sex workers	<25%	25-50%	50-75%	✓ >75%
Counselling and Testing	<25%	25-50%	✓ 50-75%	>75%
Clinical services (OI/ART)*	<25%	✓ 25-50%	50-75%	>75%
Home-based care	<25%	25-50%	50-75%	✓ >75%
Programmes for OVC**	<25%	25-50%	✓ 50-75%	>75%

*OI Opportunistic infections; **OVC Orphans and other vulnerable children

3. Does the country have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes No✓ N/A

3.1 ***IF YES,*** is there an operational definition for OVC in the country?

Yes No

3.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes No

3.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?

Yes No

IF YES, what percentage of OVC is being reached? *% [write in]*

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children? (not in the form)											
2007	Poor										Good
	0	1	2	3	4 ✓	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005: 1. No rating was done in 2005.											

A. AIDS Spending 2005

AIDS spending categories	Grand total	Public sources			International sources					Private sources
		Public Sub-total	Central/ National	Sub-national	Intl. source Sub-total	Bilaterals	UN Agencies	Global Fund	All other Intl.	Private Sub-total
I. Prevention-related activities	**235,929,088**	**42,665,923**	**1,473,025**	**41,192,898**	**132,889,445**	**85,466,285**	**11,354,090**	**34,053,162**	**2,015,908**	**60,373,720**
1. Mass media	**80,320,501**	0	0	0		25,987,526	1,422,275	1,841,736	1,905,908	49,163,057
2. Community mobilisation	**1,681,913**	20,000	0	20,000		0	1,648,913	0	10,000	3,000
3. Voluntary counselling and testing	**3,522,402**	245,700	0	245,700		0	0	3,276,702	0	0
4. Programmes for vulnerable and special populations	**9,327,974**	0	0	0		0	5,268,282	4,059,692	0	0
5. Youth - in school	**6,127,710**	600,000	600,000	0		5,477,710	0	0	50,000	0
6. Youth - out of school	**864,121**	0	0	0		608,634	205,487	0	50,000	0
7. Prevention programs for PLHA	**4,059,692**	0	0	0	4,059,692	0	0	4,059,692	0	0
8. Programs for sex workers and their clients	**40,301,044**	21,310,900	0	21,310,900	18,990,144	12,435,968	2,494,485	4,059,692	0	0
9. Programmes for MSM	**16,495,660**	0	0	0	16,495,660	12,435,968	0	4,059,692	0	0
10. Harm reduction programmes for IDUs	**16,495,660**	0	0	0	16,495,660	12,435,968	0	4,059,692	0	0
11. Workplace activities	**121,300**	121,300	121,300	0	0	0	0	0	0	0

12. Condom social marketing	**31,051,591**	0	0	0	19,843,927	11,207,663	0	8,636,264	0	11,207,663
13. Public and commercial sector condom provision	**0**	0	0	0	0	0	0	0	0	0
14. Female condom	**0**	0	0	0	0	0	0	0	0	0
15. Microbicides	**0**	0	0	0	0	0	0	0	0	0
16. Improving management of STIs	**22,409,428**	17,217,930	668,127	16,549,803	5,191,498	4,876,850	314,648	0	0	0
17. Prevention of mother-to-child transmission	**0**	0	0	0	0	0	0	0	0	0
18. Blood safety	**0**	0	0	0	0	0	0	0	0	0
19. Post-exposure prophylaxis (health care setting, rape)	**23,263**	23,263	23,263	0	0	0	0	0	0	0
20. Safe medical injections	**60,335**	60,335	60,335	0	0	0	0	0	0	0
21. Male circumsicion	**0**	0	0	0	0	0	0	0	0	0
22. Universal precautions	**0**	0	0	0	0	0	0	0	0	0
23. Others	**3,066,495**	3,066,495	0	3,066,495	0	0	0	0	0	0
II. Treatment and care components	**30,398,210**	**13,626,605**	**13,626,605**	**0**	**16,686,605**	**0**	**355,485**	**16,331,120**	**0**	**85,000**
1. Palliative care	**5,000**	0	0	0	0	0	0	0	0	5,000
2. Provider initiated testing	**751,556**	0	0	0	751,556	0	0	751,556	0	0
3. OI Treatment	**15,000**	0	0	0	0	0	0	0	0	15,000
4. OI Prophylaxis	**4,221,229**	2,717,953	2,717,953	0	1,498,276	0	0	1,498,276	0	5,000
5. Anti-retroviral therapy	**21,768,488**	8,000,000	8,000,000	0	13,728,488	0	243,900	13,484,588	0	40,000
6. Specific HIV laboratory monitoring	**2,310,000**	2,300,000	2,300,000	0	0	0	0	0	0	10,000
7. Home-based care	**8,000**	0	0	0	0	0	0	0	0	8,000

