

**Follow-up to the
Declaration of Commitment on HIV/AIDS**

**United Nations General Assembly
Special Session (UNGASS)**

**Country Report of the Philippines
January 2003 to November 2005**

Prepared by the
Philippine National AIDS Council (PNAC)

With Support from the
UN Theme Group on HIV/AIDS

Manila, Philippines
December 2005

I. Status at a glance

A. NATIONAL COMMITMENT AND ACTION

Amount of national funds disbursed by government:

2003: Phil. Pesos 35,850,000 (USD 661,448)

2004: Phil. Pesos 33,308,000 (USD 594,454)

2005: Phil. Pesos 33,308,000

National Composite Policy Index:

2003: 85.00%

2005: 91.66%

B. NATIONAL PROGRAMMES AND BEHAVIOUR

1. HIV Testing

% of most-at-risk populations who receive HIV testing and who know their test results: **partial data available for some groups**

2. Prevention

% of most-at-risk populations who have accessed HIV/AIDS programs during the last 12 months:

PIP: **data available**

MSM: **data available**

IDU: **partial data available**

% of vulnerable populations who have accessed HIV/AIDS programs during the last 12 months:

OFW: **partial data available**

OSY: no data obtained as of the time of writing of this Country Report

street children: no data obtained as of the time of writing of this Country Report

% of primary, secondary, tertiary and technical/vocational school teachers trained on HIV/AIDS: **partial data available for primary, secondary and technical/vocational levels**

% of large, medium and small-scale enterprises that have HIV/AIDS workplace policies and programs: **data available**

3. Knowledge/Behavior

% of PIP who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission:¹ **partial data available**

% of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission:² **partial data available**

% of IDU who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission:³ **partial data available**

% of OFW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: **no data obtained as of writing of this Country Report**

% of female and male sex workers reporting the use of a condom with their most recent client: **partial data available**

% of men reporting the use of a condom the last time they had anal sex with a male partner: **partial data available**

% of IDU who have adopted behaviors that reduce transmission of HIV, i.e., who both avoid sharing equipment and use condoms in the last 12 months: **partial data available**

% of sex workers who consistently used a condom in the last month: **partial data available**

% of 15-24 year olds⁴ who used a condom during their last sexual encounter with a sex worker: **partial data available**

4. Impact Alleviation

% of most-at-risk-populations who are HIV infected

PIP: **data available**

MSM: **data available**

IDU: **no data available as of writing of this Country Report**

5. Care/Treatment

% of patients with STI at public and private healthcare facilities who are appropriately diagnosed, treated and counseled: **data available for public health facilities**

% of people with advanced HIV infection receiving ARV combination therapy: **partial data available**

% of PLWHA receiving prophylaxis treatment: **partial data available**

% of PLWHA receiving OI treatment: **partial data available**

II. Overview of the HIV/AIDS Epidemic

HIV prevalence at a glance	Most-at-risk and vulnerable populations in the Philippines
<p>% of most-at-risk population who are HIV infected: 0.03%⁵</p> <p>% of PIP who are HIV infected: 0.03^{6,7} % of MSM who are HIV infected: 0.03^{8,9} % of IDU who are HIV infected: no data obtained as of writing of this Country Report¹⁰</p> <p>% of OFW who are HIV infected: no percentage figures available as of writing of this Country Report¹¹</p> <p>% of young people aged 15-24 years of age who are HIV infected:¹² no percentage figures available as of writing of this Country Report.</p>	<p>For this Country Report, the following are included as most-at-risk populations and vulnerable populations:</p> <ul style="list-style-type: none"> • Most-at-risk populations (following the guidelines for core indicators set by UNAIDS for the 2005 Country Report): People in Prostitution (RFSW, FFSW, MSW), Men Having Sex with Men (MSM), and Injecting Drug Users (IDU). • Vulnerable Groups (identified under Country-Specific Indicators): Overseas Filipino Workers (OFW), street children, out-of-school youth (OSY) <p>The above groups are regarded as “most-at-risk” and “vulnerable” since they “may be at a higher risk for HIV than others due to economic, social and even biological circumstances.”¹³</p>

A nascent epidemic: from “low and slow” to a “hidden and growing” phenomenon

For the past decade, the HIV situation in the Philippines has been described as “low and slow,” indicating low prevalence rates and slow spread of the infection even among those regarded as most-at-risk populations (classified as “high risk groups”- HRG - in the surveillance surveys).

The *2003 Technical Report of the National Epidemiology Center* (hereafter referred to in this report as *2003 NEC Technical Report*) cites that there is “[n]o evidence of an explosive increase in HIV prevalence among high risk groups (HRGs), more so, in the general population.

