

PHILIPPINE NATIONAL AIDS COUNCIL

Country Report of the Philippines

January 2008 to December 2009

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

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Acronyms

| | |
|--------|---|
| ADB | Asian Development Bank |
| AFP | Armed Forces of the Philippines |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMTP | AIDS Medium Term Plan |
| AO | Administrative Order |
| ART | Anti-retroviral Therapy |
| ARV | Anti-retroviral |
| ASRH | Adolescent Sexual and Reproductive Health |
| BCC | Behaviour Change Communication |
| BSF | Blood Service Facility |
| CFS | Clients of Female Sex Workers |
| CHD | Centre for Health Development |
| CHOWs | Community Health Outreach Workers |
| CRIS | Country Response Information System |
| CUP | Condom Use Programme |
| DBM | Department of Budget and Management |
| DepEd | Department of Education |
| DFA | Department of Foreign Affairs |
| DILG | Department of the Interior and Local Government |
| DOH | Department of Health |
| DOLE | Department of Labor and Employment |
| DSWD | Department of Social Welfare and Development |
| FSW | Female Sex Worker |
| FSI | Foreign Service Institute |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GOP | Government of the Philippines |
| 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 |
| KfW | German Development Bank |
| LAC | Local AIDS Council |
| LGU | Local Government Unit |
| MARPs | Most-at-risk populations |
| M & E | Monitoring and Evaluation |
| MDGs | Millennium Development Goals |
| MSM | Men who have Sex with Men |
| NASA | National AIDS Spending Assessment |
| NASPCP | National AIDS and STI Prevention and Control Program |
| NCPI | National Composite Policy Index |
| NDHS | National Demographic Health Survey |

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| NEC | National Epidemiology Centre |
| NEDA | National Economic and Development Authority |
| NGO | Non-Government Organization |
| NHSSS | National HIV/AIDS Sentinel Surveillance System |
| NRCO | National Reintegration Center Office |
| NSO | National Statistics Office |
| NVBSP | National Voluntary Blood Services Program |
| 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 | Program Acceleration Fund |
| PDEA | Philippine Drug Enforcement Agency |
| PE | Peer educator |
| PGH | Philippine General Hospital |
| PhilHealth | Philippine Health Insurance Corporation |
| PNGOC | Philippine NGO Council on Population, Health and Welfare, Inc. |
| 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 |
| PO | People's Organization |
| POEA | Philippine Overseas Employment Administration |
| RAATs | Regional AIDS Assistance Teams |
| 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 |
| TDFI | Tropical Disease Foundation, Inc. |
| TTI | Transfusion Transmissible Infection |
| 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 |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |

I. Status at a Glance

A. *UNGASS report writing process*

The Philippine National AIDS Council (PNAC) convened the UNGASS core team in September 2009 with support from UNAIDS. Members of the core team were the Department of Health-National Epidemiology Center (NEC), National AIDS and STD Prevention and Control Program (NASPCP) and the PNAC Secretariat; National Economic and Development Authority (NEDA); Health Action Information Network (HAIN); Philippine NGO Council on Population, Health and Welfare (PNGOC); UNAIDS; UNFPA; and, WHO. UNAIDS oriented the core team on the reporting format and the differences between of the 2010 from the 2008 UNGASS report. A work plan for the succeeding months and modalities for data collection was prepared. Workshops for the National AIDS Spending Assessment (NASA) and National Composite Policy Index (NCPI) were also scheduled. Lessons learned from the development of the 2008 UNGASS report informed the planning process for the development of the UNGASS report.

Two (2) workshops were conducted to accomplish the NCPI – one for civil society in February 2010 and another for government in March 2010. Government representatives who were tasked to accomplish the form found it difficult to complete the NCPI A. This feedback was likewise expressed by some civil society representatives who were present in the workshop. They had had difficulty in answering the questions despite explanations on the meaning of said questions. The scores generated from the results of the NCPI for this reporting period for particular questions on strategy-planning efforts in the HIV programmes, political support for the HIV programmes, and efforts in the implementation of HIV prevention programmes fell below the previous NCPI scores. This may be attributed to inappropriate agency/organisational representation to the workshop and/or a general inadequate knowledge of the National HIV Response of some CSO representatives in particular and GO representatives in general.

Data collection for the UNGASS indicators took longer or reports from partners were submitted to the PNAC late as one week into the deadline. Furthermore, large portion of the indicators to be reported in the narrative were derived from the results of the Integrated HIV Behavioural and Serologic Surveillance (IHBSS) which needed to make accurate, was also just recently validated.

In March 18, 2010 was the vetting forum, for the report. Forty (40) participants from government, civil society and multilateral agencies attended the said event...

B. *Status of the epidemic*

From January 1984 to December 2009, there were 4,424 HIV Ab seropositive cases reported to the Philippine AIDS Registry of the National Epidemiology Center of the Department of Health. Three thousand five hundred ninety two (3,592) were asymptomatic and 832 were AIDS cases. Ages ranged from 1 to 72 years old (median 32 yrs). The age groups with the most number of cases were 20 to 24 yrs (15%), 25 to 29 yrs (23%), 30 to 34 yrs (20%), and 35 to 39 yrs (16%). Seventy three percent (73%) were males.

Of the 4,424 with HIV, 90% of cases were infected through sexual contact and 1% (49) through mother-to-child transmission and 1% (8) through needle sharing among injecting

drug users. Of those who were infected through unprotected sex, data from 1984 to 2006 shows that 55% of them were infected through heterosexual contact, 29% through homosexual contact and 15% through bisexual contact. From 2007 to 2009, 41% of sexual transmission was homosexual, 32% was heterosexual, and 28% was bisexual.

The passive surveillance showed sudden increases (54%) in HIV positive cases in 2008 compared to 2007 and a 58% increase from 2008 to 2009. Compared to the monthly average during the last UNGASS report, of 20-30 new cases per month ('06-'07), the past 2 years have shown a sharp increase of 44 cases per month in '08 and 70 cases per month in 2009.

Table 1: Comparative Trend in the Mode of HIV Transmission from 1984 to 2009

| Modes of Transmission | 2009 | 2008 | 2007 | 2006 | Cumulative (1984-2009) |
|---|--------------|--------------|-------------|-------------|------------------------|
| Unsafe sexual contact | 804 (96.29) | 502 (95.08%) | 320 (93.6%) | 300 (97.1%) | 3994 (90.28%) |
| <i>Male-Male Sex</i> | 336 (41.79%) | 215 (42.83%) | 107 (33.4%) | 81 (27.0%) | 1171 (29.31%) |
| <i>Male-Female Sex</i> | 216 (26.87%) | 160 (31.87%) | 139 (43.4%) | 193 (64.3%) | 2214 (55.43%) |
| <i>Bisexual Contact</i> | 252 (31.34%) | 127 (25.3%) | 74 (23.1%) | 26 (8.7%) | 609 (15.25%) |
| Sharing of infected needles (among IDU) | 0 | 1 (0.19%) | 0 | 0 | 8 (0.18%) |
| Mother-to-Child | 2 (0.24%) | 2 (0.38%) | 8 (2.3%) | 4 (1.3%) | 49 (1.11%) |
| Contaminated Blood Products | 0 | 0 | 0 | 0 | 19 (0.42%) |
| Contaminated Needle Prick Injuries | 0 | 0 | 0 | 0 | 3 (0.07%) |
| No Data on Mode of Transmission | 29 | 23 | 14 | 5 | 351 |
| TOTAL Cases | 835 | 528 | 342 | 309 | 4424 |

C. Policy and programmatic response

The policy and programmatic anchor of the national response to HIV and AIDS is the Republic Act 8504 or the Philippine AIDS Prevention and Control Act of 1998.

The following are legal issues relating to HIV and AIDS in the Philippines:

- Provisions of Republic Act 8504 on confidentiality, non-discrimination of persons living with HIV, prohibition of compulsory testing and partner disclosure;
- Sex work is illegal, yet common in many areas;
- Drug use is often treated as a criminal, rather than social or health, issue¹
- There is no legislation supporting the harm reduction strategies for injecting drug users²

¹ www.aidsdatahub.org/phil country review

² Ibid

The principle of “**Three Ones**” is in place in the country with the national response having:

One coordinating authority – The Philippine National AIDS Council (PNAC) was constituted in 1992 and has set the following policy directions in implementing the 4th AIDS Medium Term Plan 2005 - 2010 (AMTP IV):

- 1) 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;
- 2) Ensure that measures and programmes are responsive to the identified needs of sectors, individuals, and groups most affected by the epidemic;
- 3) Give priority to the infected and affected individuals and to existing and emergent highly vulnerable groups covered by AMTP IV;
- 4) 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;
- 5) Scale up and expand effective intervention measures with corresponding ample resource support;
- 6) Ensure integration, harmony of purposes and directions of all on-going programmes and projects; and,
- 7) Establish mechanisms to ensure a protected level of funding support to achieve the goals and objectives of the AMTP IV.

One strategic plan - The national response to the HIV and AIDS epidemic is embodied in the AIDS Medium Term Plan IV (AMTP IV: 2005-2010). Imbibing the principles of the universal access to prevention, care, treatment, and support, 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 2009 to 2010 Operational Plan. Under the leadership of PNAC, both documents came about after series of consultations with various stakeholders. The Operational Plan of the AMTP IV reflects priority activities that need to be accomplished before 2010.

One monitoring and evaluation framework – The Monitoring and Evaluation System of the Philippine AIDS Response is discussed in detail in Sections IV and VII of this report.

From 2008 to 2009, the country was successful in establishing guidelines and protocols through the following documents:

- 1) DOH-AO 2009 - 0016: Policies and Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV)
- 2) DOH-AO 2009 - 0006: Guidelines on Antiretroviral Therapy (ART) among Adults and Adolescents with Human Immunodeficiency Virus (HIV)
- 3) DOH-AO 2008 - 0022: Policies and Guidelines in the Collaborative Approach of TB and HIV Prevention and Control
- 4) DOH Antiretroviral Therapy For HIV Infection, Recommendations for Adults in the Philippines 2008
- 5) Operating Guidelines for HIV and AIDS Core Team (HACT) - Draft

D. UNGASS indicator data in an overview table

Table 2 presents the country status relative to the UNGASS indicators, the source of data and corresponding notations and/or clarifications.

Table 2: Country Status per UNGASS Indicators 2009

| Indicator | Source of Data | Status | Remarks |
|---|--|---|--|
| 1. Domestic and international AIDS spending by categories and financing sources | 2009 NASA | 2008: \$7,734,114 2009: \$11,863,204 | Average annual spending is \$6,532,439 |
| 2. National Policy Composite Index | NCPI A and B | | See ANNEX 2 |
| National Programs | | | |
| 3. Percentage of donated blood units screened for HIV in a quality assured manner | Dept. of Health- Nat'l Voluntary Blood Service Programme (DOH-NVBSP) | CY 2008 % blood units screened for HIV: 96% (630,468 /658,884) -No EQAS was conducted CY 2009 % blood unit screened for HIV: 96% (242047/251298) | CY 2008 data: -Data derived from blood service facilities nationwide. -Donated Blood units: 658884 -Donated blood units screened for HIV using sequential testing method: 630468 -No EQAS conducted in 2008 due to financial constraints CY 2009 data: -Data available is derived from both GF supported (6) and non-GF (22-Partial Nat'l data collected) Blood Service Facilities -Total blood units collected: 251298 - Total blood units collected and tested for HIV using a simultaneous testing method: 242047 - Blood service facilities that participated in EQAS: 10 (funded by GF) - Total number of Blood service facilities that test for HIV: Data is currently being updated and consolidated by the Bureau of Health Facilities and Services of the Department of Health |
| 4. Percentage of adults and children with advanced HIV infection receiving ART | Department of Health- Nat'l AIDS STI Prevention and Control Programme (DOH-NASPCP) | 82% (750/919) Breakdown by sex: Women : 21% (158/750) Men : 79% (592/750) | Number of adult with advanced HIV infection who are currently receiving ART: 750 Estimated number of adults with advanced HIV infection: 919 Children below 15 years old are not included in the total number of patients reflected |

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| | | | in the figure above. At present, 19 children are currently on ART. Percentage coverage cannot be computed since there is no estimate on the number of children with advanced HIV infection, |
| 5. Percentage of HIV+ pregnant women who receive AR medicines to reduce the risk of MTCT | DOH-NASPCP | 5% (6/130) | Number of HIV+ pregnant women who received ART in the last 12 months: 6 Estimated number of HIV+ pregnant women in the last 12 months: 130 % HIV+ pregnant women who receive AR medicines: Two (2) HIV (+) pregnant women are under prophylactic regimens using a combination of 2 ARV drugs; the remaining 4 pregnant women were presently on their ART regimen. |
| 6. Percentage of estimated HIV+ incident TB cases that received Tx for TB and HIV | DOH-NASPCP | 80%(205/256) | Represents TB treatment only. Isoniazid prophylaxis not included Number adults with advance HIV infection who are currently receiving ART and who were started on TB treatment: 205 Estimated number of HIV+ TB cases: 256 |
| 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results | 2008 National Demographic Health Survey (NDHS) Table 12.4 | 0.07%(95/13594) | Number of respondents 15-49 years old tested for HIV in the last 12 months and know their results: 95 Number of respondents 15-49 years old: 13,594 Note: 2008 NDHS did not survey males. |
| 8. Percentage of MARPs that have received an HIV test in the last 12 months and who know the results | 2009 Integrated HIV and Behaviour Serologic Surveillance (IHBSS) | 14% (2022/14533) Breakdown by group: - FSW: 19% (1712/9208) - MSM: 7% (296/4367) - IDU: 1.5% (14/958) | MARPs who have received an HIV test in the last 12 months and who know the results: 2022 Total MARP interviewed: 14533 MARPs were specifically asked this question in IHBSS 2009 DOH conducts the Philippine IHBSS is every two (2) years since 2005, This is the 3 rd round (2009 IHBSS). It measures |

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| | | | behavioral risk factors through a face-to-face survey and HIV and Syphilis prevalence through blood testing |
| 9. Percentage of MARPs reached with HIV prevention programmes | 2009 IHBSS | 38% (5459/14533) Breakdown by group: - FSW:55% (5071/9208) - MSM:29 % (1278/4367) - IDU:11.5% (110/958) | Number MARPs reached with HIV prevention programs: 5459 Total MARP interviewed: 14533 |
| 10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child | | Not required | Based on the 2008 Guidelines for Preparing the UNGASS report, This indicator is required from countries with HIGH HIV prevalence |
| 11. Percentage of schools that provided life skills-based education within the last academic year | Dept. of Education (DepEd); Project data UNFPA 6 th Country Program | No data available | DepEd provided data on number of trained school attendees (pupils and students) in life skills: Data provided by the 6th Country Program of the UNFPA reports that 877 elementary and 646 high school teachers were trained on Adolescent Reproductive Health. 270 peer educators from school and community based teen centers were trained to enhance their knowledge on ARH and life skills-based teaching methodology. The project has served 24,851 elementary pupils and 39,742 secondary students for school years 2008-2009 and 2009-2010. |
| Knowledge and Behaviour | | | |
| 12. Current school attendance among orphans and among non-orphans aged 10-14 | DepEd | Indicator not reported | Precious Jewels Ministry reports 25 children under their their care attending school |
| 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 | 2008 NDHS Table 12.1 and 12.2 | 20.7% (1013/4896) | The National Demographic Health Survey (NDHS) 2008 surveyed women only. The 2008 NDHS did not survey males. Women 15-24 years old who interviewed: 4896 Women 15-24 who correctly identified HIV prevention methods and reject major misconceptions: 1013 |
| 14. Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major | 2009 IHBSS | 32% (4702/14533) Breakdown as to groups: -FSW:30% (2775/9208) -MSM:34.3% (1500/4367) | Based on the IHBSS, MARPS in these indicators represents FSW, MSM and IDU. |

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| misconceptions about HIV transmission | | -IDU:44.5% (427/958) | Total MARPs who both correctly identify ways of preventing sexual transmission and rejecting misconception: 4702 MARPS Interviewed: 14533 |
| 15. Percentage of young women and men who have had sexual intercourse before the age of 15 | 2008 NDHS Table 12.6 | 2 % (206/9792) Breakdown as to age group: - Age 15-19: 2.1 % (58/2749); - Age 20-24: 2.1% (45/2147); | The National Demographic Health Survey (NDHS) 2008 surveyed women only . The 2008 NDHS did not survey males. Number of women who report the age at which they first had sexual intercourse as under 15 years: 103 Total number of women aged of 15 to 24 years old: 4896 |
| 16. Percentage of adults aged 15-49 who have had sexual intercourse with more than 1 partner in the last 12 months | 2008 NDHS Table 12.3 | 3.2% (276/8415) Breakdown as to age group: Age 15-19: 16% (54/347) Age 20-24: 9% (99/1101) Age 25-49: 2% (123/6967) | 2008 NDHS collected information among women only . The 2008 NDHS did not survey males. Number of women aged 15-49 who have had sexual intercourse with more than 1 partner in the last 12 months: 276 Total number of women aged 15-49 years old: 8415 |
| 17. Percentage of adults aged 15-49 who have had sexual intercourse with more than 1 partner in the past 12 months who report the use of a condom during their last intercourse | 2008 NDHS Table 12.3 | 11% (30/276) Breakdown as to age group: Age 15-19: 9%(5/54) Age 20-24: 15% (15/99) Age 25-49: 8% (10/123) | 2008 NDHS collected information among women only . The 2008 NDHS did not survey males. Total women 15-49 years old who reported had more than 1 sexual partner in the last 12 months who also reported that a condom the last time they had sex: 30 Number of women aged 15-49 who reported having had more than 1 sexual partner in the last 12 months: 276 |
| 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client | 2009 IHBSS | FSW:65%(6009/9208) MSW: 306% (366/1207) | Number of female and male sex workers who reported that a condom was used with their last client: 6009 and 366 Number of female and male sex workers who reported having commercial sex in the <u>last 12 months</u> : 9208 and 1207 (males sex workers who reported to engaged in anal sex) |
| 19. Percentage of men | 2009 IHBSS | 32% (928/2929) | Number of MSM who |

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| reporting the use of a condom the last time they had sex with a male partner | | | reported that a condom was used the last time they had anal sex: 928 Number of MSM who reported having had anal sex with a male partner in the <u>last 6 months</u> : 2929 |
| 20. Percentage of IDUs who reported the use of a condom at last sexual intercourse | 2009 IHBSS | Breakdown by groups: - IDUs as clients: 22% (54/244) - IDUs as sex workers: 11% (36/332) | |
| 21. Percentage of IDUs who reported using sterile injecting equipment the last time they injected | 2009 IHBSS | 85% (814/958) | Number of IDUs who report using sterile injecting equipment the last time injected drugs: 814 Number of IDUs who report injecting drugs in the last month: 958 |
| Impact | | | |
| 22. Percentage of young women and men aged 15-24 who are HIV-infected | 2008 & 2009 Philippine HIV & AIDS Registry | | The Registry provides the number of young men and women aged 15-24 who are HIV infected. 2008: M-102, F-8 2009: M-201, F-17 |
| 23. Percentage of MARP who are HIV-infected | 2009 IHBSS | 0.47% (70/14976) Breakdown by groups: -FSW:0.24% (23/9476)- MSM:0.99% (45/4542) -IDU:0.21% (2/958) | The 2009 IHBSS uses 2 classifications for female sex workers, each with its own prevalence. RFSW:0.13% FLSW:0.39% |
| 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART | DOH-NASPCP | 85% (192/229) | Data reflected adults only Number of adults who were still alive and on ART at 12 months after initiating treatment: 192 Total number of adult who initiated ART during the 12 months prior to the beginning of the reporting period including those who have died, those who stopped ART and loss to follow up: 229 |
| 25. Percentage of infants born to HIV-infected mothers who are infected | | No data available | AIDS Registry reports 4 infants infected from HIV positive mothers in 2008 (n-2) to 2009 (n-2). There is no estimated number of infants born to HIV(+) mother, hence, percentage cannot be calculated |