8. Psychological care	**0**	0	0	0	0	0	0	0	0	0
9. Nutritional support	**0**	0	0	0	0	0	0	0	0	0
10. Dental care	**180,000**	180,000	180,000	0	0	0	0	0	0	0
11. Additional/informal providers	**0**	0	0	0	0	0	0	0	0	0
12. Hospital care	**428,652**	428,652	428,652	0	0	0	0	0	0	0
13. Outpatient care	**0**	0	0	0	0	0	0	0	0	0
14. Others	**710,285**	0	0	0	708,285	0	111,585	596,700	0	2,000
III. Orphan and vulnerable children – OVC*	**1,000,000**	**200,000**	**200,000**	**0**	**400,000**	**0**	**400,000**	**0**	**0**	**400,000**
1. Education	**200,000**	0	0	0	100,000	0	100,000	0	0	100,000
2. Basic health care support	**0**	0	0	0	0	0	0	0	0	0
3. Family/home support	**800,000**	200,000	200,000	0	300,000	0	300,000	0	0	300,000
4. Community support	**0**	0	0	0	0	0	0	0	0	0
5. Administrative costs	**0**	0	0	0	0	0	0	0	0	0
6. Others	**0**	0	0	0	0	0	0	0	0	0
IV. AIDS Programme support cost	**120,466,636**	**10,620,618**	**9,463,618**	**1,157,000**	**105,547,260**	**26,963,478**	**27,771,969**	**49,920,026**	**891,787**	**4,298,757**
1. Programme management	**40,365,348**	2,661,880	1,774,880	887,000	36,904,256	2,748,813	11,182,015	22,131,642	841,787	799,212
2. Planning and co-ordination	**3,515,177**	2,700,001	2,700,001	0	813,176	0	0	813,176	0	2,000
3. Monitoring and Evaluation	**30,784,133**	3,393,319	3,393,319	0	25,594,268	4,720,655	8,747,837	12,125,776	0	1,796,545
4. Operations Research (research and development)	**16,609,268**	0	0	0	16,609,268	7,802,960	5,806,324	2,999,984	0	0
5. Sero- surveillance	**14,901,429**	550,000	350,000	200,000	14,351,429	9,753,700	283,029	4,314,700	0	0