The *2002 Consensus Report on STI, HIV and AIDS Epidemiology* (hereafter referred to in this document as the *2002 Consensus Report*) published by the World Health Organization (WHO) and the Philippines Department of Health (DOH) identified the following as “possible factors that could explain the slow transmission of HIV/AIDS in the Philippines, based on results of studies:”

- sex workers have few sex partners,
- male population has low exposure to sex workers,
- majority of the general male population have only one sex partner
- few men engaged in anal sex,
- low prevalence of ulcerative STI,
- small IDU population (estimated at 10,000).¹⁴

The *2002 HIV/AIDS Country Profile Philippines* adds that “[t]he country’s archipelagic nature may have helped slow down the spread of HIV/AIDS in the Philippines. . . . Furthermore, the country’s detachment from mainland Asia may have helped to shield it from the rapid cross-border spread of HIV/AIDS observed elsewhere in South East Asia.”¹⁵

Another and “more probable cause of the slow transmission of HIV,” according to the *2002 Consensus Report* is the country’s accelerated response to the epidemic. The report stated that the response include:

- organized multisectoral action;
- use of local resources, active engagement of individuals and organizations;
- early institution of surveillance systems; and
- highly creative and concerted intervention effort which include peer outreach, social marketing and advocacy for policy reform to reduce structural and environmental constraints to STI/AIDS prevention.¹⁶

This assessment is echoed in the *2005 Philippine HIV and AIDS Country Profile* that cites “the early recognition of the epidemic exemplified by multi-sectoral responses by government agencies and non-government organizations to increase public awareness and fight discrimination” as possible reasons why the country was “able to sustain a fairly low level of the epidemic for a significant number of years.”

However, the *2003 NEC Technical Report* cautioned that this low and slow characteristic of the HIV/AIDS situation in the country is not a guarantee that the Philippines will be spared from a rapid increase in infections in the future. The NEC Report alerts policymakers and program planners to the fact that the Behavioral Sentinel Surveillance (BSS) showed that “consistent condom use among the HRGs was low, most IDUs still shared injecting equipment, only a small proportion of ‘sharers’ used bleach and water to share injecting equipment, and the HRGs’ health-seeking behavior when confronted with sexually transmitted infections was far from ideal, particularly the MSM.”¹⁷

The AMTP III titled, *Seizing the Opportunity: The 2000-2004 Medium Term-Plan for Accelerating the Philippine Response to HIV-AIDS (AMTP)*, described the HIV/AIDS situation in the Philippines as a “nascent epidemic” having the following characteristics:

- the level of confirmed prevalence is considered low, even among those presumed to be most vulnerable to HIV infection;
- the rate of growth in the number of HIV/AIDS cases is considered slow;
- all known routes of transmitting the infection have been observed in the country;
- many of the risky behaviors that are known to drive the spread of the infection are practiced by large numbers of people at significant levels of frequency; and
- the potential for the country to suffer a more serious epidemic exists due to the presence of underlying conditions that are likely to drive the epidemic.¹⁸

According to the *AMTP III*, “the apparently ‘low and slow’ character of the epidemic thus far is seen as a transient opportunity for action.” The situation allows the country “to act now before it is overwhelmed by a rapid increase in the number of infected persons.” It also cautions that if the “high levels of underlying risky behavior are left to fester, [these] are likely to increase the number of infected persons in the future.”

On the other hand, the *Fourth Medium Term Plan on HIV/AIDS: 2005-2010 (AMTP IV)*, states that the country is crossing over a “low and slow” situation to a “hidden and growing” HIV/AIDS phenomenon that could escalate to epidemic proportions if left unchecked.¹⁹

In December 2004, the Department of Health (DOH) reported that from a yearly average of 100 cases of new infections for 2001-2002, an average of 200 cases of new infections each year have been posted for 2003 and 2004, indicating that infections are on the rise in terms of actual numbers even if prevalence rates remain low.

Number of HIV and AIDS Cases, Modes of Transmission, and Prevalence Rates

- *Most Recent HIV Registry Report (September 2005): New HIV Ab seropositive cases and new AIDS cases*

For the month of September 2005, there were 21 new HIV Ab seropositive cases reported. Of these 14 (67%) were males and 7 (33%) were females. The mean age was 35 years (age range 23 to 50 years). Reported mode of transmission was sexual contact [heterosexual (14), homosexual (6), and bisexual 1)].

Of the 21 new HIV Ab seropositive cases, four (4) were reported as AIDS cases. Mean age was 36 years (age range 30 to 43 years). Reported mode of transmission was sexual contact [heterosexual (6) and homosexual (2)].

- *Cumulative No. of HIV Seropositive and AIDS cases*

From January 1984 to September 2005, the National AIDS Registry had posted a total of 2,354 HIV Ab seropositive cases. At the time of the report, 702 (30%) were already symptomatic (AIDS cases). Of the AIDS cases, 273 (39%) were already dead at the time of the report due to AIDS-related complications. Majority of the cases were among the 20-39 age group.

- *Modes of Transmission*

The predominant mode of transmission is still sexual intercourse (86%) for both sexes, with 73% heterosexual, 20% homosexual, and 6% bisexual. There have been a cumulative total of 33 cases of mother-to-child transmission (MTCT) from 1984 to September 2005.

- *HIV Prevalence Rates*

The 2003 national aggregate showed that the HIV seroprevalence among the HRG (PIP, MSM, IDU) in the sentinel sites was 0.03%

Among 3,000 sex workers tested for HIV in the ten (10) surveillance sites, a prevalence of 0.03% was recorded. For MSM, the prevalence was also 0.03% among 3,000 MSM tested for HIV.

Data from the NEC did not include prevalence for IDU, OFW, young people 15-24 years old, and for the general population 15-49 years old.

Estimates of Population Sizes

No official estimates for total population sizes of PIP, MSM, IDU were available for 2003, 2004 and 2005, making computing for percentages difficult. The data obtained mainly came from surveillance reports that included sampling sizes of 3,000 each for PIP and MSM. Further, no HIV Serologic Surveillance (HSS) was conducted in 2004 due to logistical constraints.