II. Overview of the AIDS Epidemic

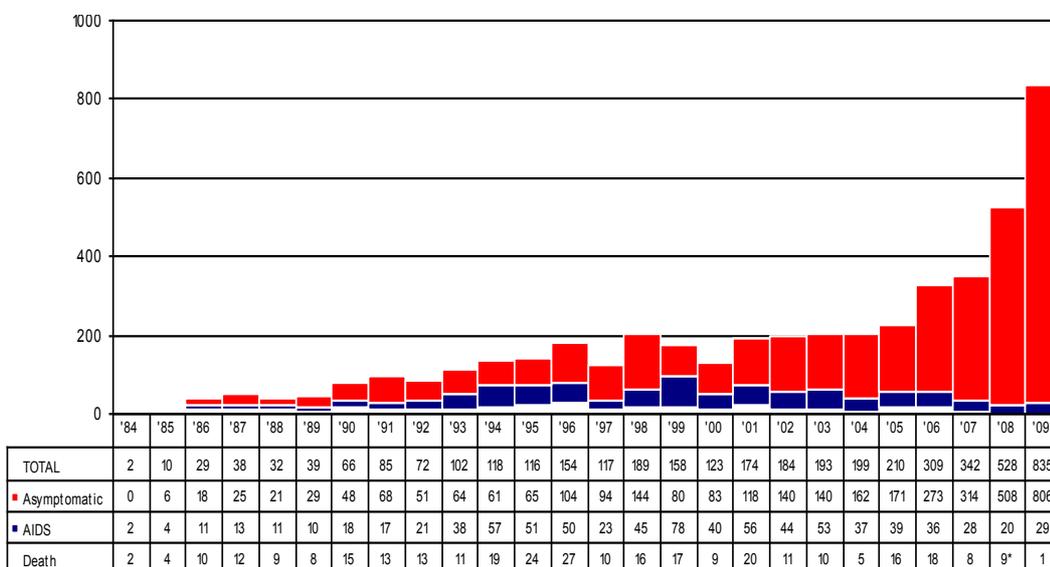
The first individual in the Philippines diagnosed with HIV was reported in 1984. Since January 1984 until December 2009, there have been a total of 4,424 individuals reported to the Philippine HIV & AIDS Registry. One third (31%) of all the new infections in the country were detected in 2008 to 2009. In 2008, an average of 44 people was diagnosed to have HIV each month. In 2009, this average increased to 70 people in one month. This is more than double the average monthly cases reported in 2007 (eg. 29 per month).

Sexual transmission remains to be the most common mode of HIV transmission in the Philippines, accounting for 96% of reported infections in 2009, and 90% of infections since the first reported case. Of the 804 cases infected through sexual contact in 2009, 41.73% was from homosexual contact, 31.34% from bisexual contact, and 26.87% from heterosexual contact.

A total of 164 returning overseas Filipino workers (OFW) were reported to be infected with HIV in 2009. This is the highest number since 1984 but accounts for only 18% of all individuals reported in that year. In 2007, OFWs comprised 31% of all newly diagnosed individuals reported in the country.

The national HIV prevalence remains to be less than 1% of the adult population. However, HIV prevalence among the most at-risk populations (MARPs) has increased from 0.08% in 2007 to 0.47% in 2009.

Figure 1. Number of HIV and AIDS Cases Reported in the Philippines by Year January 1984 - December 2009



**Table 3: Number of people diagnosed with HIV in the Philippines
January 1984 – December 2009**

| Year | Total HIV Cases | Male HIV Cases | Female HIV Cases | AIDS Cases | Deaths due to AIDS |
|-------------------------------|------------------------|-----------------------|-------------------------|-------------------|---------------------------|
| 2008 | 528 | 473 | 55 | 20 | 7 |
| 2009 | 835 | 732 | 103 | 29 | 1 |
| Cumulative (1984-2009) | 4,424 | 3,232 | 1,181 | 832 | 318 |

A limitation of this report is that at the time the UNGASS country progress report was being prepared, the DOH-NEC was finalizing the analysis of data on estimates of most at risk populations (MARPs). NEC was also conducting a Rapid Assessment of Vulnerability (RAV) in selected key areas in the Philippines to inform the forthcoming development of the Fifth AIDS Medium Term Plan 2010 – 2016. Unfortunately, both strategic sets of information did not synchronize with the timing of the country's UNGASS 2010 report.

III. National response to the AIDS epidemic

The Philippines HIV situation is a “latent epidemic” where HIV prevalence is still very low. This allows the country an opportunity to stage effective prevention actions to avert a large-scale epidemic. The national HIV program aims to prevent the maximum number of new HIV infections and focusing such interventions on the most at risk population. The AMTP IV Operational Plan for 2009 to 2010 addresses these challenges and presents key directions in scaling up prevention, treatment, care and support.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) contributes significantly to the country’s national HIV response (attachment 1).

A. *Program Management*

The national response is coordinated through the Philippine National AIDS Council (PNAC) - the highest advisory, planning and policy-making body on AIDS. The PNAC is composed of 26 government agencies, NGOs, professional organizations and representative from people living with HIV. It is charged with planning, coordinating and monitoring the country’s national response to HIV and AIDS. It sees to it that all HIV and AIDS projects and initiatives in the country respond to the current AIDS Medium Term Plan.

PNAC is supported by a Secretariat whose functions is to support PNAC plenary in its policy-decision making, insure availability and utilization of strategic information for program-planning, coordination and monitor implementation of sector-specific responses, and provision of administrative support to PNAC.

Assisting PNAC in the management of various aspects of AIDS prevention and control are the following agencies classified into sectors:

Health Sector Response

DOH - **National Center of Disease Prevention and Control** (DOH- NCDPC), National AIDS and STI Prevention and Control Program (NASPCP) provides technical leadership for the **health sector response**, through policy guidance, and evidence-based tools - technical assistance, capacity building and other resource augmentation, monitoring and evaluation within the ambit of the health system. NASPCP coordinates and implements activities on STI and HIV/AIDS program delivery on prevention, treatment, care and support.

Treatment Hubs and HIV and AIDS Core Team (HACT) is the technical and implementation arm of NASPC for all HIV related services in a hospital setting, which is currently the platform for HIV counseling and testing, treatment of opportunistic infection, universal precaution and infection control and psychosocial support to people living with HIV and AIDS.

DOH - **National Voluntary Blood Safety Program** (DOH-NVBSP) is the program management arm of the DOH in implementing Republic Act 7719, also known as the National Blood Services Act of 1994. The law aims to provide Filipinos with safe, adequate, and accessible blood coming exclusively from voluntary blood donors. The NVBSP Unit assists and works with the Regional

Blood Service Facilities nationwide.

DOH - **National Epidemiology Center** (DOH-NEC) houses the national HIV and AIDS strategic information and sentinel surveillance system, which monitors and records new cases of HIV through the Philippine HIV and AIDS Registry. It also manages and coordinates STI surveillance, implements rapid assessments of HIV vulnerability, and provides capacity development to LGUs in the area of strategic information. Every two years since 2005, it conducts the IHBSS, a national surveillance among the most at-risk population that determines prevalence of HIV and Syphilis, trends in high-risk behavior and prevention coverage.

DOH - **Centers for Health Development** (DOH-CHDs) provide technical supervision and assistance to the LGU health offices/units in areas of health programme advocacy, implementation and monitoring.

Labor Sector Response

The Department of Labor and Employment (DOLE) is the program management arm of PNAC in HIV and AIDS prevention in the workplace. The large, medium and small-scale businesses, which are under the regulatory supervision of DOLE are the key actors for this aspect of the national response. The monitoring of HIV and AIDS response in private workplaces is the function of the Occupational Safety and Health Center (OSHC).

The DOLE, under whose jurisdiction also falls the overseas labor sector, coordinates the work on HIV and AIDS of three (3) offices attached to it, namely: the Philippine Overseas Employment Administration (POEA), Overseas Workers Welfare Administration (OWWA) and the National Reintegration Center Office (NRCO). The Technical Education and Skills Development Authority (TESDA), is an educational arm of DOLE is tasked to provide trade and technical capacity building to the youth.

Education Sector Response

The **Department of Education** (DepEd) is the management and implementing arm of PNAC in the Education response to HIV and AIDS. The elementary and secondary schools under the DepEd and tertiary schools under CHED; both public and private are the ones tasked to implement HIV and AIDS education to pupils and students across the country. However, this aspect of the national response has yet to fully take off.

Social Welfare Sector Response

The **Department of Social Welfare and Development** (DSWD) is the management and implementing arm of PNAC in insuring that indigent PLHIVs are provided welfare services such as care and support and other assistance to mitigate impact of the disease to poor Filipino PLHIVs. . Among the government line agencies that are members of PNAC, the DSWD is very active in fulfilling its role in the AIDS program.

Local Government Sector Response

The **Department of the Interior and Local Government** (DILG) is supposed to coordinate and monitor local government response but have to fully exercise this role. During this reporting period, the department through its academic arm, the Local Government Academy (LGA) is training 17 Regional AIDS Assistance Teams (RAATs) to provide support to local government units in establishing/enhancing their respective local HIV programs.

The **Local Government Units** (LGUs), as health program implementers, but not limited to HIV prevention are the lifeblood of the prevention component of the national response to AIDS. LGUs implement HIV/STI prevention activities in coordination with various stakeholders including their NGO partners. The City/Municipal Health Office-Social Hygiene Clinics (CHO/MHO-SHCs) are tasked to do STI diagnosis, provide STI treatment, do voluntary counseling and testing (VCT), conduct blood donation education and activities, and report regularly on their outputs to the DOH.

Foreign Affairs Sector Response

The **Department of Foreign Affairs** (DFA) trains Foreign Service Officers in handling HIV and AIDS cases of Filipinos overseas through the Foreign Service Institute (FSI) and coordinates HIV and AIDS response to assist Filipinos overseas in HIV related cases through the Office of the Undersecretary for Migrant Workers Affairs (OUMWA)

Civil Society Sector Response

Non-governmental organizations and peoples' organizations (NGOs and POs) implement the community-based outreach and education in close partnership with the CHDs, LGUs and/or treatment hubs. The civil society sector assists the national agencies and local government units in implementing sector-specific responses at various geographic sites. There are approximately more than 50 civil society organizations implementing various HIV prevention interventions across the country.

Oversight in Planning and Programming

The **National Economic and Development Authority** (NEDA), tracks the country's AIDS spending, sees to it that HIV is included in the development plan of the country and as an indicator in country surveys. Other government agencies such as Philippine Information Agency (PIA), Department of Budget and Management, and Department of Tourism (DOT) provide support in the overall planning.

B. Prevention

The National Response prioritizes prevention intervention of HIV infection among identified MARPs (sex workers as well as clients, men who have sex with men and injecting drug users). The response also pays particular attention to vulnerable groups like the Filipino migrant workers and children and youth in difficult situations. This thrust is in keeping with the low prevalence and concentrated epidemic status.

1. Coverage

Sexually transmitted infections: Thirty-three percent (33%) of service delivery points provided STI services per 1,000 sex workers, or 100 service delivery points for 299 out of 1,000 sex workers per DOH 2007 Population Estimates. Based on data among pregnant women in ante natal clinic (ANC) supported by UNICEF, 22 out of 9,354 (0.23%) ANC attendees aged 15 years and older tested positive for syphilis.³

³ General country information Philippines_UAHealthSector_Report_2009.Care, HIV-TB, STI Worksheet

Prevention of sexual transmission of HIV and prevention of transmission through injecting drug use: The national program records at end of 2009 show there is 0.15 needle and syringe programme (NSP) sites, or three sites for every 20 IDU, to prevent HIV transmission through injecting drug use. Thirty-three thousand eight hundred twenty four (33,824) needles/syringes were distributed for an estimated 20,000 IDU, or 1.69 needles/syringes per IDU. None of the sites implement substitution therapy because there is no established evidence for substitution therapy for Nalbuphine, the commonly used substance among local IDU. Other than NSP, HIV related interventions for IDU include drug dependency treatment; HIV testing and counseling; antiretroviral therapy; STI prevention and treatment; condom programs for IDU and their sexual partners; targeted IEC; and prevention diagnosis and treatment of TB.⁴

Testing and counseling: At end of 2009, 82 (72%) of 114 health facilities provide HIV testing and counseling; 79 are public facilities, three (3) are private. Ten thousand one hundred ten (10,110) people aged 15 years and older knew of their test results after undergoing counseling and testing for HIV, both client and provider initiated methods (CICT and PICT respectively). There are existing guidelines on PICT, which includes guidance on obtaining consent, ensuring confidentiality, and facilitating disclosure of status. The guidelines also indicate providers to target counseling and testing services to MARPs (SW, MSM and IDU).⁵

Prevention in health care settings: The country's policy on post-exposure prophylaxis covers occupational exposure such as needlestick injuries in health care settings. PEP is implemented and available in tertiary level reference hospitals.⁶

Prevention of Maternal to Child Transmission (PMTCT): Of estimated 690 pregnant women, 26 (4%) received their test results after testing for HIV during pregnancy or labour and delivery or post-partum period (less than 72 hours). This figure includes those with previously known HIV status. This was a result from an initiative that involved a community-based organization in Angeles, an offshoot of the PMTCT trainings provided in the GFATM sixth round grant. Five percent (5%) or 6 out of 130 estimated HIV-infected pregnant women were assessed for ART eligibility (but this signifies 100% coverage of the women who accessed the facility).

Three (3) infants born to HIV-infected mothers received HIV test within 12 months since birth, two (2) of them had virological tests in the first two months. Two (2) infants received ARV prophylaxis to reduce MTCT. All three were started on co-trimoxazole prophylaxis. In 2009, prophylactic regimens using a combination of two antiretrovirals were most commonly used for PMTCT, estimated distributed to 65% of pregnant women eligible for treatment. Also, HIV information were included on both maternal and child health cards.⁷

⁴ General country information Philippines_UAHealthSector_Report_2009.Sexual transmission, IDU Worksheet

⁵ General country information Philippines_UAHealthSector_Report_2009. T&C Worksheet

⁶ General country information Philippines_UAHealthSector_Report_2009. [Prevention in health setting Worksheet]

⁷ General country information Philippines_UAHealthSector_Report_2009. Women and children Worksheet

2. Knowledge and Behavior Change

Universal Access has set a goal of 80% coverage of prevention programs to make an impact on the epidemic, and 60% of target populations with correct knowledge and behavior to reverse the epidemic and stop HIV transmission. The results of this year's IHBSS)⁸ showed some improvement in reach of prevention programs among MARPs especially the female sex workers (FSWs). The improvement in coverage is reflected in the improved knowledge among MARPs, which showed a general increase compared to the last UNGASS report. However, there was no change in condom use among FSWs and MSM from the previous report to the present.

What is striking in this year's IHBSS is the 900% increase in HIV prevalence among MARPs. The previous report showed low prevention coverage, low knowledge among MARPs and low condom use specifically among MSM and IDUs. The last two groups are the populations which showed a dramatic rise in prevalence this year and could be explained by the factors just mentioned. This year's results showed only slight improvement from the previous report but still not near the UA targets. With these findings its effect in the years following this report, will certainly show a continuous rise in number of cases and in the increase prevalence of HIV among MARPs is to be expected. Therefore, catching up on the prevention interventions among MARPs is imperative.

C. *Treatment, care and support*

In 2009, 114 local administrative units in the country are in need of HIV service facilities. From a previously reported 16 facilities, there are now 23 health facilities that offer antiretroviral therapy - 13 of these are public facilities, 6 are private, health facilities, and 4 are private individual health service providers." With the development of the health sector strategic plan, it is expected that the target will be updated in 2010.⁹

1. Antiretroviral therapy

In 2009, in addition to the finalization and dissemination of policy and ensuring availability of antiretrovirals drugs, DOH was also able to engage private facilities. Of expected 20 health facilities that will offer ART services, 23 now have services that prescribe ART and/or provide related clinical follow-up (115%).

Percentage of adults and children with HIV known to be on treatment after initiation of ART are as follows: 76% (131/172) after 24 months; 82% (125/152) after 36 months; and 82% (125/152) after 48 months..¹⁰

Community and home based care services are provided by NGOs, peers, and community representatives. However, the capacity to implement interim

⁸ Participation in 2009 IHBSS: Of the Round 5 sites, the cities of Baguio, Cebu, Zamboanga and General Santos, which are established surveillance sentinel sites; the cities of Makati, Mandaluyong, Marikina, Pasig and Surigao. All Round 6 sites that implemented STI and HIV and established surveillance sentinel sites such as the cities of Angeles, Quezon, Pasay, Iloilo, and Davao. None of the Round 3 sites were however included.

⁹ General country information Philippines_UAHealthSector_Report_2009.xls

comprehensive TCS services package (both human resource and logistics) needs to be strengthened.

2. Treatment Hubs and other hospitals

Through the NASPCP, 13 treatment hubs across the country are now in place where patients can access free ARV. This was made possible through the support of DOH and GFATM. The treatment hubs (hospitals) do VCT, make diagnosis, provide ARV treatment and prophylaxis and treatment of HIV and opportunistic infections, and continuing psychosocial counseling. Early infant diagnosis is now being done centrally to ensure that treatment is provided at the earliest opportune time for infants and children infected.

Hospitals with treatment hubs through their functional HIV and AIDS Core Teams (HACTs) are enumerated below:

- | | |
|--|-------------------------------|
| 1) Ilocos Training Regional Medical Center | - San Fernando, La Union |
| 2) Baguio General Hospital | - Baguio City |
| 3) San Lazaro Hospital | - Manila |
| 4) Research Institute of Tropical Medicine | - Manila |
| 5) UP- Philippine General Hospital | - Manila |
| 6) Bicol Regional and Training Hospital | - Legazpi City |
| 7) Don Vicente Sotto Memorial Medical Center | - Cebu City |
| 8) Corazon Locsin Medical Center | - Bacolod City |
| 9) Western Visayas Medical Center | - Iloilo City |
| 10) Davao Medical Center | - Davao City |
| 11) Zamboanga City Medical Center | - Zamboanga City |
| 12) Cagayan Valley Medical Center | - Tuguegarao City |
| 13) Jose B. Lingad Medical Center | - San Fernando City, Pampanga |

Aside from the 13 treatment hubs, there are also some 68 hospitals, both public and private with HACTs that have been capacitated and updated on HIV and AIDS clinical management.¹¹ Among these are three (3) private facilities serving as access points for ARV like Makati Medical Center in Luzon and two (2) clinics in Cebu. The program will continue engaging private hospitals and individuals to set up a private-public partnership for HIV and AIDS care, treatment and support. The program will improve the networking and referral system to facilitate access of patients to free ARV.