6. HIV-drug resistance surveillance	**1,102,977**	0	0	0	1,102,977	0	1,102,977	0	0	0
7. Information technology	**903,616**	0	0	0	902,616	0	0	902,616	0	1,000
8. Supervision of personnel	**50,000**	0	0	0	50,000	0	0	0	50,000	0
9. Upgrading laboratory infrastructure	**800,000**	800,000	800,000	0	0	0	0	0	0	0
10. Construction of new health centres	**0**	0	0	0	0	0	0	0	0	0
11. Drug supply systems	**116,500**	70,000	0	70,000	46,500	0	46,500	0	0	0
12. Others	**11,318,187**	445,418	445,418	0	9,172,769	1,937,350	603,287	6,632,132	0	1,700,000
V. Incentives for human resources	**30,018,623**	**1,720,392**	**853,900**	**866,492**	**28,295,231**	**15,139,614**	**4,279,729**	**6,465,888**	**2,410,000**	**3,000**
1. Monetary incentive for physicians	**178,632**	178,632	0	178,632	0	0	0	0	0	0
2. Monetary incentive for other staff	**2,997,882**	671,208	0	671,208	2,326,674	1,446,674	0	0	880,000	0
3. Formative education and build-up of AIDS workforce	**6,482,540**	16,652	0	16,652	6,465,888	0	0	6,465,888	0	0
4. Monetary incentive for nurse	**0**	0	0	0	0	0	0	0	0	0
5. Training	**20,359,570**	853,900	853,900	0	19,502,670	13,692,941	4,279,729	0	1,530,000	3,000
6. Others	**0**	0	0	0	0	0	0	0	0	0
VI. Social protection and social services (excluding orphans)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
1. Monetary benefits	**0**	0	0	0	0	0	0	0	0	0

2. In-kind benefits	**0**	0	0	0	0	0	0	0	0	0
3. Social services	**0**	0	0	0	0	0	0	0	0	0
4. Income generation	**0**	0	0	0	0	0	0	0	0	0
5. Others	**0**	0	0	0	0	0	0	0	0	0
VII. Enabling environment and developments	**19,520,877**	**2,466,800**	**1,966,800**	**500,000**	**15,401,357**	**6,580,384**	**7,381,217**	**1,224,756**	**215,000**	**1,652,720**
1. Advocacy and strategic communication	**14,570,994**	1,966,800	1,966,800	0	10,953,474	6,580,384	2,933,333	1,224,756	215,000	1,650,720
2. Human rights	**0**	0	0	0	0	0	0	0	0	0
3. AIDS-specific institutional development	**1,614,449**	500,000	0	500,000	1,114,449	0	1,114,449	0	0	0
4. AIDS-specific programmes involving women	**482,235**	0	0	0	480,235	0	480,235	0	0	2,000
5. Others	**2,853,199**	0	0	0	2,853,199	0	2,853,199	0	0	0
VIII. Research, excluding operations research	**6,356,337**	**0**	**0**	**0**	**6,356,337**	**0**	**5,606,337**	**0**	**750,000**	**0**
1. Biomedical research	**0**	0	0	0	0	0	0	0	0	0
2. Clinical research	**0**	0	0	0	0	0	0	0	0	0
3. Epidemiological research	**0**	0	0	0	0	0	0	0	0	0

4. Social science research	**0**	0	0	0	0	0	0	0	0	0
5. Behavioural research	**2,573,304**	0	0	0	2,573,304	0	2,573,304	0	0	0
6. Research in economics	**0**	0	0	0	0	0	0	0	0	0
7. Research in capacity strengthening	**0**	0	0	0	0	0	0	0	0	0
8. Vaccine-related research	**0**	0	0	0	0	0	0	0	0	0
9. Others	**3,783,033**	0	0	0	3,783,033	0	3,033,033	0	750,000	0
TOTAL	**443,689,772**	**71,300,338**	**27,583,948**	**43,716,390**	**305,576,236**	**134,149,762**	**57,148,826**	**107,994,952**	**6,282,695**	**66,813,198**
	443,689,772									

*The term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for official support as orphan.