The *2002 Consensus Report*, on the other hand, had the following estimates for HIV prevalence rates in 2001, including the estimates of population size from which the percentages were based:²⁰

PIP (sex workers): prevalence of 1%, or 5,400 cases based on estimated population of 540,000 sex workers

IDUs: prevalence of 2%, or 200 cases based on estimated population of 10,000 IDU

15-49 population: prevalence of 0.001%, or 402 cases based on estimated population of 40.2 million in 2001

Table 1. Prevalence estimates for most-at-risk populations and general population

HIGH RISK GROUP	Prevalence Estimates	
	2003 Technical Report (NEC)	2002 Consensus Report (WHO and DOH)
PIP	0.03%	1%
MSM	0.03%	no estimate provided
IDU	no estimate provided	2%
General Population 15-49 years old	no estimate provided	0.001%*

Sources: 2003 NEC Technical Report and 2002 Consensus Report on STI, HIV and AIDS Epidemiology

*based on prevalence of HIV/AIDS from blood donors screened by the Philippine Red Cross (recognizing that it may underestimate the true magnitude)

III. National Response to the HIV and AIDS epidemic

The Third (2000-2004) and Fourth (2005-2010) AIDS Medium Term Plans

The period being assessed in this country report (2003-2005) covers part of two (2) medium-term plans: the last two years of the *2000-2004 Medium Term Plan (AMTP III)*, and the first year of the *2005-2010 AIDS Medium Term Plan (AMTP IV)*.

The *AMTP III* recommended the acceleration of the Philippine response ahead of the potential acceleration of the epidemic. *AMTP III* focused the national response on an integrated package of five complementary strategies:

1. Management and advocacy: Creating an enabling environment for sustained HIV prevention;
2. Research and surveillance: Understanding the HIV epidemic, risky behavior, and factors affecting vulnerability to infection;

3. Small-scale trials in prevention and support: Demonstrating effective approaches to reduce risks from HIV infection and manage its impact;
4. Large-scale preventive interventions: Expanding implementation of effective approaches to reduce risks of HIV infection associated with the most prevalent risky behavior; and
5. Care and support: Managing the impact to those infected and affected.²¹

In its review of the past national response, the *AMTP III* noted that,

- strong foundations have been put in place that have helped advance the country's capability to confront the issues posed by HIV and AIDS;
- while the current response has adequate scope, it does not have adequate scale in terms of their coverage and output; response has been diffused and diluted;
- there is a clear danger of losing ground if the past pattern of response continues: the epidemic may continue to spread ahead of the country's ability to prevent it; and
- the country's response needs to scale up, accelerate and expand ahead of the spread of the infection.²²

Building from the gains and as well as learning from the lessons of the *AMTP III*, the current *AMTP IV* envisions that the national response for the five year period 2005-2010 must:

1. intensify prevention interventions among highly vulnerable groups identified in *AMTP III* – PIP, MSM, IDU, and clients of PIP; and scale-up prevention efforts towards other vulnerable groups such as OFW, youth and children;
2. expand coverage and integrate HIV/AIDS in the development priorities at the local level, giving priority to identified risk zones;
3. improve the coverage and quality of care and support for people living with HIV/AIDS; and
4. strengthen management support systems for the national response.²³

The *AMTP IV* likewise emphasized that “priority must be given to the infected and affected as well as the existing and emergent highly-vulnerable groups, especially those not covered in the *AMTP III*, which include OFW, youth, infected and affected children.”²⁴

Active and Passive Surveillance Systems in Place

Since 1987, the Department of Health (DOH) has put in place both passive and active surveillance systems in order to keep track of how the epidemic progresses.

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

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

The four (4) types of surveillance systems in place are the following:

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

2. *HIV Serologic Surveillance (HSS)* - started in 1993 to serve as early warning for increases in HIV seroprevalence. HSS consistently monitored what it considered as High Risk Groups (HRG) for HIV – Registered Female Sex Workers (RFSW), Freelance Female Sex Workers (FFSW), Men Having Sex with Men (MSM), and Injecting Drug Users (IDU).

3. *Behavioral Sentinel Surveillance (BSS)* - established in the ten (10) HSS sentinel sites to monitor the level of risk behaviors among HRG. Local Research Institutions recommended by the health officers implemented BSS in eight (8) sites from 1997 to 2001. In 2002, ten local government units (LGUs) institutionalized the HIV BSS, thus expanding the surveillance sites to ten. The same HRG as in the HSS were monitored but research teams were given the opportunity to include other special groups that they considered at risk in their respective sites.

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

The *2002 HIV/AIDS Country Profile Philippines* cites that “[a]ccording to behavioral and special STI prevalence studies conducted by the NHSS and Family Health International (FHI), there seems to be a potential for the rapid transmission of HIV... due to unsafe sexual practices and high STI rates.”²⁵

In 2003, there were ten (10) sentinel sites included in these surveys. However, in 2004, no HSS was conducted due to logistical constraints.

For 2005, there are ten (10) sentinel surveillance sites in the country where HIV serological surveillance and behavioral sentinel surveillance are conducted. Funding for surveillance surveys in the ten sites are provided by the United States Agency for International Development (USAID).