HIV infection being a lifetime diagnosis requires continuing support for a better quality of life. Psychosocial, spiritual, self-empowerment and values orientation training, micro-financing/livelihood support, and even burial assistance are currently being provided by the Department of Social Welfare and Development, the Department of Health, the Positive Action Foundation, Phil (PAFPI) and the Pinoy PLUS Association. Care and support activities include hospital, home and community visits, peer education and counseling.

The DSWD likewise institutionalized, care and support program under its own mandate. Services facilitated by this agency ranges from policy development and capability building of local leaders and volunteers who provide care and support to PLHIV; as well as direct livelihood assistance to PLHIVs.¹²

¹¹ AMTP IV Operational Plan 2009-2010, PNAC

¹² See DSWD report page 29-30.

With GFATM support, 200 PLHIV are enrolled to the National Health Insurance Program in 2009. The DOH and positive community are lobbying to PhilHealth to finalise the implementing rules and regulation of HIV Out-Patient Benefit Package.

To ensure that treatment services are at par with national standards, the Secretary of Health recently approved the *Guidelines on the Use of ARV, Paediatric AIDS Care Management, Implementation of Prevention of Mother-To-Child Transmission of HIV*.

D. National Composite Policy Index

While the NCPI results for this reporting period show a see-sawing trend in terms of perception or knowledge of the respondents on the developments in the National Response to HIV and AIDS, there are significant improvements in aspects like:

- *Strategy planning efforts in the HIV programmes* - PNAC adapted a costed operational plan to address findings of AMTP-IV mid-term review and the change in the Philippine epidemic;
- *Political support for the HIV programmes* - League of Cities has included HIV prevention in its advocacy to member cities;
- *Policy efforts in support of HIV prevention* - Increase access of EEWs to SHCs; Increase access of FLSW and MSM thru outreach activities; Local ordinances which provide treatment, care and support for PLHIV; and DBM policy allowing individual government agencies outside of Health to allocate funds for HIV projects;
- *Efforts in the implementation of HIV prevention programmes* - Increase in geographic areas for project implementation;
- *Efforts in the implementation of HIV treatment, care and support programmes* - Increase in geographic areas for project implementation;
- *M&E efforts of the HIV programme* - Personnel complement of National M&E unit increased from 1 to 3; most national partners and implementers are aware of importance of M&E;
- *Policies, laws, regulations in place to promote and protect human rights in relation to HIV* - ARV policies; Benefits package for PLHIVs through PhilHealth;
- *Efforts to enforce existing policies, laws, regulations* - Government policies on ARV supply and provision; Creation of benefits package for PLHIVs; Nondiscrimination policy in Armed Forces of the Philippines; and,
- *Efforts to increase civil society participation* - A CSO forum organized by PNAC; CSOs are project implementers in many HIV projects; CSOs are included in AMTP Operational Plan development, mid-term review of strategic plan, CSO coalition to monitor CCM.

E. Total AIDS Spending by Source

Table 6 shows an increasing trend in overall spending for AIDS from 2007 to 2009. The trend in domestic spending appears to be erratic. It should be noted however that there was incremental increase in the budget of the Department of Health from 2007-2009. There was a steady increase in external funding as well.

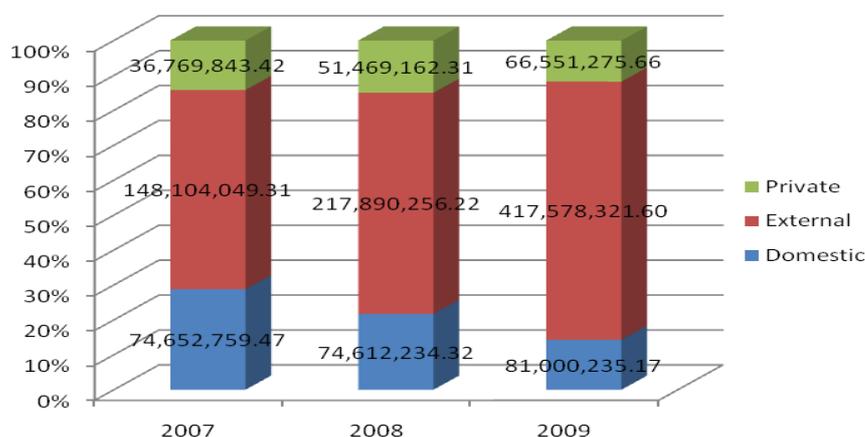
Table 6: Total AIDS Spending by Source, 2007-2009 (in Philippine Pesos)

| Spending Source | Year | | | Amount | |
|-----------------|-------------------|-------------------|-------------------|-------------------|-------------|
| | 2007 | 2008 | 2009 | Average | Percent (%) |
| Domestic | PhP74,652,759.47 | PhP74,612,234.32 | PhP81,000,235.70 | PhP76,755,093.14 | 20 |
| | \$1,617,667.34 | \$1,677,637.00 | \$1,700,356.76 | \$1,665,220.37 | |
| External | PhP148,104,049.31 | PhP217,890,256.22 | PhP417,578,321.60 | PhP261,190,915.85 | 67 |
| | \$3,209,299.77 | \$4,899,206.65 | \$8,765,803.23 | \$5,624,769.88 | |
| Private | PhP36,769,843.42 | PhP51,469,162.31 | PhP66,551,275.66 | PhP51,596,770.17 | 13 |
| | \$796,773.96 | \$1,157,270.94 | \$1,397,044.24 | \$1,117,029.71 | |
| Total | PhP259,526,652.19 | PhP343,971,652.85 | PhP565,129,832.43 | PhP389,542,779.15 | 100 |
| | \$5,623,741.07 | \$7,734,114.59 | \$11,863,204.23 | \$6,532,439.61 | |

Table 6 and Figure 3 show that the bulk of spending is from external sources. During the period 2007 to 2009, about 67 percent of the country's total resources spent on AIDS came from external sources, while 20 percent came from domestic sources. In 2008 and 2009, Global Fund contributed the most (Php128 million in 2008, and Php318 million in 2009). Other external contributors include UN agencies including Asian Development Bank (ADB), European Commission (EC), United States Agency for International Development (USAID), World Bank and WHO among others.

Domestic resources on the other hand include spending by the Department of Health (DOH), the Philippine National AIDS Council Secretariat (PNAC-SEC), Department of Social Welfare and Development (DSWD), the Occupational Safety and Health Center (OSHC) of the Department of Labor and Employment (DOLE), Department of Interior and Local Government (DILG), San Lazaro Hospital, five local government units, among others.

Figure 3. AIDS Spending by Source 2007 to 2009 (in Philippine Pesos)



The expenditures of non-government organizations (NGOs) are usually sourced from development partners and international NGOs. Notably, a lot of AIDS-related activities are being carried out by NGOs. These NGOs include: Action for Health Care Initiatives (ACHIEVE), AIDS Society of the Philippines (ASP), Health Action Information Network, Lunduyan, Positive Action Foundation Phils., Inc., Philippine NGO Council (PNGOC), TLF-SHARE Collective, Tropical Disease Foundation, among others. Private spending in this report includes corporate contributions and internally generated funds from civil society group as in the case of the DKT Philippines.

IV. Good Practices

The UNGASS Team facilitated the data gathering for the Good Practice section. The criteria used for selection were adapted from the 2008 reporting, which were: pioneering effort, appropriateness of approaches, significant impact, sustained to date, and replicability.

The call for submission of Good Practices was disseminated through the discussion group pinoy-ungass@dgroups.org. Guidelines were distributed through the e-group, in workshops and meetings participated by stakeholders. The announcement included the template or format and criteria for determining whether the practice can be considered “good practice.” Submitted articles were screened based on the criteria above. Those that were selected were further examined. Authors were contacted for additional information. Authors and members of the UNGASS Team did Editing and revisions.

Limitations: some of the good practices included here are still in the early stage of implementation, but considered because the initiative showed good results and have the potentials for sustainability and replicability. In this case, it is too early to look at impact but continuous monitoring will be done.

A. Partnership Mechanism for Treatment, Care and Support for People Living with HIV (PLHIV) and Affected Family

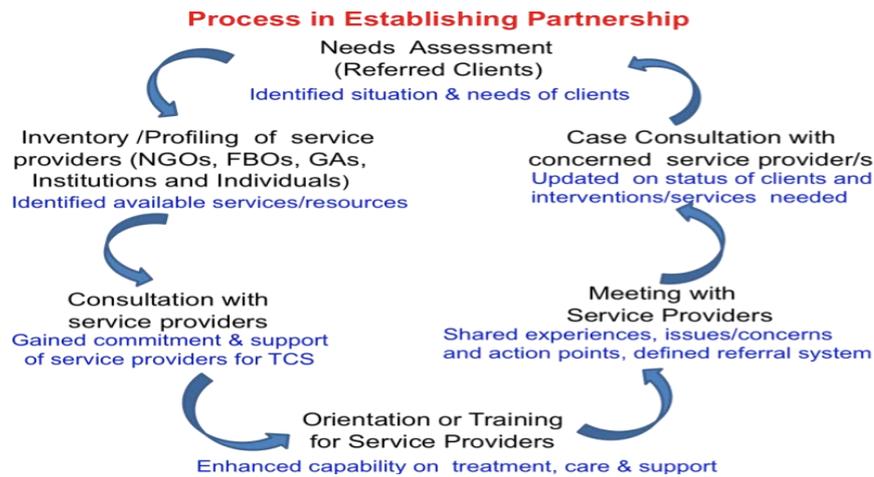
By: Alma Mondragon, Alagad Mindanao

The Alliance Against AIDS in Mindanao or Alagad Mindanao, is a multisectoral partnership of organizations formed in 1993 in Davao City. Its goal is to enhance multisectoral efforts to prevent the spread of STI, HIV and AIDS and to provide care and support to PLHIV and their affected families.

The care and support program of Alagad Mindanao started in 1997, and handling its first HIV case in 1998. In 2004, through the support of GFATM, they implemented a project that aims to enhance the delivery of treatment, care and support services to PLHIV and affected families. From one client in 1998, Alagad has handled 98 cases to date, 46 of which are currently availing the free ARV drugs. An average of 2 new PLHIV clients every month is referred to Alagad Mindanao for psychosocial care and support.

Though ARVs are free, majority of clients cannot afford the cost of treatment and other medical needs because they were either deported or jobless. For some, HIV status is not known to the family, which makes the request for assistance more difficult. To address these constraints, Alagad Mindanao facilitated the establishment of partnership mechanism to ensure a sustained coordination in the delivery of treatment, care and support (TCS) services to PLHIVs.

The figure below illustrates the process of establishing partnership mechanism



The partnership mechanism process involves several steps. During the implementation, it starts with identifying and profiling health and service providers in the locality and inviting them to a consultation. The consultation led to the formation of local support groups for HIV and AIDS TCS to enhance coordination and cooperation. Regular meetings were conducted among the support groups to share experiences. Trainings on treatment, care and support interventions were provided to enhance knowledge, skills and attitudes of service providers. Case consultations were carried out with organizations and agencies directly handling PLHIV clients. These include the Davao Medical Center (DMC)-HACT, HIV and AIDS Focal Person at CHD-DOH, Reproductive Health and Wellness Center of the City Health Office, private physicians, and those who are in-charge of private laboratories and clinics.

The partnership mechanism generated meaningful outcomes such as:

- a) Formation of support groups for treatment, care and support;
- b) Revival and reconstitution of HIV and AIDS Core Team (HACT) in 5 government hospitals namely Davao Regional Hospital in Tagum City, Northern Mindanao Medical Center in Cagayan de Oro City, Provincial Hospital in Mati City, Provincial Hospital in Malaybalay City and District Hospital in Island Garden City of Samal
- c) Establishment of the Health and Care Today (HACT) Clinic for PLHIVs in Davao Medical Center (DMC); and,
- d) Establishment of a referral system for treatment, care and support; and
- e) Formation of Mindanao Advocates, a peer support groups which facilitates the involvement of PLHIV in Mindanao.

The establishment of the HACT Clinic was in response to the increasing number of clients needing medical attention. It addresses the need for a “safe” space for PLHIV during counseling. Currently, there are at least four (4) physicians who are specialists on infectious diseases offering free services for PLHIVs.

Impact of the Practice

- 1) The formation of peer support group of PLHIV clients in Mindanao called “Mindanao Advocates” which was formally launched on May 15, 2009 facilitated the PLHIV’s meaningful involvement in HIV and AIDS education, advocacy, and care and support activities. At present, Mindanao Advocates has 34 PLHIV members.

- 2) The reactivation and reconstitution of HACT in five (5) government hospitals enhanced the provision of quality services to PLHIV. The creation of the HACT Clinic at DMC with four (4) infectious disease physicians addresses the basic primary health care needs of the PLHIV. It also responds to PLHIV's concern to have an exclusive clinic to ensure confidentiality of their case during medical consultations.
- 3) The establishment of a referral system among service providers resulted to a more systematic delivery of treatment, care and support services to PLHIV and affected family members and significant others. It facilitates referral of cases from private hospitals clinics and laboratories and hastens PLHIV's access to TCS services and ensuring confidentiality and non-discrimination.

Challenges and Lessons Learned

While exerting our efforts to sustain treatment, care and support services to PLHIV and affected family members, some challenges have been identified that affect effective and efficient provision of TCS services to clients. These are: (a) fast turn-over of trained service providers; (b) increasing number of referred PLHIV with diverse needs [e.g., livelihood/employment]; (c) sustainability of free ARV, OI drugs and laboratory examination; (d) institutionalization of HIV and AIDS programs by local government units for sustained intervention; and, (e) sustainability of programs/services of NGOs providing care and support.

Nevertheless, the functional referral system and the openness of service providers to share resources and services will strengthen collaborative efforts among service providers ensuring sustained treatment, care and support services to PLHIV and affected families in Mindanao.

B. Resource Mobilization for the Aklan Provincial Response to HIV and AIDS

By: Debbie F. Villaflor
Provincial Coordinator for STI, HIV and AIDS
Secretariat, Aklan Provincial AIDS Council

The Province of Aklan recognizes that increased vulnerability to HIV brought about by population mobility is one of the challenges that go along with tourism (local and foreign tourists) development. The Province organized the Aklan Provincial AIDS Council (APAC), a broad-based, multi-sectoral membership with the mandate to ensure collaborative efforts in HIV prevention programs including testing, treatment, care and support are established, and mechanisms for sustainability are in place and strengthened. This comprehensive programming includes financing, regulatory, service delivery and governance. A Provincial Investment Plan on HIV and AIDS was crafted and endorsed by APAC. In 2008, this Plan was integrated in the Provincial Investment Plan for Health (PIPH), which includes all health programs.

Improvement towards broader, multi-sectoral involvement in APAC was initiated in 2005. The following year (2006), this was achieved through Executive Order 16 – the Governor became honorary chairperson of the Council, the Provincial Health Office (PHO) chair, its Infection Disease Section secretariat. APAC now is composed of 11 government and six non-government seats. Sectors represented included women, children and youth, men who have sex with men, people living with HIV, mass media, and medical and allied medical professionals. It also has a Technical Working Group (TWG) responsible for ensuring integration of HIV and AIDS in projects and activities

of member agencies, and that service delivery, regulation and financing are ingrained within members' respective programming.

The third section of the Executive Order stipulated that 30 percent of the Gender and Development Fund of the Province shall be allocated to the operationalization of APAC. Ensured of its functioning such as regular meetings and strategic planning, the provision mandated the Council to formulate its Investment Plan on HIV and AIDS. The installation of Provincial Monitoring and Evaluation System for HIV and AIDS also contributed in realizing the need to develop a more comprehensive and sustainable response. These opportunities paved the way for planning and advocacy for an investment plan anchored on clearly articulated and agreed upon vision and mission.

Previous to the HIV and AIDS Investment Plan, responses were in line with meeting a donor grant's set performance indicators and the donor's thrusts. This would not cover for a comprehensive response to HIV and AIDS as the grant was suffused within an array of reproductive health programs and services. Service delivery was foremost in utilizing available resources, leaving little for policy advocacy, regulations and financing. Sustaining demand for HIV interventions also became a challenge because fast turnover of core groups of prevention advocates could not be addressed.

The HIV and AIDS Investment Plan was a product of collaborative efforts led by the TWG. In the formulation of the plan, consultative meetings were conducted and later the plan was presented for endorsement of the Council in the first quarter of 2007. Instrumental to the formulation of the HIV and AIDS Plan were the expertise of the local arm of the Department of the Interior and Local Government in interpreting provisions of the Philippine AIDS Law, the cooperation of local mass media in raising awareness and rallying for popular support of the plan, and competences in strategic planning of members being managers of their respective agencies. Ahead by three years to the PIPH, the HIV Plan's integration into it was facilitated by the fact that the Council member-endorsers were also the leaders and key players of the Provincial Government.

For the three-year HIV and AIDS Investment Plan, ₱5,509,740.16 have been identified resource needs for prevention interventions with MSM, registered and freelance sex workers and the youth, and care and support services for PLHIV. ₱2,816,000.00 represent cost for systems strengthening such as establishing referral system with Western Visayas Medical Center, strengthening of HIV and AIDS Core Teams, and developing guidelines for admission of clients with the Province's end-referral hospital. The amount also represents procurement of some drugs for STI and opportunistic infections, but much of these are also lodged within respective facility plans. No cost was allocated for antiretroviral therapy. The total amount of the five-year PIPH is ₱1,044,702,724.38; of this, ₱11,466,954.80 (1.30 percent) is for HIV and AIDS.

The HIV and AIDS Investment Plan represent the Province's priorities of being proactive in preventing further transmission of HIV and providing quality services for people living with HIV. It addresses Aklan's vulnerability to HIV and AIDS, which according to the self-assessment tool LGU Vulnerability Index is already at "medium to high risk groups". It emphasizes equal importance to HIV prevention and AIDS treatment, care and support, where prevention include access to voluntary counseling and testing and prophylactics, and where care and support extend to end-life and after-death services.

Provincial and Municipal Health Offices oversee and deliver services, in partnership also with Department of Education in prevention initiatives among in-school youth. DILG and Department of Justice provide assistance to municipalities in developing respective AIDS councils and strategic plans. While DILG monitors the councils, the Provincial Health Office monitors service delivery and utilization. The PHO also teams up with local police and Department of Social Welfare and Development for regulatory functions.

The HIV and AIDS Investment Plan maps resource needs, a framework oriented to results within a holistic design for health development in the province. It does not imply that Aklan has the capacity to already provide for everything. It factors domestic resources to counterpart with potential grants that may be received through APAC. Council operations will be covered by the Province and conduct of activities mobilized through individual agencies' resources will be supported by the Secretariat's coordination. Region VI's Center for Health Development committed funds for surveys and systems strengthening. Pledges were received for technical support services from national agencies (PNAC), NGO (HAIN) and development partners (UNAIDS, UNDP and UNFPA). Wide areas of the Plan are yet to be mobilized.

The potentials of this initiative may be seen on the multi-sectoral engagement process: when local stakeholders and communities themselves define issues and design interventions into the Plan, its ownership is increased, pro-active engagement committed, accountability for establishing local HIV and AIDS responses ensured. In addition to the HIV and AIDS investment Plan, other achievements of APAC include the provision of technical support for Municipal AIDS Councils to develop capacity for policy formulation and planning, regulating compliance of entertainment workers and establishments with health standards, and ensuring the Province's capacity to deliver testing, prophylactics provision, treatment, care and support, end-life and after-death services.