B. AIDS Spending 2006

AIDS spending categories	Grand total	Public sources			International sources					Private sources
		Public Sub-total	Central/ National	Sub-national	Intl. source Sub-total	Bilaterals	UN Agencies	Global Fund	All other Intl.	Private Sub-total
I. Prevention-related activities	**295,107,649**	**115,025,359**	**78,698,719**	**36,326,640**	**138,285,186**	**108,515,161**	**20,775,274**	**8,364,750**	**630,000**	**41,797,104**
1. Mass media	**162,856,274**	75,000,000	75,000,000	0	46,199,170	44,047,408	2,151,762		0	41,657,104
2. Community mobilisation	**6,633,617**	20,000	0	20,000	6,608,617	3,483,073	3,125,544		0	5,000
3. Voluntary counselling and testing	**4,338,127**	1,319,080	1,000,000	319,080	3,019,047	0	3,019,047		0	0
4. Programmes for vulnerable and special populations	**2,747,959**	0	0	0	2,747,959	0	895,009	1,672,950	180,000	0
5. Youth - in school	**7,505,993**	1,878,000	1,800,000	78,000	5,627,993	1,250,000	4,377,993		0	0
6. Youth - out of school	**1,262,454**	0	0	0	1,262,454	0	1,262,454		0	0
7. Prevention programs for PLHA	**2,272,950**	0	0	0	2,272,950	150,000	0	1,672,950	450,000	0
8. Programs for sex workers and their clients	**41,541,009**	21,416,000	0	21,416,000	20,125,009	16,844,076	1,607,983	1,672,950	0	0
9. Programmes for MSM	**18,517,026**	0	0	0	18,517,026	16,844,076	0	1,672,950	0	0
10. Harm reduction programmes for IDUs	**18,517,026**	0	0	0	18,517,026	16,844,076	0	1,672,950	0	0
11. Workplace activities	**528,960**	195,000	195,000	0	333,960	0	333,960		0	0

12. Condom social marketing	**272,000**	0	0	0	137,000	135,000	2,000	0	0	135,000
13. Public and commercial sector condom provision	**0**	0	0	0	0	0	0	0	0	0
14. Female condom	**0**	0	0	0	0	0	0	0	0	0
15. Microbicides	**0**	0	0	0	0	0	0	0	0	0
16. Improving management of STIs	**24,897,689**	15,161,687	668,127	14,493,560	9,736,002	8,917,452	818,550	0	0	0
17. Prevention of mother-to-child transmission	**3,180,974**	0	0	0	3,180,974	0	3,180,974	0	0	0
18. Blood safety	**0**	0	0	0	0	0	0	0	0	0
19. Post-exposure prophylaxis (health care setting, rape)	**23,263**	23,263	23,263	0	0	0	0	0	0	0
20. Safe medical injections	**12,329**	12,329	12,329	0	0	0	0	0	0	0
21. Male circumsicion	**0**	0	0	0	0	0	0	0	0	0
22. Universal precautions	**0**	0	0	0	0	0	0	0	0	0
23. Others	**0**	0	0	0	0	0	0	0	0	0
II. Treatment and care components	**6,323,921**	**5,791,983**	**5,791,983**	**0**	**506,938**	**0**	**506,938**	**0**	**0**	**25,000**
1. Palliative care	**5,000**	0	0	0	0	0	0	0	0	5,000
2. Provider initiated testing	**0**	0	0	0	0	0	0	0	0	0
3. OI Treatment	**0**	0	0	0	0	0	0	0	0	0
4. OI Prophylaxis	**2,785,685**	2,785,685	2,785,685	0	0	0	0	0	0	0
5. Anti-retroviral therapy	**437,600**	0	0	0	417,600	0	417,600	0	0	20,000
6. Specific HIV laboratory monitoring	**2,531,600**	2,531,600	2,531,600	0	0	0	0	0	0	0
7. Home-based care	**0**	0	0	0	0	0	0	0	0	0