Sentinel sites were chosen based on the following criteria: degree of urbanization, the presence of known commercial sex trade, geographical representativeness and the willingness of their LGU executives to collaborate with DOH.²⁶

These ten (10) surveillance sites are as follow:

NCR: Pasay City, Quezon City

Luzon: Angeles, Baguio

Visayas: Cebu City, Iloilo City

Mindanao: Davao, Cagayan de Oro, General Santos, Zamboanga

National Commitment and Action

National Commitment at a glance	
Government funds spent on HIV and AIDS:	
2003: Phil. Pesos	35,850,000 (USD 661,448)
2004: Phil. Pesos	33,308,000 (USD 594,454)
2005: Phil. Pesos	33,308,000
National Composite Policy Index:	2003: <u>85.00 %</u>
	2005: <u>91.66 %</u>
<i>Sources: Philippine National AIDS Council-Department of Health (PNAC-DOH) and National Economic and Development Authority (NEDA)</i>	

- ***The Philippine National AIDS Council (PNAC)***

At the center of the country response to HIV/AIDS, a strong framework for multi-sectoral coordination of multi-level activities has been formally established in the Philippine National AIDS Council (PNAC). The Council has the broad representation, legal mandate and official policy instructions to lead the country's efforts.²⁷

In 1992, the country was among the first in the region to set up a national council that focused on policymaking to address the HIV/AIDS situation in the Philippines. The Philippine National AIDS Council (PNAC) was established through Executive Order No. 39 as advisory body to the President. PNAC is a multi-sectoral body composed of members representing key government agencies and several non-government organizations (NGOs). PNAC meetings are also attended by invited observers from private agencies, professional associations, and donor agencies.

The Council is scheduled to have regular quarterly meetings – and also to convene special meetings – to deliberate and decide on key issues and recommendations for policy and program that are then forwarded to the President for approval and implementation.

- ***Republic Act No. 8504: The Philippine AIDS Prevention and Control Act of 1998***

In 1998, through Senate initiative and with strong advocacy and support from PNAC, NGOs and many other groups, the Philippines became one of the first few countries in the region to enact a landmark legislation that sought to put in place a comprehensive response to address the AIDS epidemic. Republic Act 8504 or “The Philippine AIDS Prevention and Control Act of 1998” sought to:

1. promulgate policies and prescribe measures for the prevention and control of HIV/AIDS in the Philippines;
2. institute a nationwide HIV/AIDS information and educational program;
3. establish a comprehensive HIV/AIDS monitoring system; and
4. strengthen the Philippine National AIDS Council (PNAC).

RA 8504 contains provisions on education and information, safe practices and procedures, health and support services, monitoring, confidentiality, and discriminatory acts and policies. It prohibits compulsory HIV testing.

A Note on Governmental Structures and Functions in the Philippines

The Philippines has a centralized national government based in the capital city Manila. It follows a presidential form of government with three (3) separate and co-equal branches of government: executive, legislative, and judiciary. The President directs the country's health policy through the Department of Health (DOH).²⁸

While policy is set at the national level, enforcement and implementation of these policies, rest on the local government units (LGUs). However, different political dynamics exist at each government level.²⁹

The LGUs, being autonomous from the central government, and guided by their own political and economic interests, determine their own priority programs and make their own budget allocations. Moreover, LGUs are not required to report their activities and provide local data to the national-level agencies. Thus, there is no assurance that national policies will always be followed and that data from the local levels will be received by the national agencies.

The UNGASS National Composite Policy Index (NCPI)

The UNGASS National Composite Policy Index (NCPI) is an instrument that measures the second UNGASS national commitment and action indicator. It is designed to “assess progress in the development and implementation of national level HIV/AIDS policies and strategies” and to “estimate the amount of effort put into national HIV/AIDS programmes by national level government, NGOs, and by international organizations.”³⁰

The NCPI is divided into two parts: Part A pertains to the assessment of national efforts by government agencies and is to be administered to governments' officials. Part B provides civil society with a tool to assess national efforts and is to be administered to representatives of governments' primary partners including non-governmental organizations.

The NCPI looks into the following policy areas:

1. Strategic Plan – pertains to the presence of an action framework to combat HIV and AIDS; to be answered by government agencies;
2. Prevention – whether the country has policies/strategies that promote IEC on HIV and AIDS;
3. Human Rights – presence of policies, laws and regulations and its implementation to protect PLWA against discrimination;
4. Care and Treatment – presence of policies and its implementation to promote HIV and AIDS care and support with attention to barriers for women, children and most-at-risk populations³¹

***NGO Assessment of the National Response:
Narrative of NGO inputs to NCPI Part B***

A. Processes followed to obtain the NGO inputs

To generate NGO inputs for the NCPI Part B for civil society, the following processes were undertaken:

1. Selection of NGOs that will be invited to participate and contribute to the processes

Selection was done in consultation with Pinoy UNGASS, the Philippine National AIDS Council (PNAC), the Global Fund Project, and UNAIDS. Pinoy UNGASS is a national network of NGOs that monitors the implementation of UNGASS commitments. NGOs selected must have existing programs on HIV and AIDS and must have been working on these issues for at least three (3) years.

It will be emphasized at this point that the process does not claim to have included all NGOs working on HIV and AIDS in the country. Due to logistical and time constraints, the number of those that could be invited was limited. Over 40 NGOs were invited coming from the following: member NGOs of Pinoy UNGASS, PNAC member NGOs, and some of the major networks of HIV/AIDS NGOs in the regions.