Alignment with the National Response – namely, the National Medium-Term Plan – was assured. The Council is committed to continue in ensuring this alignment in future planning initiatives. This year, the Aklan Provincial AIDS Council is working on the Second Investment Plan for HIV and AIDS, which shall be integrated with the Provincial Investment Plan for Health for 2010 to 2013.

C. *Partnerships with Catholic Institutions for Enhanced HIV Treatment, Care and Support Services*

By: Merceditas Apilado

The psychosocial and spiritual needs of PLHIV have to be addressed by the continuum of care that is provided by a country's health system. Partnerships with faith-based organizations which provide related services are essential for enhancing the comprehensiveness and quality of treatment, care and support services for PLHIV and their affected families. This example of a good practice in partnerships among institutions providing treatment, care and support can be used by government health systems, private health facilities, civil society organizations, faith-based organizations, and PLHIV support groups.

The Problem that was addressed

In countries which have a concentrated HIV epidemic, or one where the prevalence is relatively low, the government health care system may not be prepared to respond

to the wide range of treatment, care and support needs of PLHIV. PLHIV may have specialized needs, such as access to an adequate supply of blood, which need to be addressed.

In a predominantly Catholic country like the Philippines, spiritual care is an essential component of a care and support program for PLHIV and their affected families. Other psycho-social support services which are needed include counseling as well as hospital and home visits.

To address these gaps in the health care system, the HIV and AIDS Ministry of the Camillians in the Philippines initiated and established partnerships with government, other faith-based institutions, civil society organizations, and PLHIV groups. The health facilities and services that are administered by the Camillians were also made available and responsive to the needs of PLHIV and their affected families. The HIV and AIDS Ministry of the Camillians has thus contributed to enhanced care and support services through increased access to spiritual care, psycho-social support, and medical services including adequate blood supply.

Context

With support from the Global Fund, a number of government hospitals have been designated as “treatment hubs” for PLHIV. In Metro Manila, where over 50 percent of the country’s HIV cases have been diagnosed, the three treatment hubs are the San Lazaro Hospital, Research Institute for Tropical Medicine, and the Philippine General Hospital. These hospitals have noted an increase in the number of cases of HIV that need to be attended to.

PLHIV organizations play a very important role in ensuring access to services. The meaningful involvement of people living with HIV (MIPA) is a principle that the country upholds.

It is in this context that the Catholic institution, the Order of the Ministers of the Infirm (known as the “Camillians”), began their HIV and AIDS ministry in the Philippines in 2007. The Catholic Church is generally considered as an influential force in Philippine society. Catholic institutions in the country are also involved in the administration of schools, hospitals, drop-in centers, and other facilities.

History and Process

The Order of the Ministers of the Infirm was established in 1581 by St. Camillus de Lellis, in Italy. Saint Camillus is the patron saint of the sick, and also of physicians and health care workers. It has established its presence in 37 countries throughout the world. The Camillians are engaged in hospital work, community-based health programs, parishes, chaplaincies, polyclinics, leprosaria, and homes for the aged and the sick. When HIV and AIDS emerged as new threats to the health of humanity, the Camillians included HIV in their ministry as well. Camillians in Thailand, Kenya, Namibia and Europe had been in the ministry even before it became a mandate of the Order.

In September 2007, the Camillians in the Philippines initiated a process of dialogue and discussions to plan and develop their Ministry on HIV and AIDS. The Camillians also began to establish partnerships with various organizations, including UNAIDS, treatment hubs, and PLHIV groups.

A member of the Order had been designated as the lead person for the HIV/AIDS Ministry, although the responsibility for the Ministry does not rest with the lead person alone. Capacity building on HIV was thus a cornerstone of the Ministry to ensure that members of the Order could participate actively and meaningfully in the Ministry. All of the 85 college seminarians of the Order had undergone pastoral training on HIV, while 80 percent of the priests and brothers have also been trained. Moreover, the staff members of the health facilities operated by the Order have also undergone training. The Camillians adapted the Training Manual for Pastoral Workers which had been developed by UNAIDS, and which had been endorsed by the Catholic Bishops' Conference of the Philippines.

The Camillians strengthened their partnerships with the San Lazaro Hospital and the Research Institute for Tropical Medicine, where they provide spiritual care and counselling to in-patients. Outpatients and newly-diagnosed PLHIV are also referred to the Ministry by the treatment hubs and by PLHIV support groups such as Pinoy Plus, PAFPI and Babae Plus. Twice a month, the Ministry conducts hospital visits at San Lazaro Hospital to provide accompaniment and opportunities for sharing and fellowship. The Ministry coordinates with the Daughters of Charity, a Catholic congregation that also provides spiritual care to PLHIV.

The Ministry provides spiritual care and support is through the following:

- Spiritual Enrichment, such as Recollections and Fellowship
- Celebration of the Sacraments: Eucharist, Anointing of the Sick and the Sacrament of Reconciliation

The spiritual accompaniment that the Camillians provide is aimed at helping PLHIV to gain a deeper understanding of their inner self and their illness, and to develop a closer relationship with God. In this way, the Ministry hopes to reduce the self-stigmatization that PLHIV may go through as a result of being diagnosed HIV-positive.

In addition to the spiritual and psycho-social needs, the Ministry also responds to medical needs of PLHIV and affected families such as accessing blood units, (particularly for PLHIV who may experience a drop in platelets and thrombocytes). To address this need, the Ministry made use of an existing Memorandum of Agreement (MOA) with the National Kidney and Transplant Institute (NKTi). As stipulated in the MOA, when blood donation campaigns are conducted by the Camillians within their institutions (E.g. among their college seminarians), a percentage of the blood units collected is allocated for referrals from the Ministry. Partner treatment hubs refer patients in need of blood to the HIV/AIDS Ministry, which then assesses the referrals. Those who are considered priority patients are provided with the needed blood units, which is then picked up at the NKTi by representatives from PLHIV support groups and brought to the hospital where the patient is confined.

In addition to providing spiritual and psycho-social support to affected families, the Ministry also provided referrals and medical services to sick and indigent family members of PLHIV through the clinics and hospitals administered by the Order.

Resources Required for the Practice

A defining characteristic of Catholic institutions is the spirituality and altruism which serve as the foundation of their ministry. The essence of Camillian spirituality is "To see Christ in the sick, and to be Christ for the sick."

An essential requirement is the appropriate knowledge, skills and attitudes of the members of the Order, as well as the staff members of the health facilities administered by the Order. This entailed a series of trainings on HIV and pastoral care which the Camillians conducted in partnership with key organizations.

An important factor in the effective provision of care is the designation of a member of the Order as a focal person in charge of the Ministry.

Policies and partnership agreements, such as the Memorandum of Agreement with the National Kidney and Transplant Institute and partnership agreements with San Lazaro Hospital and Research Institute for Tropical Medicine also need to be in place.

Existing infrastructure such as hospitals and clinics administered by the Camillians were also brought into the response to HIV by integrating HIV services into the services provided by these facilities.

The Camillians also mobilized resources for the Ministry from donations and from their own funds.

Impact

The Ministry has been able to provide care and support services to a cumulative total of more than 200 PLHIV for the past two years, and impact evaluation is yet to be carried out. However, feedback from beneficiaries would indicate that the Ministry has contributed to addressing their spiritual and psychosocial needs as well as that of the affected families.

Challenges, critical issues and lessons learnt

While the success of the Ministry is founded on the partnerships that were established, the very process of establishing partnerships had been the foremost challenge for the Camillians. Several attempts to establish the program met with some resistance from various organizations which were hesitant about working with Catholic institutions. Despite the resistance, the Camillians continued their efforts to establish their Ministry, as part of their mission and charism.

Another challenge has been resource mobilization, particularly from government and development partners. The Camillians have been able to mobilise some funds within their own institution and networks, but they see the need to mobilise additional funds from development partners and government in order to continue and expand their Ministry.

Among the lessons learned in carrying out the work of the Ministry are:

- Innovative approaches need to be developed as ministry to PLHIV is different from ministry to people afflicted with other diseases, because of the psychosocial, economic and political dimensions of HIV.
- The Camillians have found deeper meaning in their work as Ministers of the Infirm in facing the challenge of providing care to PLHIV.
- The Camillians have learned to view their Ministry not as the work of an individual or of an institution, but as the work of the Catholic Church, as one Ecclesial community.

D. *Yearn, Learn, and Earn Through "Peertrepreneurship" (YouthLEAP) Kabataang Gabay sa Positibong Pamumuhay (Peers for Positive Living), Iloilo City, Philippines*

By: John Piermont Montilla

Context

Hundreds of street peer educators and other at-risk youth are left without better development endeavours, next level competencies and capacities to sustain their change objectives after serving projects and NGOs once external funding and subsidies ceased. These same peer educators and their peers go back to their previous conditions and return to their service providers with same needs. One way of breaking this cycle is enabling them to earn while honing their capacities in self organizing, income generating and accessing opportunities for quality life.

YouthLEAP is a retention strategy that transitions peer educators into entrepreneurs. It offers peer educators entrepreneurial skills training, provision of start-up capital and access to support facilities for product development, and opportunities for sales/income generation. Income generated from the sales enable peer educators to subsidise their own needs, including peer education efforts. Youth share their responsibility while leading and sustaining behaviour change that empower them and make a difference in the lives of other youth.

In 2006, KGPP started integrating entrepreneurial efforts in its HIV prevention projects. Through the Heal, Empower, Affirm-Reaffirm and Transform (HEART) project, initiated in 2005 with Japanese supporters from the World Youth Peace Summit, street children produced artworks out of their healing therapy and showcased these during the "Street Children Art Festival" held at the World Expo 2005 in Aichi, Japan. The project aimed to help children express their hopes and dreams, and to build a worldwide support network for children living in the streets. KGPP earned Php 200,000 (US\$ 4,337) out of the artworks that were transformed into calendars. However, due to lack of support facilities to sustain the art production, the entrepreneurial component of HIV projects was discontinued. In 2008, the HEART project was revived and KGPP was provided a small grant for the art therapy and "Peertrepreneurship" Venture initiative with support from the International Youth Foundation, through Starbucks Social Entrepreneurs' Fund, and with help from the National Youth Commission and Coca-Cola Foundation.

Description of the Practice

Participants to the "Peertrepreneurship Ventures" were selected based on a set of criteria and have to complete a 40 hours peer education training/mentoring, Served his/her community 240 hours of community outreach and peer education and Recruited at least 100 peers to become rookies (learners) with 80% of them perfected the UNGASS knowledge scores within 6-month of peer education interventions.

Steps in Implementation: The participant also goes through a four-step entrepreneuring competence to become a "peertrepreneur".

STEP 1: YEARN –Youth engagement are facilitated periodically particularly on activities such as (1) dream-building, (2) self-measurement of change, (3) engagement in community dialogue and decision-making processes at all levels (peer-group, family, school, community, Barangay Governance, City, Region), and (4) business planning.

STEP 2: LEARN – are the capacities and continuing training needed to improve knowledge, attitudes, skills and entrepreneurial capacities for product development, business management and basic bookkeeping, customer service and personality development of peertrepreneurs for them to be effective and efficient small-business managers. Learning also bridge adults and youth for guidance and mentoring.

STEP 3: EARN – are the youth’s financial and physical capital through mobilization of individual and group savings, provision of support-facility, employment through remunerative and skills-enhancing product development, income generating activities and sales.

STEP 4: Youth LEAP! – is the celebrative step expressed during YLEAP exhibitions showcasing and sharing youth’s yearning, learning and earning performances and the resulting products they develop for sale during tourism, conferences, fairs and campaign events. Knowledge fairs and trainings are provided during replication phase where successful peer entrepreneurs serve as resource persons and mentors to new enrollees.

Phases of Implementation: For a facilitating agency to start a “Peertrepreneurship” Venture, it is expected to develop minimum of three ventures within one year in one city. Replication to other communities and localities depends on the success of the first year operations.

Phase 1, resourcefulness or the investment phase - Mobilization of multiple fund sources to support youth in running a venture and a start-up capital (knowledge, social, financial) for every venture. All resources shall come from contributed sources. It normally takes 1-2 months to generate the needed capital to run each venture where: 1) support-facility is already in place, 2) business operations per peer ventures are continuing per event and/or per month, and 3) recover capital and at least 20% net income is gained every event.

Phase 2, sustainability phase - Generation of funds from both earned and contributed income to pursue each venture’s financial and social objectives. Divided into two interconnected components- interdependency sub-phase, during which sources shall come from both contributed and earned income leveraged to support a social and financial objective. As earned income increases, contributed income decreases, reaching a leverage point of 50-50 until self-sufficiency is attained. Self-sufficiency is the ability of each venture to generate 100% revenue.

Phase 3, replication phase- The venture will then be replicated to other peer groups/communities utilizing the most successful venture as model for replication. Pool of youth trainers will serve as mentors, trainers and facilitators during training and capacity building for their next-in-line peers, other peer groups and newcomers. Furthermore, when “peertrepreneurs” graduate by reaching their ultimate aspirations (i.e., transitioned to full time schooling/college, job placement, and employment), new peer educators who had satisfied their peer education work would replace them.

Resources Needed: The total cost per peer educator to be successfully transformed into a “peertrepreneur” during the first year of operation is Php5, 000 (US\$108). Three (3) ventures with 60 peers will constitute a total of PhP 300,000 (US\$ 6,506) with the total annual investment costs distributed in three key result areas:

- Youth’s social assets that include community consultations, recruitment and selection, project orientation and press conference.

- Youth's knowledge assets include social entrepreneurship and social values, business management and basic bookkeeping, food preparation, production, safety and quality assurance; operations and maintenance of facilities, equipments and machineries; customer service and personality development and continuing training.
- Youth's financial capital and venture operations include Business Planning and Mobilisation of Savings; and operations of 5 revenue streams: production, sales and distribution, knowledge transfer and training, support-facility center.

Benefits of the Practice

Peer educators earn their own income through engagement in product development, remunerative skills-enhancing yet sustainable income generating opportunities. Individual dividends generate earning comparable to peer educator's monthly stipend, and generate surplus that can subsidize own HIV and STI health needs comparable to donor-supported costs. For some who reduced risk-behaviors, dividends can go to their education-support and subsistence. Peer educators continue generating income and promote their change efforts even after project funding ends, allowing them to be mentors and resource persons for transfer of learning initiative and thus giving chances to next-in-lines to become peer educators

V. Major Challenges and Remedial Actions

With the face of the epidemic changing in the Philippines due to increasing infections among MSM and IDUs- now called people who inject drugs (PWID) in the Philippines - the challenge is in scaling up prevention among these groups, given the policy environment and considering that results of the 2009 IHBSS. The IHBSS report reveals that high knowledge about HIV does not translate to safer behavior. What new strategies can be used? What will work in the Philippine setting with cultural norms that discourage open discussion of sex and sexuality among young people? How should the program respond given the following challenges confronting it?

The table below reports on advancements made on the challenges identified in the 2008 UNGASS Report. It also presents the continuing and emerging challenges and proposed courses of action to meet them.

A. Policy and Political Support- a cross cutting concern

| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|--|---|--|--|
| Republic Act 8504 (National AIDS Act of 1998) and Political Leadership | Policy Statement on Drug Harm Reduction to prevent HIV and AIDS being drafted | The amendment to RA 8504 to make it more relevant to the ever evolving dynamics of HIV prevention in the country is caught in Congress 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. Harmonizing laws governing drug users with RA 8504 programme | Lobby at Congress / invoke House of Representative focal person to liaise fast-tracking of amendments to the RA 8504 Dissemination of amendments to stakeholders |
| | 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. | Lack of political support for the HIV and AIDS response at national and local levels. For example, only the Department of Health has contributed to the PNAC budget and only a small proportion of the budget has been allocated to carry out HIV and AIDS activities at the local levels; | 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. |
| Strengthening PNAC and the PNAC Secretariat | PNAC organizational assessment and organisational development plan in place, but need to be implemented in a speedier manner. | <i>Inadequate mainstreaming of HIV and AIDS in agency programming.</i> Most member-government agencies do not have focal units on HIV and AIDS response, which limits the extent of HIV and AIDS mainstreaming in agency programming and budgeting. | Establishment of focal units on HIV and AIDS within the Member-government agencies that will facilitate mainstreaming of PNAC's programs and activities, ensure budget allocation and institutionalize National response to the epidemic. Identify permanent |

| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|---|---|---|---|
| | <p>The Executive Committee has been organized and has been operational since 2009.</p> <p>PNAC Secretariat: team building conducted and Organizational Development is on-going</p> <p>Additional PNAC Secretariat staff appointed</p> | <p>Agency mandate is not sufficient to generate outputs and outcomes for HIV and AIDS response. PNAC members need technical assistance and guidance on how to identify measurable targets based on their understanding of their mandates, develop a work plan according to their “deliverables”, and monitor and evaluate their performance against these parameters.</p> <p>As a whole, the positioning of PNAC as focal body in negotiation for HIV and AIDS donor-funding is yet to be realized. (2008 PNAC Report)</p> <p><i>Organizational structure and human resource limitations.</i> The Council’s large membership poses a challenge on the speed of decision-making processes.</p> <p>Both the AMTP IV MTR in 2008 and 2006 Capacity Assessment Project or Organization Development (OD)¹³ have noted that the down-sizing of PNAC Secretariat staff, absence of competency-based personnel development program and lack of strategic orientation on the Secretariat functions constraint PNAC’s performance of its role and responsibilities in the National Response to HIV and AIDS. The capacity of most member-agencies in terms of HIV and AIDS advocacy is limited too and more training is needed. (2008 PNAC Report)</p> | <p>representatives - focal units per member organization, starting last quarter of 2009</p> <p>Active partnership of major line agencies with sectoral representatives for effective and efficient implementation of services and interventions (2008 PNAC Report)</p> <p>Collective marketing and promotion of AIDS Medium Term Plan (AMTP) by the PNAC members is highly necessary to ensure harmonization and achievement of HIV and AIDS response at the national and local levels. This is a good way to facilitate the effective utilization of AMTP objectives, strategies, activities and targets by donors, NGOs, CBOs, business sector, government agencies and other stakeholders in HIV and AIDS programming, implementation of interventions, budget allocation, and monitoring and evaluation. (2008 PNAC Report)</p> <p>Improvement of existing structures of the Council and Secretariat through a programmatic approach using a Capacity Development Plan (2008 PNAC Report)</p> |
| <p>Establishing local responses to HIV and AIDS</p> | <p>To date, 32 LGUs have local AIDS Ordinances with corresponding budgetary allocations (although small) and functional LACs that direct and oversee the local response.</p> <p>17 Regional AIDS Assistance Teams (RAATs) established</p> | <p>Instilling good governance at the local level by building capacities of local chief executives and its local partners plays an important role in ensuring a successful HIV response. As commitments may change with the fluid political leadership, continued advocacy and technical support to LGUs (e.g. capacity building in various</p> | <p>PNAC will provide technical support to LGUs in need of guidance and skills on policy development. Through the DILG, the Council will monitor the activities of LGUs on HIV and AIDS to ensure that local response is being carried out</p> <p>In collaboration with DILG,</p> |

¹³ Noted in PNAC, Capacity Assessment Project, 2006:5-7.

| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|---|--|--|---|
| | and being trained .by DILG to help set up/enhance local responses | aspects to establish or sustain local responses) is crucial. | LCP, and LPP-come up with a database of local enactments related to HIV AND AIDS prevention and control and monitor implementation of the same. |
| <p>Financing (Source: 2009 NASA Report) Total AIDS spending from 2007 to 2009 (Figure 3)</p> <p>The bulk of spending is from external sources , the biggest contributors of which are GFATM</p> | <p>The GFATM support accelerated prevention and treatment and care and support activities in 2006 to 2007.</p> <p>The USAID funds supported the systems strengthening.</p> | <p>The 2007-2009 AIDS spending assessment results point to the following concerns:</p> <ul style="list-style-type: none"> • 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 and soon to be developed AMTP V. • the need to effectively and efficiently use available resources <ul style="list-style-type: none"> – Given the uncertainty of continuing funds from external sources and in light of the need to use aid effectively (Paris Declaration 2005), harmonisation 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 <ul style="list-style-type: none"> - 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 | <p>Increase in domestic budget allocation and spending for HIV and AIDS-related programs and interventions with the support of the Executive Branch and the President. This includes making available the Php 20 million approved budget as provided for in RA 8504. The Secretariat will develop a work plan and budget that will serve as basis for financial projections</p> <p>Proactive promotion and marketing of the AMTP among the international donor agencies as parameters for programming and funding assistance. Strengthen advocacy campaign for AMTP to local and international development partners</p> |

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| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|--|--|--|---|
| | | <p>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.</p> <ul style="list-style-type: none"> • 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. | |
| <p>Lack of policy guidelines on: HIV counseling and testing in diagnostic centers for OFWs</p> | <p>A number of policy guidelines have been approved – namely; ARV guidelines, VCT, PEP</p> <p>Many guidelines still need to be written and approved to facilitate institution of interventions specifically among the IDUs and vulnerable sectors like the OFWs.</p> | <p>The country needs to continue efforts for policy guidelines on:</p> <ul style="list-style-type: none"> • IDU harm reduction • Proper HIV testing protocol for OFWs (pre and post test counseling at the diagnostics clinic level) • Philhealth’s Outpatient HIV and AIDS benefit | <p>The dialogue between the anti drug enforcers and the HIV and AIDS sector has been ongoing for two years. A draft policy guideline on drug harm reduction has been developed in February 2010 and is expected to be firmed up within this year.</p> |
| <p>Strengthening monitoring of human rights</p> | <p>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.</p> <p>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.</p> | <ul style="list-style-type: none"> • Continues to be a challenge in the coming years; <p>Absence of pro-active enforcement mechanisms to promote and protect human rights, and provide legal assistance and access to justice mechanisms for people living with HIV, most-at-risk populations, and vulnerable populations</p> | <p>Continue advocacy work to concerned authorities on this matter</p> |
| <p>Setting up and strengthening M & E System</p> | <p>National M & E System development completed and pilot-</p> | <ul style="list-style-type: none"> • Nationwide, multisectoral, multi- organisational implementation of the National M&E System; | <p>Enhancement and utilization of the M & E</p> |

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| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|---|---|--|--|
| | <p>tested;</p> <ul style="list-style-type: none"> Developing and maintaining data bases for MARPs and VPs for more effective policy making and programming and HIV and AIDS | <ul style="list-style-type: none"> 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 | <p>system</p> <p>Identify and appoint M & E focal points from each Member agency. Baselines, targets and performance indicators will be defined and capacity building on operating and using M & E systems will be conducted</p> |
| Civil society involvement and participation | <ul style="list-style-type: none"> CSO participation in UA process CSO participation in strategic planning CSO participation in operational planning and budgeting of AMTP 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 | Continue engagement of CSOs through advocacy, capacity building and funding |

B. Prevention

| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|--|---|---|---|
| Strengthening HIV and AIDS outreach and education; | <p>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, and needle and syringe distribution to IDUs.</p> <ul style="list-style-type: none"> There is an ongoing HIV and AIDS prevention for uniformed personnel, particularly in the Philippines (AFP). Armed Forces of the | <p>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.</p> <ul style="list-style-type: none"> HIV and AIDS education in schools is still very limited; teachers not yet trained in life skills education on HIV and AIDS. As of 2009, there is no data available as to the number of elementary and secondary schools in the country with HIV integration in the curriculum. | <p>Scale up prevention among particular MARPs but particularly in areas where contribution to the infection prevalence are high</p> <p>The education agencies like DepEd, CHED and TESDA should mainstream HIV and AIDS in their respective curricula</p> <p>Capacity building of teachers</p> <p>The national response need to establish an HIV education programme for the general population</p> |
| Strengthening of correct and consistent condom | 100% Condom Use Programme (CUP) have been | The programme needs to intensify promotion of correct and consistent | Procure condoms, lubricants, needles |

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| Issues | Progress made in 2008-2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|--|---|---|--|
| use and ensuring supplies are available; | implemented in 15 LGUs; Condom promotion and distribution in 29 GFATM project sites. | condom use among the MARPs, vulnerable and general population. Sustaining 100% CUP in LGUs where it had been implemented; • Introduction and acceptance of 100% CUP by other LGUs | and syringes, and IEC materials and ensure availability and access whenever and wherever needed; Advocacy to LGUs on 100% CUP |
| 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 | |
| Institutionalising AIDS in the workplace Programmes | Limited AIDS in the workplace programmes; | No HIV and AIDS policy and programs in government workplaces; 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, treatment, care and support have scaled up due to GFATM support, more efforts still need to be undertaken, coordinated and sustained at the national and local levels by the national government, the local government units, civil society and other stakeholders | |

C. Treatment, Care and Support

| Issues | Progress made in 2008 – 2009 | Continuing/Emerging challenges in the years to come | Recommendation/Proposed Course of Action |
|---|---|--|---|
| Sustainable access of PLHIV and affected families to treatment, care and support. | Significant improvement – from 11 treatment hubs across the country , there are now 13 referral hospitals • 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 | Strengthen health system and communities Increase resources and collaboration among service providers to ensure efficient delivery of services to PLWHAs to widen coverage |
| Impact Mitigation | Very limited to Nil services | Will be a continuing challenge | Include as agenda for the AMTP 5 |

D. Health Systems Strengthening

| Issues | Progress made in 2008 – 2009 | Continuing/Emerging challenges in the years to come | Recommendation/ Proposed Course of Action |
|----------------|--|--|--|
| Human Resource | Capacity building of health service providers: physicians, nurses, medical technologists, social | Economic migration of health professionals overseas; Fast turnover of trained health Inadequate funds for capacity | Increase health financing; Implement provisions of Human Resources for Health Plan such as establishment of a |

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| | | | |
|---------------------------------|---|---|--|
| | workers and community support groups on HIV and AIDS | building | mechanism to manage HRH migration and retain HRH in the country. |
| Service Delivery Structures | City/municipal health offices and hospitals trained on various skills on STI/HIV and AIDS | Equipping the health service delivery structures at all levels to manage HIV and AIDS | Capacity building |
| Health Products and Logistics | ARV and OI drugs and condoms, lubricants, needles and syringes, STI drugs and limited units of diagnostic equipment and reagents access and availability made possible by augmentation from GF AIDS Rounds 3, 5 and 6 projects; | The number of PLHIVs that would need ARV and OI drugs cases in the future will soon overtake the projected requirement procured through GF AIDS projects. Lack of diagnostics | Increase financing from domestic sources and external donors |
| Information System | SSESS, AIDS Registry, IHBSS, CRIS, and National AIDS M & E system in place | Slow roll out of M & E System | Enhancement and utilization of the M & E system Hasten roll out to health delivery structures downstream |
| Community Systems Strengthening | CSO, and communities participating | Difficulty in enabling ex-Metro Manila CSOs' participation due to fund limitation | Provide funding for participation of CSOs outside of Metro Manila Continue engagement of CSOs through advocacy, capacity building. |
| Health Financing | | As pointed out in various National AIDS Spending Assessment (NASA) Reports (from 2005- 2006 and 2007-2009), there is a general decline in AIDS spending in recent years. RA 8504 mandates that PhP 20 million be allocated to the operation of the council and its secretariat through the DOH, however, findings of the AMTP IV MTR, showed that only PhP 9 million was made available for its operations. Earlier performance and low budget utilization were factors attributed to its current allocation. | PNAC should do financial projections to determine funding requirements for programs by line category and administrative operations and serve as sound basis for budget allocation. |
| Leadership and Governance | | Political champions for HIV advocacy are few. Coupled with this scenario is the frequent change in leadership resulting in non-continuation or shift of commitment as well as emphasis of support to policies and programs. Denial by some political leaders of presence of HIV Stigma and discrimination still present even in some "enlightened" LGUs | Continue advocacy to policy and decision makers |

VI. Support from the Country's Development Partners

Key support from the country's development partners range from service delivery interventions to technical assistance. Bilateral agencies generally supported activities on prevention (communication and behavior change, programs for MARPs, STI management), surveillance, monitoring and evaluation, training, and advocacy.

Global Fund (GF) assistance is geared towards service delivery. Specifically, GF provided support to programs for MARPs namely: men having sex with men (MSM), female sex workers (FSW), and injecting drug users (IDUs). Notably, these are interventions that government cannot provide because of policy limitations (prostitution and substance abuse are illegal). Hence, activities for MARPs are usually carried out by NGOs. In addition, GF also supported blood safety, anti-retroviral drugs, prophylaxis, and treatment of OIs. Notably, assistance from Global Fund Round 3 through the *Accelerating STI and HIV prevention and care through intensified delivery of services to vulnerable groups and people living with HIV in strategic areas in the Philippines* project ended in 2009. Meanwhile, the Round 5 project *Upscaling the national response to HIV/AIDS through the delivery of services and information to populations at risk and people living with HIV/AIDS* will end in 2010 and the Round 6 project *Scaling Up HIV Prevention, Treatment, Care and Support Through Enhanced Voluntary Counseling and Testing and Improved Blood Safety Strategies* is on-going and will be completed in 2012.

On the other hand, the UN's most recent joint program *Promoting Leadership and Mitigating the Negative Impacts of AIDS* supported MSM, social services, enabling environment for local policy makers, research, and migrant workers. Multilateral agencies (ADB and WB) supported technical assistance and Packard International provided support to prevention activities.

Table 6: Support from Development Partners
(based on 2009 NASA Report)

| Function | Bilateral | Global Fund | UN Agencies | Other Int'l. |
|---------------------------------------|-----------|-------------|-------------|--------------|
| Prevention | ✓ | ✓ | ✓ | ✓ |
| Care and Tx | | ✓ | | |
| Orphans and Vulnerable Children (OVC) | | | ✓ | |
| Programme Management | ✓ | ✓ | ✓ | |
| Human Resources | ✓ | ✓ | | |
| Social Protection | | | ✓ | |
| Enabling Environment | ✓ | | ✓ | |
| Research | | ✓ | ✓ | |

VII. Monitoring and Evaluation Environment

A vital component of Program Support is the availability of accurate, timely and accessible data to inform program planning. PNAC, being the overall manager of the national response is also responsible for its monitoring and evaluation through the National HIV and AIDS Monitoring and Evaluation System. The on-going institutionalisation of the system at various levels is marked by challenges- be it technological, structural, human resource and sometimes political- at almost every level.

Among the essential tasks of Monitoring and Evaluation is the building of evidence base to inform program planning. Part of this evidence base is the geographic vulnerability mapping and IHBSS.

Research is also essential in building evidences. A separate “HIV and AIDS Research Agenda 2005-2010” was developed as a basis for future research activities.

Assisting PNAC in the monitoring of various aspects of AIDS prevention and control are the following agencies:

- DOH reports the output of the health sector to PNAC. Since 1987, the DOH through the National Epidemiology Center (NEC) has put in place both passive and active surveillance systems in order to keep track of the epidemic. NEC manages *AIDSWATCH*, the HIV monitoring system, which includes the AIDS Registry (passive) and systematic surveillance or *IHBSS* is carried out every two years with MARPs (SW, MSM and IDU). The DOH-NEC collects and validates STI and HIV reports from social hygiene clinics and hospitals through the *Sentinel STI Etiologic Surveillance System (SSESS)* - set up in December 2001 and made operational in 2003. Since some sexually transmitted infections (STI) are considered as co-factors for HIV transmission, monitoring STI trends guide program intervention to prevent transmission of HIV.
- The government line agencies managing the other aspects of HIV prevention (education, labor and social welfare and services) are also responsible for reporting to PNAC.
- NEDA tracks the NASA and analyzes annual AIDS spending to inform the national response
- Health Action Information Network (HAIN) is the NGO tasked by PNAC to manage the data coming from the civil society sector and reports them to the National AIDS Monitoring and Evaluation System.

Every five years there is also HIV related demographic household survey, but it does not include HIV testing. Both the MARPs surveillance and general population demographic survey contain sexual and drug use behavior surveys.

M & E Challenges

While there are many challenges to the National HIV and AIDS Monitoring and Evaluation System, the most urgent need is to enhance data collection and data quality as well as the Institutional arrangements both at the national and local levels.

The challenges as listed are based on the recommended 12 components of a functional M&E System.

1. *Organizational Structures with M&E functions*

- At present, M&E advisory groups are convened on an ad-hoc capacity, (e.g., UNGASS Core Team, Surveillance Technical Advisory Group, HIV Estimation Core Group), thus most of the time, these are not officially organized and have no established terms or reference. There is need, therefore to formalize these advisory committees and establish corresponding terms of reference and timelines.

- NEC-DOH is responsible for routine health information but this is limited only to the AIDS registry. It also conducts IHBSS, SSESS, Rapid Assessments of Vulnerability (RAV), special investigations, projections, among others. The HIV Registry is limited to recording new cases only. It however, does not capture start of ART, and AIDS deaths (causes of deaths) among those newly diagnosed. . NASPCP on the other hand, routinely collects program indicators from SHCs.

- Member government agencies of PNAC should routinely monitor accomplishments of and other critical information from their respective constituencies. (e.g., DILG should collect data from LGUs; DepEd should collect data from all schools, DOLE from workplaces, etc, and report these to PNAC)

- Need to formalize and strengthen partnerships to plan, coordinate and manage the M&E system

2. *Human Resources for M&E*

- Need to update human resource gaps that were identified in the AMTP4 and National Research Agenda and at all levels and conduct M&E capacity assessment and subsequently develop and implement a M&E capacity building plan,

3. *Need to finalize the National Multi-sectoral M&E Plan*

4. *Need to mobilize resources for the National M&E Plan implementation and roll out to local government units.*

5. *Need to establish a regular promotion of M&E among policy-makers, program managers, program staff and other stakeholders.*

Annexes

1. Annex 1: NCPI questionnaires A and B
2. Annex 2: Survey response details
3. Annex 3: Contribution of the Global Fund AIDS Grants

Annex 1: National Composite Policy Index (NCPI) questionnaire

Part A

[to be administered to government officials]

1. Has the country developed a national multi-sectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes No Not Applicable (N/A)

Period covered: *[write in]*

IF NO or NOT APPLICABLE, briefly explain why.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1 How long has the country had a multisectoral strategy?

Number of Years: *[write in]*

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors Included in strategy

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]* Yes No Yes No

Appendix 4

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry. 93

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

1.3 Does the multi-sectoral strategy address the following target populations, settings and crosscutting issues?

Target populations

a. Women and girls

b. Young women/young men

c. Injecting drug users

d. Men who have sex with men

e. Sex workers

f. Orphans and other vulnerable children

g. Other specific vulnerable subpopulations*

Settings

h. Workplace

i. Schools

j. Prisons

Cross-cutting issues

k. HIV and poverty

l. Human rights protection

m. Involvement of people living with HIV

n. Addressing stigma and discrimination

o. Gender empowerment and/or gender equality

1.4 Were target populations identified through a needs assessment?

Yes No

IF YES, when was this needs assessment conducted?

Year: *[write in]*

Appendix 4

* Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

[write in]

1.6 Does the multisectoral strategy include an operational plan?

Yes No

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals? Yes No

b. Clear targets or milestones? Yes No

c. Detailed costs for each programmatic area? Yes No

d. An indication of funding sources to support programme implementation? Yes No

e. A monitoring and evaluation framework? Yes No

1.8 Has the country ensured “full involvement and participation” of civil society* in the development of the multi-sectoral strategy?

Active involvement Moderate involvement No involvement

IF active involvement, briefly explain how this was organised:

Appendix 4

* Civil society includes among others: networks of people living with HIV; women’s organizations; young people’s organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multi-sectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multi-sectoral strategy?

Yes, all partners Yes, some partners No

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment/UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes No N/A

2.1 **IF YES**, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan Yes No N/A

b. Common Country Assessment / UN Development Assistance Framework Yes No N/A

c. Poverty Reduction Strategy Yes No N/A

d. Sector-wide approach Yes No N/A

e. Other: [write in] Yes No N/A

2.2 **IF YES**, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)

HIV prevention Yes No

Treatment for opportunistic infections Yes No

Antiretroviral treatment Yes No

Care and support (including social security or other schemes) Yes No

HIV impact alleviation Yes No

Reduction of *gender* inequalities as they relate to HIV prevention/treatment, care and/or support

Yes No

Reduction of *income* inequalities as they relate to HIV prevention/treatment, care and/or support

Yes No

Reduction of stigma and discrimination Yes No

Women's economic empowerment (e.g. access to credit, access to land, training) Yes No

Other: [write in] Yes No

3. Has the country evaluated the impact of HIV on its socioeconomic 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 for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)? Yes No

4.1 **IF YES**, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication Yes No

Condom provision Yes No

HIV testing and counselling Yes No

Sexually transmitted infection services Yes No

Antiretroviral treatment Yes No

Care and support Yes No

Others: [write in] Yes No

If HIV testing and counselling is provided to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g. indicate if HIV testing is voluntary or mandatory etc):

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes No

5.1 **IF YES**, for which subpopulations?

- a. Women Yes No
- b. Young people Yes No
- c. Injecting drug users Yes No
- d. Men who have sex with men Yes No
- e. Sex Workers Yes No
- f. Prison inmates Yes No
- g. Migrants/mobile populations Yes No
- h. Other: *[write in]* Yes No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented: Briefly comment on the degree to which these laws are currently implemented:

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations? Yes No

6.1 **IF YES**, for which subpopulations?

- a. Women Yes No
- b. Young people Yes No
- c. Injecting drug users Yes No
- d. Men who have sex with men Yes No
- e. Sex Workers Yes No
- f. Prison inmates Yes No
- g. Migrants/mobile populations Yes No
- h. Other: *[write in]* Yes No

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

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006? Yes No

7.1 Have the national strategy and national HIV budget been revised accordingly? Yes No

7.2 Have the estimates of the size of the main target populations been updated? Yes No

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

Estimates of current and future needs Estimates of current needs only No

7.4 Is HIV 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 groups? Yes No

IF YES, for which population groups?

Briefly explain how this information is used:

(c) Is coverage monitored by geographical area? Yes No

IF YES, at which geographical levels (provincial, district, other)?

Briefly explain how this information is used:

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs? **Yes No**

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

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

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums 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 recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes No

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 **IF YES**, when was it created? Year: *[write in]*

2.2 **IF YES**, who is the Chair? Name: Position/Title: *[write in]*

2.3 **IF YES**, does the national multisectoral AIDS coordination body: have terms of reference? **Yes No**

have active government leadership and participation? **Yes No**

have a defined membership?

IF YES, how many members? *[write in]* include civil society representatives?