8. Psychological care	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**
9. Nutritional support	**0**	0	0	0	0	0		0	0	0
10. Dental care	**180,000**	180,000	0	0	0	0		0	0	180,000
11. Additional/informal providers	**0**	0	0	0	0	0		0	0	0
12. Hospital care	**294,698**	294,698	0	0	0	0		0	0	294,698
13. Outpatient care	**0**	0	0	0	0	0		0	0	0
14. Others	**0**	0	0	89,338	0	89,338		0	0	0
III. Orphan and vulnerable children – OVC*	**639,799**	**639,799**	**0**	**519,799**	**0**	**0**	**0**	**519,799**	**0**	**639,799**
1. Education	**100,539**	100,539	0	100,539	0	0		100,539	0	100,539
2. Basic health care support	**0**	0	0	0	0	0		0	0	0
3. Family/home support	**539,260**	539,260	0	419,260	0	0		419,260	0	539,260
4. Community support	**0**	0	0	0	0	0		0	0	0
5. Administrative costs	**0**	0	0	0	0	0		0	0	0
6. Others	**0**	0	0	0	0	0		0	0	0
IV. AIDS Programme support cost	**12,276,818**	**11,891,818**	**385,000**	**80,795,161**	**31,055,448**	**26,682,288**	**21,280,425**	**1,777,000**	**1,211,364**	**12,276,818**
1. Programme management	**2,838,080**	2,453,080	385,000	37,143,310	2,801,817	11,933,067	21,280,425	1,128,000	1,080,079	2,838,080
2. Planning and co-ordination	**2,700,001**	2,700,001	0	0	0	0		0	2,000	2,700,001
3. Monitoring and Evaluation	**3,443,319**	3,443,319	0	17,336,259	3,963,312	13,372,947		0	2,000	3,443,319
4. Operations Research (research and development)	**0**	0	0	14,006,153	13,158,764	847,389		0	0	0
5. Sero- surveillance	**350,000**	350,000	0	9,908,280	9,908,280	0		0	0	350,000

6. HIV-drug resistance surveillance	**0**	0	0	0	0	0	0	0	0	0
7. Information technology	**266,449**	0	0	0	265,449	0	265,449	0	0	1,000
8. Supervision of personnel	**85,000**	0	0	0	85,000	30,000	0	0	55,000	0
9. Upgrading laboratory infrastructure	**0**	0	0	0	0	0	0	0	0	0
10. Construction of new health centres	**0**	0	0	0	0	0	0	0	0	0
11. Drug supply systems	**4,351,705**	2,500,000	2,500,000	0	1,851,705	1,066,990	190,715	0	594,000	0
12. Others	**770,708**	445,418	445,418	0	199,005	126,285	72,720	0	0	126,285
V. Incentives for human resources	**19,189,009**	**1,104,257**	**1,104,257**	**0**	**18,084,752**	**12,471,212**	**5,237,539**	**0**	**376,000**	**0**
1. Monetary incentive for physicians	**0**	0	0	0	0	0	0	0	0	0
2. Monetary incentive for other staff	**708,316**	0	0	0	708,316	708,316	0	0	0	0
3. Formative education and build-up of AIDS workforce	**0**	0	0	0	0	0	0	0	0	0
4. Monetary incentive for nurse	**0**	0	0	0	0	0	0	0	0	0
5. Training	**18,480,692**	1,104,257	1,104,257	0	17,376,435	11,762,896	5,237,539	0	376,000	0
6. Others	**0**	0	0	0	0	0	0	0	0	0
VI. Social protection and social services (excluding orphans)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
1. Monetary benefits	**0**	0	0	0	0	0	0	0	0	0

2. In-kind benefits	**0**	0	0	0	0	0	0	0	0	0
3. Soc ial services	**0**	0	0	0	0	0	0	0	0	0
4. Income generation	**0**	0	0	0	0	0	0	0	0	0
5. Others	**0**	0	0	0	0	0	0	0	0	0
VII. Enabling environment and developments	**18,357,783**	**1,804,800**	**1,804,800**	**0**	**14,684,903**	**8,701,458**	**5,978,446**	**0**	**5,000**	**1,868,079**
1. Advocacy and strategic communication	**14,620,471**	1,804,800	1,804,800	0	10,952,592	8,701,458	2,246,134		5,000	1,863,079
2. Human rights	**0**	0	0	0	0	0	0		0	0
3. AIDS-specific institutional development	**446,600**	0	0	0	446,600	0	446,600		0	0
4. AIDS-specific programmes involving women	**3,290,712**	0	0	0	3,285,712	0	3,285,712		0	5,000
5. Others	**0**	0	0	0	0	0	0		0	0
VIII. Research, excluding operations research	**4,888,351**	**0**	**0**	**0**	**4,888,351**	**0**	**2,117,151**	**2,021,200**	**750,000**	**0**
1. Biomedical research	**0**	0	0	0	0	0	0		0	0
2. Clinical research	**0**	0	0	0	0	0	0	0	0	0
3. Epidemiological research	**0**	0	0	0	0	0	0		0	0