2. Fielding of NCPI Part B Questionnaire

The NCPI Part B Questionnaire was fielded to over 40 key NGOs and NGO networks with existing programs on HIV/AIDS for their representatives to fill-up.

3. NGO Consultation Meetings for the NCPI Part B

Two separate NGO consultation meetings were held in 2005: the first one in September 27 and the second in October 28. For these consultations, a combined total of about 35 NGOs and NGO networks from Luzon, Visayas, Mindanao and the National Capital Region (NCR) with programs on HIV and AIDS were invited to attend; of this number, 24 were able to participate. Some of those who were not able to participate sent their filled-up questionnaires (by email, facsimile; some were picked up from their offices as requested) while representatives of one NGO with programs in Luzon were interviewed.

4. Multi-sectoral Validation Meeting with NGOs and government agencies

A Multi-sectoral Validation Meeting was convened on November 14, 2005 to validate the data obtained as well as the draft of the Country Report. For this validation meeting, over 40 NGOs and NGO networks as well as key government agencies were invited. A total of 30 NGOs and government agencies were able to participate. All participants were given copies of the draft 2005 Country Report for them to review and comment on.

B. NGO inputs

During the two consultation meetings, the multi-sectoral validation meeting, and the interview with one NGO, some of the following observations were shared:

B.1 Human Rights

1. Information on provisions of RA 8504 not widely circulated

While NGOs were aware of the existence of a law on HIV and AIDS, information on and specific provisions of RA 8504 are not widely circulated nor popularized. Some NGOs also said that some of the law's provisions were not clear. Many NGO representatives, government officials, and local government officials were not familiar with specific provisions.

2. Advocacy for more specific provisions on equal access to prevention and care services

There was strong advocacy from NGOs for certain provisions of the law to be made more specific (e.g., to include specific provisions ensuring equal access of most-at-risk populations, and of women and men, to prevention and care services). The participants cited that while the law states that it applies to all individuals, it also does not explicitly state that it ensures equal access of most-at-risk populations, and of women and men, to prevention and care services.

3. Role of Human Rights Commission

NGO participants noted that while a Human Rights Commission exists, it is not pro-active but rather reactive towards HIV- and AIDS-related cases.

B.2 Civil Society Participation

1. NGOs invited to planning meetings but not to budget meetings

While some NGOs are invited to participate in planning meetings to develop strategic plans, these same groups are not invited to meetings beyond the planning stage (e.g., they are not involved in meetings that discuss budget matters).

2. NGOs not involved in technical review meetings

Many NGOs are not aware of – and are not involved – in the technical review meeting(s) convened by government agencies.

3. NGOs and PLWHA are not involved in ethical review committees for research on HIV and AIDS

B.3 Prevention

HIV and AIDS education in the schools still very limited; teachers not yet trained in life skills education on HIV and AIDS

Some NGOs shared that while there are attempts by local schools in their areas to integrate teaching HIV and AIDS into their curriculum, most of the time, it is still the NGO personnel who are asked to teach. The teachers themselves have not yet been trained to teach HIV and AIDS to their students.

B.4 Care and Support

1. Programs addressing needs of orphaned and vulnerable children still very limited

Some NGO participants, especially those from the regions, were not aware whether there were programs addressing the needs of orphaned and vulnerable children. The participants noted that the needs of children affected by HIV and AIDS are not adequately being addressed by government agencies, LGUs, private agencies, and by NGOs themselves. They cited that very few NGOs and private agencies are working in this area.

2. Programs addressing needs of orphaned and vulnerable children not reflected in government reports

An NGO that has been providing care and support for children affected by HIV and AIDS for more than a decade indicated that their programs and activities are often not reflected nor acknowledged in government reports (e.g., the AMTP IV writes on page 12 that “There is no care and support program focusing on children”).

B.5 Other observations, experiences and concerns expressed by the participating NGOs

1. Positive and negative experiences working with LGUs

NGOs have varied experiences working with local government units (LGUs) and local government officials (LGOs). Some NGOs have positive experiences working with supportive LGUs/LGOs. Others, however, encounter difficulties trying to work with LGUs and with LGOs who are indifferent or are even hostile to programs on HIV and AIDS, especially those that have discriminatory attitudes towards specific groups.

2. NGO perceptions regarding decreases and increases in programs and efforts on HIV and AIDS

Decreased number and scope of programs and efforts: Some NGOs indicated that there are less programs and efforts in 2005 compared to 2003 due to the following reasons: decreased funding from donor agencies; phasing out of the USAID-funded AIDS Surveillance and Education Project (ASEP); efforts of NGOs, government agencies and LGUs were not sustained due to inadequate funding and high turnover of staff (e.g., trained personnel have left to work in other agencies or abroad).

Increased advocacy efforts: Some NGOs, on the other hand, indicated that advocacy efforts in their areas have increased in 2005 compared to 2003.

The NGOs were optimistic that the multi-year Global Fund project will help provide much needed resource inputs to enable NGOs and government agencies to continue doing their work on HIV and AIDS.

3. National government commitment and support not felt by NGOs in the regions

NGOs from the regions indicated that they do not feel the support and commitment of the national government.

There is consensus among participating NGOs - particularly those coming from the regions - that not enough is being done by national agencies to address the problems and needs resulting from the AIDS epidemic.