IF YES, how many? *[write in]* include people living with HIV?

IF YES, how many? *[write in]* include the private sector?

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 coordination to avoid parallel funding and duplication of effort in programming and reporting?

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/ programmes?

Yes No N/A

IF YES, briefly describe the main achievements:

Briefly describe the main challenges:

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

Percentage: *[write in]*

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs Yes No

Technical guidance Yes No

Procurement and distribution of drugs or other supplies Yes No

Coordination with other implementing partners Yes No

Capacity-building Yes No

Other: *[write in]* Yes No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies? Yes No

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

Yes No

IF YES, name and describe how the policies / laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Overall, how would you rate the *political support* for the HIV programme in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

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

Yes No N/A

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

Check for key message explicitly promoted

a. Be sexually abstinent

b. Delay sexual debut

c. Be faithful

d. Reduce the number of sexual partners

e. Use condoms consistently

f. Engage in safe(r) sex

g. Avoid commercial sex

h. Abstain from injecting drugs

i. Use clean needles and syringes

j. Fight against violence against women

k. Greater acceptance and involvement of people living with HIV

l. Greater involvement of men in reproductive health programmes

m. Males to get circumcised under medical supervision

n. Know your HIV status

o. Prevent mother-to-child transmission of HIV

Other: *[write in]*

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media? Yes No

2. Does the country have a policy or strategy promoting HIV-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 most-at-risk or other vulnerable sub-populations*? Yes No

IF NO, briefly explain:

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

- Check which specific populations and elements are included in the policy/strategy
- IDU* MSM**
 - Sex workers
 - Clients of sex workers
 - Prison inmates
 - Other populations* [write in]

Targeted information on risk reduction and HIV education

Stigma and discrimination reduction

Condom promotion

HIV testing and counselling

Reproductive health, including sexually transmitted infections prevention and treatment

Vulnerability reduction (e.g. income generation) N/A N/A N/A N/A

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 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

4. Has the country identified specific needs for HIV prevention programmes? Yes No

IF YES, how were these specific needs determined?

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

4.1 To what extent has HIV prevention been implemented?

HIV prevention component The majority of people in need have access

Blood safety Agree Don't Agree N/A

Universal precautions in health care settings Agree Don't Agree N/A

Prevention of mother-to-child transmission of HIV Agree Don't Agree N/A

IEC* on risk reduction Agree Don't Agree N/A

IEC* on stigma and discrimination reduction Agree Don't Agree N/A

Condom promotion Agree Don't Agree N/A

HIV testing and counselling Agree Don't Agree N/A

Harm reduction for injecting drug users Agree Don't Agree N/A

Risk reduction for men who have sex with men Agree Don't Agree N/A

Risk reduction for sex workers Agree Don't Agree N/A

Reproductive health services including sexually transmitted infections prevention and treatment Agree Don't Agree N/A

School-based HIV education for young people Agree Don't Agree N/A
HIV prevention for out-of-school young people Agree Don't Agree N/A
HIV prevention in the workplace Agree Don't Agree N/A
Other: *[write in]* Agree Don't Agree N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

1. Does the country have a policy or strategy to promote comprehensive HIV 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 address barriers for women? Yes No

2.1 **IF YES**, does it address barriers for most-at-risk populations? Yes No

2. Has the country identified the specific needs for HIV treatment, care and support services? Yes No

IF YES, how were these determined?

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

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service The majority of people in need have access

Antiretroviral therapy Agree Don't Agree N/A

Nutritional care Agree Don't Agree N/A

Paediatric AIDS treatment Agree Don't Agree N/A

Sexually transmitted infection management Agree Don't Agree N/A

Psychosocial support for people living with HIV and their families

Agree Don't Agree N/A

Home-based care Agree Don't Agree N/A

Palliative care and treatment of common

HIV-related infections

Agree Don't Agree N/A

HIV testing and counselling for TB patients Agree Don't Agree N/A

TB screening for HIV-infected people Agree Don't Agree N/A

TB preventive therapy for HIV-infected people Agree Don't Agree N/A

TB infection control in HIV treatment and care facilities Agree Don't Agree N/A

Cotrimoxazole prophylaxis in HIV-infected people Agree Don't Agree N/A

Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) Agree Don't Agree N/A

HIV treatment services in the workplace or treatment referral systems through the workplace

Agree Don't Agree N/A

HIV care and support in the workplace (including alternative working arrangements) Agree Don't Agree N/A

Other: *[write in]* Agree Don't Agree N/A

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

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

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children? Yes No N/A

5.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country? Yes No

5.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes No

5.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions? Yes No

IF YES, what percentage of orphans and vulnerable children is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan? Yes In progress No

IF NO, briefly describe the challenges:

1.1 **IF YES**, years covered: *[write in]*

1.2 **IF YES**, was the M&E plan endorsed by key partners in M&E? Yes No

1.3 **IF YES**, was the M&E plan developed in consultation with civil society, including people living with HIV? Yes No

1.4 **IF YES**, 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

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include? a data collection strategy

IF YES, does it address:

routine programme monitoring

behavioural surveys

HIV surveillance

Evaluation / research studies

a well-defined standardised set of indicators Yes No

guidelines on tools for data collection Yes No

a strategy for assessing data quality (i.e., validity, reliability) Yes No

a data analysis strategy Yes No

a data dissemination and use strategy Yes No

3. Is there a budget for implementation of the M&E plan? Yes In progress No

3.1 **IF YES**, what percentage of the total HIV programme funding is budgeted for M&E activities? % *[write in]*

3.2 **IF YES**, has *full* funding been secured? Yes No

IF NO, briefly describe the challenges:

3.3 **IF YES**, are M&E expenditures being monitored? Yes No

4. Are M&E priorities determined through a national M&E system assessment? Yes No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit? Yes In progress No

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

5.1 **IF YES**, is the national M&E Unit based in the National AIDS Commission (or equivalent)? Yes No

in the Ministry of Health? Yes No

Elsewhere? *[write in]* Yes No

5.2 **IF YES**, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:

Position: *[write in]* Full time / Part time? Since when?:

Position: *[write in]* Full time / Part time? Since when?:

[Add as many as needed]

Number of temporary staff:

Position: *[write in]* Full time / Part time? Since when?:

Position: *[write in]* Full time / Part time? Since when?:

[Add as many as needed]

5.3 **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 for inclusion in the national M&E system?

Yes No

IF YES, briefly describe the data-sharing mechanisms:

What are the major challenges?

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities? No Yes, but meets irregularly Yes, meets regularly

6.1 Does it include representation from civil society? Yes No

IF YES, briefly describe who the representatives from civil society are and what their role is:

7. Is there a central national database with HIV- related data? Yes No

7.1 **IF YES**, briefly describe the national database and who manages it *[write in]*

7.2 **IF YES**, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above

b. Yes, but only some of the above: *[write in]*

c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level Yes No

At subnational level

IF YES, at what level(s)? *[write in]* Yes No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level;*

and data are analyzed and used at different levels)

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data? Yes No

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?: Low High 0 1 2 3 4 5

Provide a specific example:

What are the main challenges, if any?

9.2 for resource allocation?: Low High 0 1 2 3 4 5

Provide a specific example:

What are the main challenges, if any?

9.3 for programme improvement?: Low High 0 1 2 3 4 5

Provide a specific example:

What are the main challenges, if any?

10. Is there a plan for increasing human capacity in M&E at national, sub-national and service-delivery levels?: a. Yes, at all levels

b. Yes, but only addressing some levels: *[write in]*

c. No

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

At national level? Yes No

IF YES, Number trained: *[write in]*

At subnational level? Yes No

IF YES, Number trained: *[write in]*

At service delivery level including civil society? Yes No

IF YES, Number trained: *[write in]*

10.2 Were other M&E capacity-building activities conducted other than training? Yes No

IF YES, describe what types of activities: *[write in]*

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009? 2009

Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

Part B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.) Yes No

1.1 **IF YES**, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision: *[write in]*

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations? Yes No

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

- a. Women Yes No
- b. Young people Yes No
- c. Injecting drug users Yes No
- d. Men who have sex with men Yes No
- e. Sex Workers Yes No
- f. Prison inmates Yes No
- g. Migrants/mobile populations Yes No
- h. Other: *[write in]* Yes No

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

Briefly describe the content of these laws:

Briefly comment on the degree to which they are currently implemented:

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations? Yes No

3.1 **IF YES**, for which subpopulations?

- a. Women Yes No
- b. Young people Yes No
- c. Injecting drug users Yes No
- d. Men who have sex with men Yes No
- e. Sex Workers Yes No
- f. Prison inmates Yes No
- g. Migrants/mobile populations Yes No
- h. Other: *[write in]* Yes No

IF YES, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy? Yes No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations? Yes No

IF YES, briefly describe this mechanism:

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation? Yes No

IF YES, describe some examples:

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

- a. HIV prevention services Yes No

b. Antiretroviral 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 and include information on any restrictions or barriers to access for different populations:

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support? **Yes No**

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support 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 and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes No

IF YES, briefly describe the content of this policy:

9.1 **IF YES**, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations? **Yes No**

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

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 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 including people living with HIV? **Yes No**

IF YES, describe the approach and effectiveness of this review committee:

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-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 compliance with human rights standards in the context of HIV efforts **Yes No**

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

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV 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 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 in place to reduce HIV-related stigma and discrimination?
Yes No

IF YES, what types of programmes?

Media Yes No

School education Yes No

Personalities regularly speaking out Yes No

Other: *[write in]* Yes No

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009? 2009 Very poor
Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?
Low High 0 1 2 3 4 5

Comments and examples:

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)? Low High 0 1 2 3 4 5

Comments and examples:

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in
a. the national AIDS strategy? Low High 0 1 2 3 4 5
b. the national AIDS budget? Low High 0 1 2 3 4 5
c. national AIDS reports? Low High 0 1 2 3 4 5

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

Comments and examples:

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?
a. developing the national M&E plan? Low High 0 1 2 3 4 5

b. participating in the national M&E committee / working group responsible for coordination of M&E activities? Low High 0 1 2 3 4 5

c. M&E efforts at local level? Low High 0 1 2 3 4 5

Comments and examples:

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)? Low High 0 1 2 3 4 5

Comments and examples:

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

Comments and examples:

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

Prevention for youth <25% 25-50% 51-75% >75%

Prevention for most-at-risk-populations

- Injecting drug users <25% 25-50% 51-75% >75%

- Men who have sex with men <25% 25-50% 51-75% >75%

- Sex workers <25% 25-50% 51-75% >75%

Testing and Counselling <25% 25-50% 51-75% >75%

Reduction of Stigma and Discrimination <25% 25-50% 51-75% >75%

Clinical services (ART/OI)* <25% 25-50% 51-75% >75%

Home-based care <25% 25-50% 51-75% >75%

Programmes for OVC** <25% 25-50% 51-75% >75%

*ART = Antiretroviral Therapy; OI=Opportunistic infections

**OVC = Orphans and other vulnerable children

Overall, how would you rate the efforts to increase *civil society participation* in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

1. Has the country identified the specific needs for HIV prevention programmes? Yes
No

IF YES, how were these specific needs determined?

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

1.1 To what extent has HIV prevention been implemented?

HIV prevention component The majority of people in need have access

Blood safety Agree Don't Agree N/A

Universal precautions in health care settings Agree Don't Agree N/A

Prevention of mother-to-child transmission of HIV Agree Don't Agree N/A

IEC* on risk reduction Agree Don't Agree N/A

IEC* on stigma and discrimination reduction Agree Don't Agree N/A

Condom promotion Agree Don't Agree N/A

HIV testing and counselling Agree Don't Agree N/A

Harm reduction for injecting drug users Agree Don't Agree N/A

Risk reduction for men who have sex with men Agree Don't Agree N/A

Risk reduction for sex workers Agree Don't Agree N/A

Reproductive health services including sexually transmitted infections prevention and treatment Agree Don't Agree N/A

School-based HIV education for young people Agree Don't Agree N/A

HIV Prevention for out-of-school young people Agree Don't Agree N/A

HIV prevention in the workplace Agree Don't Agree N/A

Other: *[write in]* Agree Don't Agree N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

1. Has the country identified the specific needs for HIV treatment, care and support services? Yes No

IF YES, how were these specific needs determined?

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

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service The majority of people in need have access

Antiretroviral therapy Agree Don't Agree N/A

Nutritional care Agree Don't Agree N/A

Paediatric AIDS treatment Agree Don't Agree N/A

Sexually transmitted infection management Agree Don't Agree N/A

Psychosocial support for people living with HIV and their families

Agree Don't Agree N/A

Home-based care Agree Don't Agree N/A

Palliative care and treatment of common HIV-related infections Agree Don't Agree N/A

HIV testing and counselling for TB patients Agree Don't Agree N/A

TB screening for HIV-infected people Agree Don't Agree N/A

TB preventive therapy for HIV-infected people Agree Don't Agree N/A

TB infection control in HIV treatment and care facilities

Agree Don't Agree N/A

Cotrimoxazole prophylaxis in HIV-infected people Agree Don't Agree N/A

Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) Agree Don't Agree N/A

HIV treatment services in the workplace or treatment referral systems through the workplace

Agree Don't Agree N/A

HIV care and support in the workplace (including alternative working arrangements)

Agree Don't Agree N/A

Other programmes: *[write in]* Agree Don't Agree N/A

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009? 2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children? Yes No N/A

2.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country? Yes No

2.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes No

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2.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions? **Yes No**

IF YES, what percentage of orphans and vulnerable children is being reached? % *[write in]*

Overall, how would you rate the efforts to *meet the HIV-related needs* of orphans and other vulnerable children in 2009? 2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

Annex 2: Survey Response Details

Survey Response Details

Response Information

Started: 3/4/2010 2:09:18 AM

Completed: 3/25/2010 3:35:30 AM

Last Edited: 3/26/2010 1:39:43 AM

Total Time: 21.01:26:12.1330000

User Information

Username: ce_PH

Email:

Response Details

Page 1

1) Country

Philippines (0)

2) Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Jessie F. Fantone MD M&E Officer, Philippine National AIDS Council Secretariat

3) Postal address:

Philippine National AIDS Secretariat, 3rd floor, Bldg 15, Dept of Health, Sta Cruz Manila, Philippines

4) Telephone:

Please include country code

(63)(2) 7430512 Mobile: (63)0919-9332348

5) Fax:

Please include country code

63-2-7438301 loc 2551

6) E-mail:

fantonej@ymail.com

7) Date of submission:

Please enter in DD/MM/YYYY format

24/03/2010

Page 3

8) Describe the process used for NCPI data gathering and validation:

NCPI-A: NCPI-A questionnaires were reproduced and individually delivered to all government PNAC members in the 1st week of November 2009 with a cover letter requesting their cooperation in completing the forms. Due to the length of the questionnaire, the government agencies were given a month to complete the questionnaire. They were required to inform the secretariat when they completed the questionnaire, for pick-up by the secretariat.

Submission was extended up to February of 2010 due to the poor response and return of questionnaires. Eventually, the core team decided to conduct a workshop similar to the NCPI-B to gather the government representatives in one venue and once and for all complete the NCPI-A. This was conducted on February 23, 2010. A vetting workshop for the draft report was conducted on March 18, 2010 with 47 participants in attendance. Stakeholders were shown the draft report and indicator data. Questions on the draft were answered and the draft report was made available to all stakeholders by providing them with the username and password for viewing the online data entry tool. This allowed interactive comments and suggestions for changes from all stakeholders involved in preparing the report. For NCPI-B, a shorter process was involved due to the immediate conduct of a workshop for civil society organizations. This was done on February 4, 2009 with 24 representatives from various

CSOs and bilateral organizations in attendance. All the questions of the NCPI-B were answered in plenary and a consensus response was produced at the end of the workshop. The same CSO representatives were also present in the Vetting Forum.

9) Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

In both workshops, a consensus was reached in items that required a single answer by votation following the rule that the item with the most votes wins. Dissenting answers or opinions were recorded and were included in the remarks.

10) Highlight concerns -if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

An observation from the NCPI-A for government officials revealed their general inadequate knowledge of the country response unlike the CSOs responses. This also explained their difficulty in answering and returning questionnaires. It was also noted that during the NCPI-A workshop, representatives who were not aware of some issues relied on the responses of these representatives who were more knowledgeable of the issue e.g. Treatment, Care and Support. There were also areas, like prevention, wherein the participants cited numerous improvements and achievements from the previous report yet gave an over-all lower rating.

11) NCPI - PART A [to be administered to government officials]

| Organization | Names/Positions | Respondents to Part A [Indicate which parts each respondent was queried on] |
|--|------------------------------|---|
| Respondent 1 Philippine National AIDS Council Secretariat | Ferchito L. Avelino/Director | A.I, A.II, A.III, A.IV, A.V |

12)

| Organization | Names/Positions | Respondents to Part A [Indicate which parts each respondent was queried on] |
|---|-------------------------------------|---|
| Respondent 2 Dept. of Labor | Pureza Fontelera/Program Officer | A.I, A.II, A.III, A.IV, A.V |
| Respondent 3 Dept. of Health | Joel Atienza/NASPCP Program Officer | A.I, A.II, A.III, A.IV, A.V |
| Respondent 4 Dept. of Tourism | Ma. Amparo Cabrera/Medical Officer | A.I, A.II, A.III, A.IV, A.V |
| Respondent 5 Dept. of Interior and Local Government | Cesar Montances/PNAC Rep | A.I, A.II, A.III, A.IV, A.V |
| Respondent 6 Dept. of Foreign Affairs | Evan P. Garcia/Asst. Secretary | A.I, A.III |
| Respondent 7 National Economic Development Authority | Arlene Ruiz/NEDA Rep | A.I, A.II, A.III, A.IV, A.V |
| Respondent 8 Philippine Information Agency | Lyndon Plantilla/PIA Rep | A.I, A.II, A.III, A.IV, A.V |
| Respondent 9 Dept of Justice | Precoius Fojas/DOJ Rep | A.I, A.II |
| Respondent 10 Dept of Social Welfare and Development | Marilyn Moral/Project Officer | A.I, A.II, A.III, A.IV, A.V |
| Respondent 11 | | |
| Respondent 12 | | |
| Respondent 13 | | |
| Respondent 14 | | |
| Respondent 15 | | |
| Respondent 16 | | |
| Respondent 17 | | |
| Respondent 18 | | |
| Respondent 19 | | |
| Respondent 20 | | |
| Respondent 21 | | |
| Respondent 22 | | |
| Respondent 23 | | |
| Respondent 24 | | |
| Respondent 25 | | |

13)

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

| Organization Names/Positions | | | Respondents to Part B [Indicate which parts each respondent was queried on] |
|------------------------------|--------------|----------------------------------|--|
| Respondent 1 | World Vision | Dr. Yvonne Duque/Project Officer | B.I, B.II, B.III, B.IV |

14)

| Organization | Names/Positions | Respondents to Part B [Indicate which parts each respondent was queried on] | |
|---------------|---|--|------------------------|
| Respondent 2 | PAFPI | Rodel Navarra | B.I, B.II, B.III, B.IV |
| Respondent 3 | TRIDEV | Toti Uysingco | B.I, B.II, B.III, B.IV |
| Respondent 4 | ACHIEVE | Mara Quesada | B.I, B.II, B.III, B.IV |
| Respondent 5 | Pinoy Plus Association | Rain Castillo | B.I, B.II, B.III, B.IV |
| Respondent 6 | Foundation for Adolescent Development | Cecilia Villa | B.I, B.II, B.III, B.IV |
| Respondent 7 | Pilipinas Shell Foundation Inc. | Devani Ardiente | B.I, B.II, B.III, B.IV |
| Respondent 8 | AIDS Society of the Philippines | Glenn Catubig | B.I, B.II, B.III, B.IV |
| Respondent 9 | Womens Health Care Foundation | Rebecca Ramos | B.I, B.II, B.III, B.IV |
| Respondent 10 | Lunduyan | Irene Fellizar | B.I, B.II, B.III, B.IV |
| Respondent 11 | ISSA | Marlon Lacsamana | B.I, B.II, B.III, B.IV |
| Respondent 12 | UNAIDS | Peter Mosende | B.I, B.II, B.III, B.IV |
| Respondent 13 | Health Action Initiatives Network | Noemi Leis | B.I, B.II, B.III, B.IV |
| Respondent 14 | Trade Union Congress of the Philippines | Rolagenia Reyes | B.I, B.II, B.III, B.IV |
| Respondent 15 | PNGOC | Ruthy Libatique | B.I, B.II, B.III, B.IV |
| Respondent 16 | TLF | Anastacio Marasigan | B.I, B.II, B.III, B.IV |
| Respondent 17 | RITM Foundation | Rosanna Ditangco | B.I, B.II, B.III, B.IV |
| Respondent 18 | UP-PGH | Edsel Salvana | B.I, B.II, B.III, B.IV |
| Respondent 19 | World Health Organization | Madeline Salva | B.I, B.II, B.III, B.IV |
| Respondent 20 | UNFPA | Jovanni Templonuevo | B.I, B.II, B.III, B.IV |
| Respondent 21 | | | |
| Respondent 22 | | | |
| Respondent 23 | | | |
| Respondent 24 | | | |
| Respondent 25 | | | |

15)

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes (0)

16) **Period covered:**

2008-2009

17)

1.1 How long has the country had a multisectoral strategy?

Number of Years

20

18)

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

| | Included in strategy | Earmarked budget |
|-----------------|----------------------|------------------|
| Health | Yes | Yes |
| Education | Yes | No |
| Labour | Yes | Yes |
| Transportation | No | |
| Military/Police | No | |
| Women | Yes | Yes |
| Young people | Yes | Yes |
| Other* | Yes | Yes |

19) **If "Other" sectors are included, please specify:**

Local Government, Tourism, Foreign Affairs

20)

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

The military and police in the Philippines are not currently included in the National Strategic Plan but conduct HIV related activities as an institution and are funded from their own budget.