4. Social science research	**0**	0	0	0	0	0	0	0	0	0
5. Behavioural research	**0**	0	0	0	0	0	0	0	0	0
6. Research in economics	**0**	0	0	0	0	0	0	0	0	0
7. Research in capacity strengthening	**0**	0	0	0	0	0	0	0	0	0
8. Vaccine-related research	**0**	0	0	0	0	0	0	0	0	0
9. Others	**4,888,351**	0	0	0	4,888,351	0	2,117,151	2,021,200	750,000	0
TOTAL	**439,309,653**	**136,643,016**	**99,931,376**	**36,711,640**	**257,765,089**	**160,743,280**	**61,297,636**	**31,666,375**	**4,057,799**	**44,901,547**
	439,309,653							**875,201,576**		

C. AIDS Spending 2007

AIDS spending categories	GRAND TOTAL	Public sources			International sources						Private sources
		Public Sub-total	Central/ National	Sub-national	Intl. source Sub-total	Bilaterals	Dev. Bank	UN Agencies	Global Fund	All other Intl.	Private Sub-total
I. Prevention-related activities	**105,417,474**	**23,249,570**	**4,486,528**	**36,489,570**	**85,382,684**	**52,876,565**	**0**	**13,916,188**	**18,589,931**	**0**	**63,784**
1. Mass media	**51,720,327**	0	0	0	51,720,327	50,372,077	0	898,250	450,000	0	0
2. Community mobilisation	**93,200**	20,000	0	20,000	73,200	0	0	73,200		0	0
3. Voluntary counselling and testing	**2,894,770**	1,350,000	1,000,000	350,000	1,544,770	0	0	100,000	1,444,770	0	0
4. Programmes for vulnerable and special populations	**11,579,779**	0	0	0	11,579,779	0	0	8,975,782	2,603,997	0	0
5. Youth - in school	**1,692,273**	75,000	0	75,000	1,617,273	0	0	1,617,273		0	0
6. Youth - out of school	**0**	0	0	0	0	0	0	0		0	0
7. Prevention programs for PLHA	**794,790**	0	0	0	794,790	0	0	535,500	259,290	0	0
8. Programs for sex workers and their clients	**24,471,619**	21,604,570	0	21,604,570	2,867,049	0	0	502,141	2,364,908	0	0
9. Programmes for MSM	**2,674,312**	0	0	0	2,674,312	0	0	0	2,674,312	0	0
10. Harm reduction programmes for IDUs	**602,436**	0	0	0	602,436	0	0	0	602,436	0	0
11. Workplace activities	**703,750**	200,000	200,000	0	503,750	0	0	503,750		0	0