The NGOs all agreed that while there are already many programs and activities being conducted all over the country, 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. They emphasized that the national government has to demonstrate firmer commitment and support to HIV and AIDS programs and allocate resources for such.

Budgetary allocations: Domestic and External Sources

Aside from policy and program, budgetary allocations are seen as indicators of commitment by government agencies, local government units, NGOs, private agencies, bilateral and multilateral agencies.

The National Economic and Development Authority (NEDA) has compiled the following figures for allocations from domestic (from national and LGU budgets) and external sources (from donor agency contributions):

For the period 2003, total allocation for HIV and AIDS and STI prevention and control programs from domestic sources was Pesos 35,850,000 (USD661,448). This includes Pesos 27,753,000 (USD512,047) from the National Government (NG), and Pesos 8,097,000 (USD149,391) from the Local Government Units (LGUs). Another Pesos 229,982,000 (USD 4,243,202) came from external sources.

For 2004, the total figures from domestic sources was Pesos 33,308,000 (USD594,454), with Pesos 8,148,000 (USD502,373) coming from the National Government and Pesos 5,160,000 (USD92,093) from the LGUs. A total of Pesos 125,005,000 (USD2,231,028) came from external sources.

For 2005, the total figure (as of December 21, 2005) is Pesos 33,308,000 from domestic sources, and Pesos 145,954,000 (USD2,653,927) from external sources.

For domestic figures, there was a decrease in allocation from 2003 to 2004 from 35,850,000 pesos to 33,308,000 pesos. There was same level of spending for 2004 and 2005 (33,308,000 pesos per year).

For funds coming from external sources, it can be noted that there was a big decrease in the amounts from 229,982,000 in 2003 to 125,005,000 in 2004. While the figures for 2005 (145,954,000 pesos) are slightly higher compared to 2004 figures (125,005,000), it still did not match the amounts posted in 2003 (229,982,000).

**Allocations for HIV and AIDS Programmes:
Domestic and External Sources**

Table 2. Domestic Sources

Name of Agency	Main Programs	Budget (in Phil. Peso and US Dollar)		
		2003 USD1=PhP54.20	2004 USD1=PhP56.03	2005 USD1=PhP55.00
Philippine National AIDS Council (PNAC)	Advocacy, Training, management	9,543,000 (176,70)	9,445,000 (168,570)	9,445,000
Department of Health: - National AIDS and STD Control Program	Prevention, Surveillance	3,093,000 (57,084)	2,851,000 (50,883)	2,851,000
- DOH-CHDs (estimates only)	Prevention, Surveillance	2,308,000 (42,580)	2,191,000 (39,10)	2,191,000
- RITM & San Lazaro (estimates only)	Treatment, Care and support	2,315,000 (42,710)	2,610,000 (46,580)	2,610,000
- SACCL	Testing	1,469,000 (27,103)	1,198,000 (21,810)	1,198,000
- NEC	Surveillance	6,881,000 (126,550)	300,000 (5,3540)	300,000
- Others			6,173,000 (110,173)	6,173,000
Department of Education (DepEd)	School-based AIDS Education Program	2,058,000 (37,970)	2,058,000 (36,730)	2,058,000
Department of Labor and Employment – Occupational Safety and Health Center (DOLE-OSHC)	Workplace-based advocacy and training	86,000 (1,586)	36,000 (642)	36,000
Commission on Higher Education (CHED)	Prevention		1,286,000 (22,951)	1,286,000
LGUs	Advocacy and Prevention	8,097,000 (149,390)	5,160,000 (92,090)	5,160,000
TOTAL		P 35,850,000 (\$661,448)	P 33,308,000 (\$594,454)	P 33,308,000

Source: National Economic Development Authority (NEDA), Philippine National AIDS Spending Assessment (NASA) Report

*same level of spending as in 2004

Note: Only a few LGUs provided expenditure data. This does not include expenditure of other public health facilities.

Table 3. External Sources

Name of Agency	Main Programs	Budget (in Phil. Peso and US Dollar)		
		2003 USD1=PhP54.20	2003 USD1=PhP56.03	2005 USD1=PhP55.00
USAID	Prevention, Surveillance	83,080,000 (1,532,841)	6,594,000 (117,686)	82,500,000 (1,500)
KfW	Prevention, Social Marketing	48,904,000 (902,287)	49,442,000 (882,420)	
Packard	Prevention	30,794,000 (568,154)	1,220,000 (21,774)	