- 21) 1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

| Target populations | |
|--|-----|
| a. Women and girls | Yes |
| b. Young women/young men | Yes |
| c. Injecting drug users | Yes |
| d. Men who have sex with men | Yes |
| e. Sex workers | Yes |
| f. Orphans and other vulnerable children | Yes |
| g. Other specific vulnerable subpopulations* | Yes |
| Settings | |
| h. Workplace | Yes |
| i. Schools | Yes |
| j. Prisons | Yes |
| Cross-cutting issues | |
| k. HIV and poverty | Yes |
| l. Human rights protection | Yes |
| m. Involvement of people living with HIV | Yes |
| n. Addressing stigma and discrimination | Yes |
| o. Gender empowerment and/or gender equality | Yes |

- 22) 1.4 Were target populations identified through a needs assessment?

Yes (0)

- 23) IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2005

- 24) 1.5 What are the identified target populations for HIV programmes in the country?

Sex workers, Males who have sex with males, Injecting Drug Users, Clients of Sex Workers, Out of school youth, children, migrant workers

- 25) 1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

- 26) 1.7 Does the multisectoral strategy or operational plan include:

| | |
|---|-----|
| a. Formal programme goals? | Yes |
| b. Clear targets or milestones? | Yes |
| c. Detailed costs for each programmatic area? | Yes |
| d. An indication of funding sources to support programme? | Yes |
| e. A monitoring and evaluation framework? | Yes |

- 27) 1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement (0)

28)

IF active involvement, briefly explain how this was organised:

CSOs have been involved as members of the Philippine National AIDS Council ever since its establishment in 1992. They are actively involved in all aspects of the response and often have lead many of the activities in the country

29)

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes (0)

30)

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, some partners (0)

31)

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

Some may be aligned but not harmonized.

32)

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes (0)

33)

2.1 IF YES, in which specific development plan(s) is support for HIV integrated?

| | |
|--|-----|
| a. National Development Plan | Yes |
| b. Common Country Assessment / UN Development Assistance Framework | Yes |
| c. Poverty Reduction Strategy | Yes |
| d. Sector-wide approach | Yes |
| e. Other: Please specify | |

34)

2.2 IF YES, which specific HIV-related areas are included in one or more of the development plans?

| HIV-related area included in development plan(s) | |
|--|-----|
| HIV prevention | Yes |
| Treatment for opportunistic infections | Yes |
| Antiretroviral treatment | Yes |
| Care and support (including social security or other schemes) | Yes |
| HIV impact alleviation | Yes |
| Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support | Yes |
| Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support | Yes |
| Reduction of stigma and discrimination | Yes |
| Women's economic empowerment (e.g. access to credit, access to land, training) | Yes |
| Other: Please specify | |

35) 3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes (0)

36) 3.1 *IF YES*, to what extent has it informed resource allocation decisions?

3 (3)

37) 4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

No (0)

38) 5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

39) 5.1 *IF YES*, for which subpopulations?

| | |
|--------------------------------|-----|
| a. Women | Yes |
| b. Young people | Yes |
| c. Injecting drug users | Yes |
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. Prison inmates | Yes |
| g. Migrants/mobile populations | Yes |
| Other: Please specify | |

40)

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

Republic Act 8504. The Philippine AIDS Prevention and Control Act of 1998

41)

Briefly comment on the degree to which these laws are currently implemented:

Poorly Implemented

42)

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

43) **6.1 IF YES, for which subpopulations?**

| | |
|--------------------------------|-----|
| a. Women | Yes |
| b. Young people | Yes |
| c. Injecting drug users | Yes |
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. Prison inmates | |
| g. Migrants/mobile populations | Yes |
| Other: Please specify | |

44) **IF YES, briefly describe the content of these laws, regulations or policies:**

The existence of anti-vagrancy laws prevent children from accessing social hygiene services. Drug enforcement laws which criminalizes possession of injecting equipment.

45) **Briefly comment on how they pose barriers:**

See above.

46) **7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?**

Yes (0)

47) **7.1 Have the national strategy and national HIV budget been revised accordingly?**

Yes (0)

48) **7.2 Have the estimates of the size of the main target populations been updated?**

Yes (0)

49) **7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?**

Estimates of current and future needs (0)

50) **7.4 Is HIV programme coverage being monitored?**

Yes (0)

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

Yes (0)

52) **(b) IF YES, is coverage monitored by population groups?**

Yes (0)

53) **IF YES, for which population groups?**

For Most at Risk groups such as sex workers, MSMs, IDUs and Migrant workers.

54) **Briefly explain how this information is used:**

The information guides program planners on where focus is needed, as well as provide feedback if programs are effective.

55)

(c) Is coverage monitored by geographical area?

56)

IF YES, at which geographical levels (provincial, district, other)?

Major cities.

57)

Briefly explain how this information is used:

Provide information on level of risks for local government officials and the need for a response if necessary.

58)

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

59)

Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

5 (5)

60)

Since 2007, what have been key achievements in this area:

1. Adaptation of Costed Operational Plan to address the findings of the AIDS Medium Term Plan 4 and change in the Philippine epidemic.

61)

What are remaining challenges in this area:

1. Poor implementation of HIV in the curriculum of the education sector 2. Low reach of prevention activities 3. Obstacles in implementation such as opposition against condom use

62)

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

| | |
|---|-----|
| | |
| President/Head of government | Yes |
| Other high officials | Yes |
| Other officials in regions and/or districts | Yes |

63)

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes (0)

64)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

1992

65)

2.2 IF YES, who is the Chair?

| | |
|----------------|--------------------------|
| Name | Francisco T. Duque |
| Position/title | Secretary Dept of Health |

66)

2.3 IF YES, does the national multisectoral AIDS coordination body:

| | |
|---|-----|
| have terms of reference? | Yes |
| have active government leadership and participation? | Yes |
| have a defined membership? | Yes |
| include civil society representatives? | Yes |
| include people living with HIV? | Yes |
| include the private sector? | Yes |
| have an action plan? | Yes |
| have a functional Secretariat? | Yes |
| meet at least quarterly? | Yes |
| review actions on policy decisions regularly? | Yes |
| actively promote policy decisions? | Yes |
| provide opportunity for civil society to influence decision-making? | Yes |
| strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting? | Yes |

67)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?

Please enter an integer greater than or equal to 1

26

68)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include civil society representatives", how many?

Please enter an integer greater than or equal to 1

9

69)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include people living with HIV", how many?

Please enter an integer greater than or equal to 1

2

70)

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes (0)

71)

IF YES, briefly describe the main achievements:

1. Creation of 5 year strategic plans which are now costed. It is now on its 5th medium term plan 2. Produced Republic Act 8504 which is the Philippine HIV and AIDS Prevention Law 3. The Philippine National AIDS Council provides the venue for all sectors involved in the response can interact.

72)

Briefly describe the main challenges:

Due to the low prevalence and slow growth of the epidemic, the response has settled into complacency. Government has prioritized other diseases with higher mortality rate resulting in loss of interest from some members of the council

73)

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

Please enter the rounded percentage (0-100)

10

74)

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

| | |
|---|-----|
| Information on priority needs | Yes |
| Technical guidance | Yes |
| Procurement and distribution of drugs or other supplies | Yes |
| Coordination with other implementing partners | Yes |
| Capacity-building | Yes |
| Other: Please specify | |

75)

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

Yes (0)

76)

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

No (0)

77)

Overall, how would you rate the political support for the HIV programmes in 2009?

5 (5)

78)

Since 2007, what have been key achievements in this area:

League of Cities have included HIV prevention in its advocacy to member cities.

79)

What are remaining challenges in this area:

1. Not many political champions for HIV advocacy 2. Frequent change in leadership resulting in non-continuation of policies 3. Denial by some political leaders of presence of HIV 4. Stigma and discrimination still present even in some "enlightened" local government units

80)

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

Yes (0)

81)

1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

- a. Be sexually abstinent (0)
- b. Delay sexual debut (0)
- c. Be faithful (0)
- d. Reduce the number of sexual partners (0)
- e. Use condoms consistently (0)
- f. Engage in safe(r) sex (0)
- g. Avoid commercial sex (0)
- h. Abstain from injecting drugs (0)
- i. Use clean needles and syringes (0)
- j. Fight against violence against women (0)
- k. Greater acceptance and involvement of people living with HIV (0)
- l. Greater involvement of men in reproductive health programmes (0)
- m. Males to get circumcised under medical supervision (0)
- n. Know your HIV status (0)
- o. Prevent mother-to-child transmission of HIV (0)

82)

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

Yes (0)

83)

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

Yes (0)

84)

2.1 Is HIV education part of the curriculum in:

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

85)

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

Yes (0)

86)

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

Yes (0)

87)

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

Yes (0)

88) 3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

| | |
|---|--|
| Targeted information on risk reduction and HIV education | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations |
| Stigma and discrimination reduction | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations |
| Condom promotion | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations |
| HIV testing and counselling | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations |
| Reproductive health, including sexually transmitted infections prevention and treatment | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations |
| Vulnerability reduction (e.g. income generation) | |
| Drug substitution therapy | |
| Needle & syringe exchange | Injecting drug user |

89) You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

Overseas Filipino Workers

90) Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

7 (7)

91) Since 2007, what have been key achievements in this area:

-Increase access of entertainment establishment workers to Social Hygiene Clinics. -Increase access of freelance sex workers and MSM thru outreach activities. -Local ordinances which provide treatment, care and support for PLHIV -DBM policy allowing individual government agencies outside of HEalth to allocate funds for HIV projects

92) What are remaining challenges in this area:

-No HIV and AIDS workplace policy in government agencies -Difficulty in convincing drug enforcement agencies to consider harm reduction approaches to IDUs -Difficulty in amending laws -IDU program is limited in scope - OFW intervention not focused

93) 4. Has the country identified specific needs for HIV prevention programmes?

Yes (0)

94) IF YES, how were these specific needs determined?

These were determined during the mid-term evaluation of the 4th AIDS Medium Term Plan.

95)

4.1 To what extent has HIV prevention been implemented?

| HIV prevention component | The majority of people in need have access |
|---|--|
| Blood safety | Agree |
| Universal precautions in health care settings | Don't agree |
| Prevention of mother-to-child transmission of HIV | Don't agree |
| IEC* on risk reduction | Agree |
| IEC* on stigma and discrimination reduction | Agree |
| Condom promotion | Agree |
| HIV testing and counselling | Agree |
| Harm reduction for injecting drug users | Don't agree |
| Risk reduction for men who have sex with men | Don't agree |
| Risk reduction for sex workers | Agree |
| Reproductive health services including sexually transmitted infections prevention and treatment | Agree |
| School-based HIV education for young people | Don't agree |
| HIV prevention for out-of-school young people | Agree |
| HIV prevention in the workplace | Agree |
| Other: please specify | |

96)

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

6 (6)

97)

Since 2007, what have been key achievements in this area:

-Increase in geographic areas for project implementation

98)

What are remaining challenges in this area:

-Still poor reach to target populations despite increase in project sites -Lack of resources -Prioritization of HIV programs by the government -Frequent turnover of implementors -Non-sustainability and discontinuation of foreign-funded projects

99)

1. Does the country have a policy or strategy to promote comprehensive HIV 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 (0)

100)

1.1 IF YES, does it address barriers for women?

Yes (0)

101)

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

102)

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

103)

IF YES, how were these determined?

-thru the integrated hematologic and behavioral sentinel surveillance. -thru the AIDS Registry

104)

2.1 To what extent have the following HIV treatment, care and support services been implemented?

| | The majority of people in need have access |
|---|--|
| HIV treatment, care and support service | |
| Antiretroviral therapy | Agree |
| Nutritional care | Don't agree |
| Paediatric AIDS treatment | Agree |
| Sexually transmitted infection management | Agree |
| Psychosocial support for people living with HIV and their families | Agree |
| Home-based care | Agree |
| Palliative care and treatment of common HIV-related infections | Agree |
| HIV testing and counselling for TB patients | Agree |
| TB screening for HIV-infected people | Agree |
| TB preventive therapy for HIV-infected people | Don't agree |
| TB infection control in HIV treatment and care facilities | Agree |
| Cotrimoxazole prophylaxis in HIV-infected people | Agree |
| Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) | Don't agree |
| HIV treatment services in the workplace or treatment referral systems through the workplace | Agree |
| HIV care and support in the workplace (including alternative working arrangements) | Agree |
| Other: please specify | |

105)

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

Yes (0)

106)

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 (0)

107)

IF YES, for which commodities?:

antiretroviral drugs

108)

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

8 (8)

109)

Since 2007, what have been key achievements in this area:

-Access of PLHIV needing ARV close to 100% -Expansion of CD4 testing centers

110)

What are remaining challenges in this area:

-Livelihood/health insurance for PLHIV -Sustainability of ARV supply after 2012

- 111)** 5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?
- Yes (0)
- 112)** 5.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?
- Yes (0)
- 113)** 5.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?
- No (0)
- 114)** 5.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?
- No (0)
- 115)** Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?
- 4 (4)
- 116)** Since 2007, what have been key achievements in this area:
- none
- 117)** What are remaining challenges in this area:
- Addressing HIV related needs of orphans and vulnerable children
- 118)** 1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?
- Yes (0)
- 119)** 1.1 IF YES, years covered:
Please enter the start year in yyyy format below
- 2005
- 120)** 1.1 IF YES, years covered:
Please enter the end year in yyyy format below
- 2010
- 121)** 1.2 IF YES, was the M&E plan endorsed by key partners in M&E?
- Yes (0)

122)

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes (0)

123)

1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, most partners (0)

124)

2. Does the national Monitoring and Evaluation plan include?

| | |
|---|-----|
| [REDACTED] | |
| a data collection strategy | Yes |
| a well-defined standardised set of indicators | Yes |
| guidelines on tools for data collection | Yes |
| a strategy for assessing data quality (i.e., validity, reliability) | Yes |
| a data analysis strategy | Yes |
| a data dissemination and use strategy | Yes |

125)

If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

| | |
|-------------------------------|-----|
| [REDACTED] | |
| routine programme monitoring | Yes |
| behavioural surveys | Yes |
| HIV surveillance | Yes |
| Evaluation / research studies | Yes |

126)

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

Yes (0)

127)

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".

5

128)

3.2 IF YES, has full funding been secured?

No (0)

129)

3.3 IF YES, are M&E expenditures being monitored?

Yes (0)

130)

IF you answer "NO" for Question 3.2, i.e., indicating the full funding has NOT been secured, briefly describe the challenges:

The costed need for full funding of M&E exceeds the entire budget of the Health Department. It has to make do with what is being currently provided.

131)

4. Are M&E priorities determined through a national M&E system assessment?

Yes (0)

132)

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

It was part of the mid term evaluation of the 4th National Strategic Plan. UCO M&E Officer also provides assessment based on 12 requirements for a functional M&E which is done annually.

133)

5. Is there a functional national M&E Unit?

Yes (0)

134)

5.1 IF YES, is the national M&E Unit based

| |
|--|
| [REDACTED] |
| in the National AIDS Commission (or equivalent)? Yes |
| in the Ministry of Health? |
| Elsewhere? (please specify) |

135)

Number of permanent staff:

Please enter an integer greater than or equal to 0

136)

Number of temporary staff:

Please enter an integer greater than or equal to 0

2

137)

Please describe the details of all the permanent staff:

| | Position | Full time/Part time? | Since when? (please enter the year in yyyy format) |
|--------------------|---------------|----------------------|---|
| Permanent staff 1 | M&E Officer | Full time | 2008 |
| Permanent staff 2 | M&E Assistant | Full time | 2009 |
| Permanent staff 3 | | | |
| Permanent staff 4 | | | |
| Permanent staff 5 | | | |
| Permanent staff 6 | | | |
| Permanent staff 7 | | | |
| Permanent staff 8 | | | |
| Permanent staff 9 | | | |
| Permanent staff 10 | | | |
| Permanent staff 11 | | | |
| Permanent staff 12 | | | |
| Permanent staff 13 | | | |
| Permanent staff 14 | | | |
| Permanent staff 15 | | | |

138)

Please describe the details of all the temporary staff:

| | Position | Full time/Part time? | Since when? (please enter the year in yyyy format) |
|--------------------|------------------------|----------------------|---|
| Temporary staff 1 | Information Technician | Part time | 2009 |
| Temporary staff 2 | Data Clerk | Part time | 2009 |
| Temporary staff 3 | | | |
| Temporary staff 4 | | | |
| Temporary staff 5 | | | |
| Temporary staff 6 | | | |
| Temporary staff 7 | | | |
| Temporary staff 8 | | | |
| Temporary staff 9 | | | |
| Temporary staff 10 | | | |
| Temporary staff 11 | | | |
| Temporary staff 12 | | | |
| Temporary staff 13 | | | |
| Temporary staff 14 | | | |
| Temporary staff 15 | | | |

139)

5.3 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 for inclusion in the national M&E system?