12. Condom social marketing	**3,481,340**		0	0	6,085,829	2,504,488		100,000	3,481,340	0	63,784
13. Public and commercial sector condom provision	**2,388,150**		0	0	2,388,150	0		0	2,388,150	0	0
14. Female condom			0	0	0	0		0		0	0
15. Microbicides			0	0	0	0		0		0	0
16. Improving management of STIs	**2,095,727**		3,254,865	14,440,000	2,095,727	0		0	2,095,727	0	0
17. Prevention of mother-to-child transmission			0	0	380,000	0		380,000		0	0
18. Blood safety			0	0	0	0		0		0	0
19. Post-exposure prophylaxis (health care setting, rape)	**225,000**		23,263	0	455,292	0		230,292	225,000	0	0
20. Safe medical injections			8,400	0	0	0		0		0	0
21. Male circumsicion			0	0	0	0		0		0	0
22. Universal precautions			0	0	0	0		0		0	0
23. Others			0	0	0	0		0		0	0
II. Treatment and care components	**15,908,058**	**6,913,126**	**6,863,126**	**50,000**	**8,528,832**	**0**	**0**	**560,684**	**7,907,639**	**60,509**	**466,100**
1. Palliative care	**155,000**	0	0	0	150,000	0		150,000		0	5,000
2. Provider initiated testing	**181,920**	0	0	0	181,920	0		181,920		0	0

3. OI Treatment	**50,000**	50,000	0	50,000	0	0	0	0		0	0
4. OI Prophylaxis	**3,065,580**	2,931,421	2,931,421	0	134,159	0	0	0	134,159	0	0
5. Anti-retroviral therapy	**6,452,280**	0	0	0	6,452,280	0	0	0	6,452,280	0	0
6. Specific HIV laboratory monitoring	**3,560,285**	3,560,285	3,560,285	0	0	0	0	0		0	0
7. Home-based care	**455,509**	0	0	0	210,509	0	0	150,000		60,509	245,000
8. Psychological care	**259,290**	0	0	0	259,290	0	0	0	259,290	0	0
9. Nutritional support	**180,000**	0	0	0	0	0	0	0		0	180,000
10. Dental care	**180,000**	180,000	180,000	0	0	0	0	0		0	0
11. Additional/informal providers	**0**	0	0	0	0	0	0	0	236,700	0	0
12. Hospital care	**414,805**	175,605	175,605	0	236,700	0	0	0	825,210	0	2,500
13. Outpatient care	**3,600**	0	0	0	0	0	0	0		0	3,600
14. Others	**949,789**	15,815	15,815	0	903,974	0	0	78,764		0	30,000
III. Orphan and vulnerable children (OVC)*	**169,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**169,000**
1. Education	**135,000**	0	0	0	0	0	0	0		0	135,000
2. Basic health care support	**0**	0	0	0	0	0	0	0		0	0
3. Family/home support	**0**	0	0	0	0	0	0	0		0	0
4. Community support	**0**	0	0	0	0	0	0	0		0	0
5. Administrative costs	**34,000**	0	0	0	0	0	0	0		0	34,000
6. Others	**0**	0	0	0	0	0	0	0		0	0

IV. AIDS programme support cost	**67,506,413**	**4,447,785**	**3,715,977**	**731,808**	**55,581,525**	**22,866,450**	**1,350,000**	**9,001,564**	**22,038,285**	**325,226**	**7,477,103**
1. Programme management	**19,800,587**	1,326,768	594,960	731,808	17,665,776	10,088,850		3,596,538	3,777,615	202,773	808,043
2. Planning and co-ordination	**7,460,926**	1,100,000	1,100,000	0	6,271,017	2,739,237		0	3,531,780	0	89,908
3. Monitoring and Evaluation	**8,155,130**	1,314,440	1,314,440	0	6,750,690	2,107,263		3,747,964	773,010	122,453	90,000
4. Operations Research (research and development)	**3,451,600**	0	0	0	3,451,600	0		1,600	3,450,000	0	0
5. Sero- surveillance	**5,062,796**	0	0	0	5,062,796	281,261		150,000	4,631,535	0	0
6. HIV-drug resistance surveillance	**0**	0	0	0	0	0		0		0	0
7. Information technology	**2,295,855**	0	0	0	2,295,855	0		0	2,295,855	0	0
8. Supervision of personnel	**0**	0	0	0	0	0		0		0	0
9. Upgrading laboratory infrastructure	**3,407,420**	0	0	0	3,407,420	0		200,000	3,207,420	0	0
10. Construction of new health centres	**270,000**	270,000	270,000	0	0	0		0		0	0
11. Drug supply systems	**779,070**	0	0	0	779,070	0		408,000	371,070	0	0
12. Others	**16,823,029**	436,577	436,577	0	9,897,300	7,649,839	1,350,000	897,461		0	6,489,151
V. Incentives for human resources	**6,268,200**	**2,053,225**	**2,003,225**	**50,000**	**4,214,975**	**0**	**0**	**2,744,279**	**623,235**	**847,462**	**0**
1. Monetary incentive for physicians	**251,190**	0	0	0	251,190	0		0	251,190	0	0