Name of Agency	Main Programs	Budget (in Phil. Peso and US Dollar)		
		2003 USD1=PhP54.20	2003 USD1=PhP56.03	2005 USD1=PhP55.00
PSI-DFID	Prevention	4,689,000 (86,512)		
AMKOR	Advocacy, Training	111,000 (2,047)	141,000 (2,516)	
JICA	Prevention	1,247,000 (23,007)	286,000 (5,104)	
PHANSuP UK	Advocacy, Training	287,000 (5,295)	998,000 (17,811)	
CAFOD UK	Advocacy, Research	1,019,000 (18,800)	756,000 (13,492)	
British Embassy	Prevention	59,000 (1,088)		
Save the Children (UK)	Prevention related activities	820,000 (15,129)	600,000 (10,708)	
Save the Children (US)	Prevention, Advocacy, Monitoring and Evaluation		200,000 (3,569)	
Ford Foundation	Prevention, Advocacy, Monitoring and Evaluation	2,157,000 (39,797)	1,990,000 (35,516)	
Global Fund	Prevention, Treatment and Care		13,465,000 (240,317)	
EU	Prevention	42,835,000 (790,313)		
PSI-DFID	Prevention	4,689,000 (86,512)		
UNICEF	Prevention, Advocacy, Training	1,200,00 (22,140)	35,490,00 (633,410)	
UNFPA		4,282,000 (79,003)	5,022,000 (89,630)	22,766,000 (413,927)
Christian AID	Training		41,000 (731)	
Plan International	Training		300,000 (5,354)	
WHO	Training		616,000 (10,994)	
UNAIDS	Prevention, Advocacy, Monitoring and Evaluation	8,498,000 (156,789)	7,844,000 (139,996)	7,688,000 (140,000)
UNDP	Advocacy, Prevention			5,500,00 (100,000)
TOTAL		229,982,000 (4,243,202)	125,005,000 (2,231,028)	145,954,000 (2,653,927)

Source: National Economic Development Authority (NEDA,) Philippine National AIDS Spending Assessment (NASA) Report

Table 4. Summary of Figures for Domestic Sources and External Sources

Name of Agency	Main Programs	Budget		
		2003 USD1=PhP54.20	2004 USD1=PhP56.03	2005 USD1=PhP55.00
1. Domestic Sources	Advocacy, training, Prevention, Surveillance Treatment, Care	35,850,000 (USD661,448)	33,308,000 (USD594,454)	33,308,000*
2. External Sources	Advocacy, Training, Prevention, Surveillance, Treatment and Care, Social Marketing, Monitoring and Evaluation	229,982,000 (USD4,243,202)	125,005,000 (USD2,231,028)	145,954,000 (USD2,653,927)
TOTAL		265,832,000 (USD4,904,649)	158,313,000 (USD2,825,482)	179,620,000

Source: National Economic Development Authority (NEDA), Philippine National AIDS Spending Assessment (NASA) Report

*same level of spending as in 2004

Prevention activities include: IEC, condom social marketing, STI management and treatment
 Treatment includes: treatment of opportunistic infections (OI), prophylaxis for OI
 Program Support includes: advocacy, training, surveillance, monitoring and evaluation

National Programmes

National programmes at a glance	
HIV Testing and Prevention	
1. HIV testing	
<i>% of most-at-risk populations who receive HIV testing in the last 12 months and who know the results</i>	
PIP:	3,300 PIP tested for Syphilis and HIV from June to July 2005 (data from GFATM project)
MSM:	1,400 MSM tested for Syphilis and HIV from June to July 2005 (data from GFATM project)
	15 MSM out of 15 MSM tested (data from Remedios AIDS Foundation)
IDU:	no data obtained as of writing of this Country Report
<i>% of OFW who receive HIV testing and who know their test results</i>	
	no data obtained as of writing of this Country Report

2. Prevention

% of most-at-risk populations who have accessed HIV/AIDS programs during the last 12 months

PIP: no final percentage figures available since there is no official estimate of PIP population for 2003, 2004, 2005³²

4% (4,431 number of PIP [new contacts] out of 115,000 total estimated population of PIP); for female freelance sex workers; data covers the period from February to September 2005³³ (data from LEAD Project)

4,224 PIP reached by prevention programs between August 2004 to August 2005 (data from Global Fund project)

MSM: no final percentage figures available since there is no official estimate of MSM population for 2003, 2004, 2005

3% (6,014 number of MSM who have accessed HIV/AIDS programs during the last 12 months out of 200,000 total estimated population of MSM); data covers the period from February to September 2005³⁴ (data from LEAD Project)

2,558 MSM reached by prevention programs between August 2004 to August 2005 (data from Global Fund project)

IDU: no percentage figures available since there is no official estimate of IDU population for 2003, 2004 and 2005

441 IDU who have accessed HIV/AIDS programs during the last 12 months [no size estimate due to lack of data]; data covers the period from February to September 2005³⁵ (data from LEAD Project)

800 IDU reached by prevention programs between August 2004 to August 2005 (data from Global Fund project)

% of vulnerable populations who have accessed HIV/AIDS programs during the last 12 months

OFW: no percentage figures available since there is no official estimate of OFW population for 2003, 2004, 2005

3,084 OFW (data from Global Fund project)

12,780 out of targeted 15,000 OFW for Oct 2004 to June 2005 (data from PAFPI project)

OSY: no percentage figures obtained since there is no official estimate of OSY population available as of writing of this Country Report

street children: no percentage figures obtained since there is no official estimate of street children population available as of writing of this Country Report

% of primary, secondary, tertiary and technical/vocational school teachers trained on HIV/AIDS

Primary and Secondary Levels (c/o DepEd): 111 officers and personnel trained in 2003 on the “Integration of AIDS Education in the Basic Education Curriculum”

Technical/Vocational Level (c/o TESDA): 37 teachers trained in October 2003; no further trainings were held in 2004 and 2005

% of large, medium and small-scale enterprises that have HIV/AIDS workplace policies and programs

Large-scale enterprises: 11% in 2004; 32% as of June 2005

Medium-scale enterprises: 9% in 2004; (no figures provided for 2005)

Small-scale enterprises: 27% in 2004; 16% as of June 2005

1. HIV Testing

There are hundreds of public and private clinics and laboratory facilities all over the country accredited to do HIV testing. The STD/AIDS Cooperative Central Laboratory (SACCL) reports that there are around 500 HIV laboratories and 2,000 clinical laboratories nationwide.