Yes (0)

140)

IF YES, briefly describe the data-sharing mechanisms:

M&E reporting framework requires all AIDS Council members to submit reports annually to PNAC M&E Unit.

141)

What are the major challenges?

-No designated M&E point person yet in reporting units. -M&E culture not yet fully appreciated in all levels. - Unequal technology availability among reporting units

142)

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

Yes, but meets irregularly (0)

143)

6.1 Does it include representation from civil society?

Yes (0)

144)

IF YES, briefly describe who the representatives from civil society are and what their role is:

Many sit in the National AIDS Council and are involved in all aspects of the National Response. Others work in different projects and maintain a working relationship with the Council by providing information and updates on their activities. Also see annex of CSOs involved in preparing this report.

145)

7. Is there a central national database with HIV- related data?

Yes (0)

146)

7.1 IF YES, briefly describe the national database and who manages it

-The national database is an adaptation of the Country Response Information System provided by UNAIDS called CRISPINOY. It is linked to the PNAC website and contains information on all groups and organizations involved in the country response.

147)

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, but only some of the above (0)

148) For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.

the content of the HIV services (0)
geographical coverage of HIV services (0)
implementing organizations (0)

149)

7.3 Is there a functional* Health Information System?

| | |
|----------------------|-----|
| | |
| At national level | Yes |
| At subnational level | No |

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150) 8. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

Yes (0)

151) 9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

4 (4)

152) Provide a specific example:

-When a change in the mode of transmission from mainly heterosexual to homosexual was detected in 2007, a review and refocusing of national strategy was initiated to address the change

153) What are the main challenges, if any?

-Sharing of data among implementers -Technological glitches/lack of technology to facilitate reporting -Non-appreciation of data -Data for decision making still not common among implementers

154) 9. To what extent are M&E data used

9.2 for resource allocation?:

4 (4)

155) Provide a specific example:

-Some local governments increased allocations due to data on increasing number of HIV cases discovered during surveillance.

156) What are the main challenges, if any?

-And some local governments have no resources to allocate for M&E activities

157) 9. To what extent are M&E data used

9.3 for programme improvement?:

4 (4)

158) Provide a specific example:

-The increase in number of HIV cases among MSMs and IDUs resulted in a refocus and creation of strategies where there were none, and a scaling up where programs were in place.

159) What are the main challenges, if any?

-Rolling out M&E to most local gov't units. Initial pilot project implementation for M&E at the local level in 10 sites revealed problems from lack of personnel to lack of equipment and many other problems

160) 10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, but only addressing some levels (0)

- 161) For Question 10, you have checked "Yes, but only addressing some levels", please specify**
at national level (0)
at subnational level (0)

- 162) 10.1 In the last year, was training in M&E conducted**

At national level? Yes

At subnational level? Yes

At service delivery level including civil society?

- 163) Please enter the number of people trained at national level.**

Please enter an integer greater than 0

10

- 164) Please enter the number of people trained at subnational level.**

Please enter an integer greater than 0

51

- 165) 10.2 Were other M&E capacity-building activities conducted other than training?**

No (0)

- 166) Overall, how would you rate the M&E efforts of the HIV programme in 2009?**

7 (7)

- 167) Since 2007, what have been key achievements in this area:**

-Personnel complement of National M&E unit increased from 1 to 3 -Most national partners and implementers aware of importance of M&E

- 168) What are remaining challenges in this area:**

-Despite a budget, it is still lacking if all components of a functional M&E system are to be implemented.

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

Yes (0)

- 170) 1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision:**

The basic law is RA 8504 which contains a general anti-discrimination provisions (Article 7)

- 171) 2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?**

Yes (0)

172)

2.1 IF YES, for which subpopulations?

| | |
|--------------------------------|-----|
| a. Women | Yes |
| b. Young people | Yes |
| c. Injecting drug users | No |
| d. Men who have sex with men | No |
| e. Sex Workers | No |
| f. prison inmates | No |
| g. Migrants/mobile populations | Yes |
| Other: Please specify | |

173)

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

The Implementing Rules and Regulations of RA 8504. Monitoring by the Philippine National AIDS Council and its Secretariat.

174)

Briefly describe the content of these laws:

Article 7 of RA 8504 describes different types of discrimination ranging from the workplace, in schools, on travel restriction, inhibition from public service, denial of burial services and corresponding penalties for their violation.

175)

Briefly comment on the degree to which they are currently implemented:

not implemented

176)

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

Yes (n)

177)

3.1 IF YES, for which subpopulations?

| | |
|--------------------------------|-----|
| a. Women | No |
| b. Young people | Yes |
| c. Injecting drug users | Yes |
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. prison inmates | No |
| g. Migrants/mobile populations | Yes |
| Other: Please specify | |

178)

IF YES, briefly describe the content of these laws, regulations or policies:

-Laws criminalizing possession of injecting equipment -Vagrancy laws -Laws on drug testing

179)

Briefly comment on how they pose barriers:

-Drug enforcement laws prohibiting possession of injecting equipment have resulted in arrests of IDU outreach workers who are implementing needle exchange programs. -Vagrancy laws have resulted in limited access of young sex workers and MSMs to health services

180)

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

Yes (0)

181)

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Section 2,b of RA 8504 states that "The state shall extend to every person suspected or known to be infected with HIV and AIDS full protection of his/her human rights and civil liberties"

182)

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

No (0)

183)

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

184)

IF YES, describe some examples:

Most at risk populations are actively involved in the Philippine National AIDS Council as members. They are always included in all activities such as planning, workshops, training, policy formulation following the principles of GIPA and MIPA.

185)

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

| | |
|---|-----|
| a. HIV prevention services | Yes |
| b. Antiretroviral treatment | Yes |
| c. HIV-related care and support interventions | No |

186)

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

-Although services are free, no definite policy and guidelines are in place. These are still in development. -HIV and AIDS Information for departing overseas workers are provided for a fee which are given to recruitment agencies

187)

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (0)

188)

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

No (0)

189)

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

Yes (0)

190)

IF YES, briefly describe the content of this policy:

-RA 8504 Article IV, Sec 23: Local government units, in coordination and in cooperation with concerned government agencies, non-government organizations, persons with HIV and AIDS, and groups most at risk of HIV infection shall provide community-based HIV and AIDS prevention and care services

191)

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes (0)

- 192) **IF YES, briefly explain the different types of approaches to ensure equal access for different populations:**
- Current example is the AMTP4 Costed OpPlan which utilizes specific intervention packages for each type of most at risk group.
- 193) **10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?**
- Yes (0)
- 194) **11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?**
- Yes (0)
- 195) **11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?**
- No (0)
- 196) **- 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-related issues within their work**
- No (0)
- 197) **- 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**
- No (0)
- 198) **- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts**
- No (0)
- 199) **13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?**
- No (0)
- 200) **- Legal aid systems for HIV casework**
- No (0)
- 201) **- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV**
- Yes (0)
- 202) **- Programmes to educate, raise awareness among people living with HIV concerning their rights**
- Yes (0)
- 203) **15. Are there programmes in place to reduce HIV-related stigma and discrimination?**
- Yes (0)

204)

IF YES, what types of programmes?

| | |
|--------------------------------------|-----|
| Media | No |
| School education | No |
| Personalities regularly speaking out | Yes |
| Other: please specify | |

205)

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

5 (5)

206)

Since 2007, what have been key achievements in this area:

-ARV policies -Benefits package for PLHIVs

207)

What are remaining challenges in this area:

-No concrete system for redress -Commission on Human Rights not aware of HIV and human rights issues - Even so called enlightened LGUs who have been implementing HIV and AIDS programs for so long still discriminate against PLHIVs

208)

Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?

4 (4)

209)

Since 2007, what have been key achievements in this area:

-Government policies on ARV supply and provision -Creation of benefits package for PLHIVs -Non-discrimination policy in Armed Forces of the Philippines

210)

What are remaining challenges in this area:

-Presence of laws detrimental to HIV implementation -Discriminatory laws to high risk groups -Disallowing political representation of high risk groups -lack of legal system for redress -conflicting policies on HIV testing

211)

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

5 (5)

212)

Comments and examples:

-CSOs through their activism and constant involvement in most issues in the HIV response have influenced top leaders to take notice of the HIV and AIDS situation in the country even more than government efforts. Being in the forefront of national and local commemorations/events have made these leaders more aware of HIV and AIDS

213)

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

5 (5)

214)

Comments and examples:

-During the development of the Costed Operational Plan of the 4th AIDS Medium Term Plan, CSOs were involved in all aspects of its development.

215)

a. the national AIDS strategy?

5 (5)

216)

b. the national AIDS budget?

4 (4)

217)

c. national AIDS reports?

5 (5)

218)

Comments and examples:

CSOs are involved in data collection, report preparation, provision of data, conduct of workshops.

219)

a. developing the national M&E plan?

4 (4)

220)

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

3 (3)

221)

c. M&E efforts at local level?

4 (4)

222)

Comments and examples:

-CSOs took the lead in developing the M&E system starting in 2003 up to the formal establishment of the National M&E unit in 2006.

223)

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

4 (4)

224)

Comments and examples:

All of these organizations are included in various CSO HIV efforts. Some are PNAC members but most are represented in the PNAC through the 8 CSO sitting PNAC members.

225)

a. adequate financial support to implement its HIV activities?

2 (2)

226)

b. adequate technical support to implement its HIV activities?

3 (3)

227)

Comments and examples:

-Workplace not a priority, so technical support not readily available -Many CSOs competing for the same support

228)

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

| | |
|--|--------|
| Prevention for youth | >75% |
| Prevention for most-at-risk-populations | |
| - Injecting drug users | >75% |
| - Men who have sex with men | >75% |
| - Sex workers | 51-75% |
| Testing and Counselling | 25-50% |
| Reduction of Stigma and Discrimination | >75% |
| Clinical services (ART/OI)* | <25% |
| Home-based care | >75% |
| Programmes for OVC** | 51-75% |

229)

Overall, how would you rate the efforts to increase civil society participation in 2009?

8 (8)

230)

Since 2007, what have been key achievements in this area:

-A CSO forum organized by PNAC -CSOs are project implementers in many HIV projects -CSOs are included in OpPlan development, mid-term review of strategic plan, CSO coalition to monitor CCM

231)

What are remaining challenges in this area:

-Archipelagic problem in including other NGOs

232)

1. Has the country identified the specific needs for HIV prevention programmes?

Yes (0)

233) IF YES, how were these specific needs determined?

Through researches, consultations, surveillance.

234) 1.1 To what extent has HIV prevention been implemented?

| HIV prevention component | The majority of people in need have access |
|---|--|
| Blood safety | Agree |
| Universal precautions in health care settings | Don't agree |
| Prevention of mother-to-child transmission of HIV | Don't agree |
| IEC* on risk reduction | Don't agree |
| IEC* on stigma and discrimination reduction | Don't agree |
| Condom promotion | Don't agree |
| HIV testing and counselling | Don't agree |
| Harm reduction for injecting drug users | Don't agree |
| Risk reduction for men who have sex with men | Don't agree |
| Risk reduction for sex workers | Don't agree |
| Reproductive health services including sexually transmitted infections prevention and treatment | Don't agree |
| School-based HIV education for young people | Don't agree |
| HIV prevention for out-of-school young people | Don't agree |
| HIV prevention in the workplace | Don't agree |
| Other: please specify | |

235) Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

4 (4)

236) Since 2007, what have been key achievements in this area:

-Improvement in blood safety -Creation of PMTCT guidelines

237) What are remaining challenges in this area:

-Lack of political will -Difficulty in pushing for supportive policies -Obstacles against condom promotion -Low priority of HIV among LGUs

238) 1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

239)

IF YES, how were these specific needs determined?

Through forums, research and surveys.

240)

1.1 To what extent have the following HIV treatment, care and support services been implemented?

| | The majority of people in need have access |
|---|--|
| HIV treatment, care and support service | |
| Antiretroviral therapy | Agree |
| Nutritional care | Don't agree |
| Paediatric AIDS treatment | Agree |
| Sexually transmitted infection management | Don't agree |
| Psychosocial support for people living with HIV and their families | Don't agree |
| Home-based care | Don't agree |
| Palliative care and treatment of common HIV-related infections | Agree |
| HIV testing and counselling for TB patients | Don't agree |
| TB screening for HIV-infected people | Don't agree |
| TB preventive therapy for HIV-infected people | Don't agree |
| TB infection control in HIV treatment and care facilities | Don't agree |
| Cotrimoxazole prophylaxis in HIV-infected people | Don't agree |
| Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) | Agree |
| HIV treatment services in the workplace or treatment referral systems through the workplace | Don't agree |
| HIV care and support in the workplace (including alternative working arrangements) | Don't agree |
| Other: please specify | |

241)

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

6 (6)

242)

Since 2007, what have been key achievements in this area:

-Achievements still in draft stage as of this reporting.

243)

What are remaining challenges in this area:

-Approval by involved agencies of policies to address gaps in HIV treatment, care and support. -Coordination of key stakeholders -Getting data on orphans

244)

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

No (0)

Annex 3: Contribution of the Global Fund AIDS Grants

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) supports HIV prevention, treatment, care and support initiatives in key geographic areas and contributes significantly to the country's national HIV response. The AIDS Round 3 project concluded in June 2009, Round 5 will soon be completed in September 2010 and Round 6 will soon start with Phase 2 (to run for three years) in the second half of 2010. Despite the GFATM support and while all grant performance are high, coverage is low when compared to the Universal Access targets set by the country.¹⁴

- a) *GFATM-supported AIDS ROUND 3 Project:*¹⁵

The HIV prevention component consisted of BCC community outreach activities focused on FSW, MSM, IDU and OFW from 11 sites (eight cities and three municipalities). The implementers included SHCs of the 11 sites, six CHDs, five NGOs as implementing partners including the sub-recipient PNGOC; the grant's principal recipient, Tropical Disease Foundation, Inc. (TDFI was also an NGO. When the project's Phase II concluded in August 2009, the coverage achieved (*percentage of accomplishment is based on R3 targets and not on UA targets of the country*) is generally more than the targets set. Refer to Tables 4 and 5.
- b) *GFATM-supported AIDS ROUND 5 Project:*¹⁶

The Round 5 grant supported the response in 18 sites (14 cities and 4 municipalities) and provided STI and HIV prevention services for FSW, MSM and OFW, and three sites for IDU. In addition to 21 SHC and 12 CHDs, the project was implemented by 12 NGO as sub-recipients. Until December 2009, TDFI was the principal recipient. The project will conclude in September 2010, and Phase II achievements can be found in Tables 4 and 5. (*Percentage of accomplishment is based on R5 targets and not on UA targets of the country.*)
- c) *GFATM-supported AIDS ROUND 6 Project:*¹⁷

The DOH is the principal recipient of Round 6 where support for HIV prevention and treatment was provided to 16 sites (15 cities and 1 metropolitan area) and 23 Blood Service Facility (BSF) ensured safe blood supply with public education and testing of donated blood units for HIV and other TTIs. Performance accomplishments as of September 2009 are also reflected in Tables 4 and 5. (*Percentage of accomplishment is based on R3 targets and not on UA targets of the country.*)

¹⁴ Universal Access Targets of the Philippines is reflected in the AIDS Medium Term Plan Operational Plan 2009-2010. PNAC 20009

¹⁵ Data Source - HIV Round 3 PUDR_Mar-Julu09 approved by TWG_2Sep_09.ppt

¹⁶ Data Source - Data Source - Round_5_HIV_PU_7DR_11_15_2009.xls

¹⁷ Data Source - http://www.theglobalfund.org/grantdocuments/6PHLH_1403_616_gpr.pdf

Table 4: Consolidated cumulative accomplishments of GFATM AIDS grants 2004-2009 on MARPs

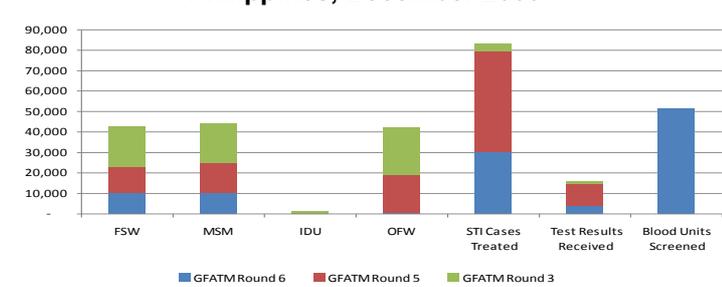
| MARP | Number of MARP reached by HIV prevention activities | | | | | | Total % of accomplishment of R 3, 5 and 6 |
|------------|---|------|-----------------|------|--|-----------------------------|---|
| | Round 3 | | Round 5 | | Round 6 | | |
| | No. | % | No. | % | No. | % | |
| FSW | 19665/ 17700 | 111% | 12470/ 8244 | 151% | 20,699/ 15,390 (not disaggregated) | 120% (not disaggregated) | 123% (86563/70464) |
| MSM | 19184/ 16750 | 115% | 14545/ 12400 | 117% | | | |
| IDU | 1011/ 800 | 126% | 2512/ 1600 | 157% | Not applicable | Not applicable | 147% (3523/2400) |
| OFW | 22969/ 18200 | 126% | 15507/ 11286 | 137% | 972/920 | 106% | 130% (39448/30406) |

Diagnosis and treatment of STIs and Conduct of Voluntary Counseling and Testing: A key prevention intervention is the diagnosis and treatment of sexually transmitted infections (STI). Rounds 3, 5 and 6 collectively were able to enhance STI diagnosis and treatment and HIV testing proficiency of 53 social hygiene clinics (SHC) and 13 treatment hubs. Table 5 presents the accomplishments against targets of the three (3) GFATM HIV and AIDS grants.

Table 5: Consolidated cumulative accomplishments of GFATM AIDS grants 2004-2009 on STI and VCT

| MARP | Number of STIs Treated and VCT conducted and received results | | | | | | Total % of accomplishment of R 3, 5 and 6 |
|------------|---|------|-----------------|------|----------------|------|---|
| | Round 3 | | Round 5 | | Round 6 | | |
| | No. | % | No. | % | No. | % | |
| STI | 3757 /810 | 464% | 49500/ 32000 | 155% | 30037 /1769 | 120% | 241% (83294/34579) |
| VCT | 1291/ 910 | 142% | 10516/ 7400 | 142% | 4088/ 4624 | 88% | 253% (15895/6274) |

Figure 2: Global Fund contribution (in US Dollars) to coverage of selected HIV programs Philippines, December 2009



Blood Safety: the Global Fund Round 6 (GFR6) also supported the , Donor Recruitment activities, Capability Building, Enhancement of Integrated Blood

Bank Information System (IBBIS), Development of learning materials, Philippine Clinical Practice Guidelines for the Rationale Use of Blood and Blood Products and strategies for implementation, Manual for Blood Donor Selection and Counseling and updated the Manual for Blood Service Facilities in the Philippines. The Research Institute for Tropical Medicine (RITM) also conducted External Quality Assurance Scheme (EQUAS) in CY 2009 to 10 BSF out of 23 GFR6 Blood Safety sites.

Of the total 658,884 blood units donated, 630,468 or 95.7% were screened for HIV. Data from Global Fund Round 6 reports a 102% accomplishment (51,183/50,000) blood units screened simultaneously for HIV and other TTI in Six (6) BSF conducted centralized testing out of 23 GFR6 blood safety sites.