2. Monetary incentive for other staff	**879,320**	0	0	0	879,320	0		0	372,045	507,275	0
3. Formative education and build-up of AIDS workforce	**0**	0	0	0	0	0		0		0	0
4. Monetary incentive for nurse	**0**	0	0	0	0	0		0		0	0
5. Training	**4,797,504**	2,053,225	2,003,225	50,000	2,744,279	0		2,744,279		0	0
6. Others	**340,187**	0	0	0	340,187	0		0		340,187	0
VI. Social protection and social services (excluding orphans)	**0**	**1,841,000**	**70,000**	**0**	**70,000**	**1,768,500**	**0**	**0**	**1,768,500**	**0**	**0**
1. Monetary benefits	**0**	0	0	0	0	0		0		0	0
2. In-kind benefits	**1,788,500**	0	0	0	0	0		0		0	0
3. Social services	**52,500**	20,000	0	20,000	1,768,500	0		1,768,500		0	0
4. Income generation	**0**	50,000	0	50,000	0	0		0		0	2,500
5. Others		0	0	0	0	0		0		0	0
VII. Enabling environment and development	**9,879,438**	**2,567,600**	**2,487,600**	**80,000**	**7,247,525**	**349,300**	**0**	**3,893,370**	**2,948,895**	**55,961**	**64,313**
1. Advocacy and strategic communication	**8,075,226**	2,487,600	2,487,600	0	5,523,313	349,300		2,169,158	2,948,895	55,961	64,313
2. Human rights	**0**	0	0	0	0	0		0		0	0
3. AIDS-specific institutional development	**1,804,212**	80,000	0	80,000	1,724,212	0		1,724,212		0	0

4. AIDS-specific programmes involving women	**0**	0	0	0	0	0		0		0	0
5. Others	**0**	0	0	0	0	0		0		0	0
VIII. Research, excluding operations research	**2,689,800**	**0**	**0**	**0**	**2,689,800**	**0**	**1,350,000**	**1,339,800**	**0**	**0**	**0**
1. Biomedical research	**0**	0	0	0	0	0		0		0	0
2. Clinical research	**0**	0	0	0	0	0		0		0	0
3. Epidemiological research	**1,250,000**	0	0	0	1,250,000	0		1,250,000		0	0
4. Social science research	**0**	0	0	0	0	0		0		0	0
5. Behavioural research	**1,075,500**	0	0	0	1,075,500	0	1,075,500	0		0	0
6. Research in economics	**0**	0	0	0	0	0		0		0	0
7. Research in capacity strengthening	**0**	0	0	0	0	0		0		0	0
8. Vaccine-related research	**0**	0	0	0	0	0		0		0	0
9. Others	**364,300**	0	0	0	364,300	0	274,500	89,800		0	0
TOTAL	**209,679,383**	**39,301,306**	**19,556,456**	**37,471,378**	**165,413,841**	**76,092,315**	**2,700,000**	**33,224,385**	**52,107,984**	**1,289,157**	**8,242,799**
	230,684,475										

*The term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for official support as orphan.

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Note: Two (2) citing guide styles were used: Turabian (printed materials) and MLA (Internet/Online sources).

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