However, getting percentage figures on HIV testing among most-at-risk populations as well as among vulnerable groups is difficult since not all of these clinics and laboratories report their data to national level agencies.

For this indicator, no percentage figures were obtained. However, actual figures were available from projects currently being implemented.

Below is a listing of actual numbers obtained from the Global Fund Project as well as from Remedios AIDS Foundation regarding most-at-risk populations who receive HIV testing in the last 12 months and who know the results.

PIP: 3,300 PIP tested for Syphilis and HIV from June to July 2005 (*data from GFATM project*)

MSM: 1,400 MSM tested for Syphilis and HIV from June to July 2005 (*data from GFATM project*)
15 MSM out of 15 MSM tested (*data from Remedios AIDS Foundation*)

IDU: no data obtained as of writing of this Country Report

No percentage data was obtained for OFW who have received HIV testing and who know their test results.

Meanwhile, voluntary counseling and testing among males aged 15-49 is very low. Moreover, of those ever tested, only 2.7% received their test results. Percentage who tested for HIV and who received their results in the past 12 months is only 0.6%.

Table 5. Voluntary counseling and testing among men aged 15-49 (in percentage)

	Percent
Ever tested	
Received results	2.7
No results	0.9
Never tested	92.0
Don't know/missing	4.4
Percentage tested for HIV and received results in past 12 months	0.6

Source: Philippines National Demographic and Health Survey 2003, as cited in the 2005 Philippine HIV and AIDS Country Profile

2. Prevention Programmes

Percentage of most-at-risk populations accessing HIV/AIDS programs during the last 12 months

PIP: No final percentage figures were available for Persons in Prostitution (PIP) since there are no official estimates of PIP population for 2003, 2004 and 2005 coming from the Department of Health.³⁶ Actual figures are available from two (2) major projects currently being implemented. These are:

4% (4,431 number of PIP [new contacts] who have accessed HIV/AIDS programs out of 115,000 total estimated population of PIP); for female freelance sex workers; data covers the period from February to September 2005³⁷ (data from LEAD Project)

4,224 PIP reached by prevention programs between August 2004 to August 2005 (data from Global Fund project)

MSM: No final percentage figures were available for Men Having Sex with Men (MSM) since there are no official estimates of MSM population for 2003, 2004 and 2005 coming from the Department of Health. Actual figures are available from two (2) major projects currently being implemented. These are:

3% (6,014 number of MSM who have accessed HIV/AIDS programs during the last 12 months out of 200,000 total estimated population of MSM); data covers the period from February to September 2005³⁸ (data from LEAD Project)

2,558 MSM reached by prevention programs between August 2004 to August 2005 (data from Global Fund project)

IDU: No final percentage figures were available for Injecting Drug Users (IDU) since there are no official estimates of IDU population for 2003, 2004 and 2005 coming from the Department of Health.³⁹ Actual figures are available from two (2) major projects currently being implemented. These are:

441 IDU who have accessed HIV/AIDS programs during the last 12 months
(no size estimate due to lack of data); data covers the period from February to
September 2005⁴⁰ (*data from LEAD Project*)

800 IDU reached by prevention programs between August 2004 to August 2005
(*data from Global Fund project*)

As for percentage figures for OFW who have accessed HIV/AIDS programs during the last 12 months, these were also not available since there were no official estimates for OFW for 2003, 2004 and 2005. Nevertheless, actual figures were obtained from the following:

3,084 OFW (*data from Global Fund project*)

12,780 out of targeted 15,000 OFW for Oct 2004 to June 2005 (*data from PAFPI project*)

No percentage figures were likewise obtained for OSY and street children since there are no official estimates of OSY and street children population available as of writing of this Country Report

***Life Skills Based Approach to HIV and AIDS Education:
Percentage of primary, secondary, tertiary and technical/
vocational school teachers trained on HIV/AIDS***

1. Training of teachers at the primary and secondary levels (c/o the Department of Education)

HIV and AIDS topics and issues had been integrated into the curriculum for primary and secondary levels in 2002. IEC materials have been revised and printing of these materials is scheduled in 2006.

In 2003, a total of 111 officers and personnel underwent the “Training of Trainers on the Integration of AIDS Education in the Basic Education Curriculum.” Three batches of participants composed of teachers, administrators, coordinators of programs, medical officers, supervisors, principals and district supervisors attended the three-day training activities. Participants came from the following areas:

First batch (April 21-23, 2003): 30 participants from Regions 1 and 3

Second batch (May 5-7, 2003): 31 participants from Regions 4, 5 and the National Capital
Region NCR

Third batch (May 12-14, 2003): 50 participants from Regions 7, 8, 9 and CARAGA

2. Training of teachers at the technical/vocational school levels (c/o the Technical Education and Skills
Development Authority - TESDA)

Two trainings were held in 2003 attended by a combined total of 37 teachers from Regions 1, 3, 5, 9, Cordillera Administrative Region (CAR) and the NCR. No other trainings were held in 2004 and 2005.

An official training manual has been developed but printing has been put on hold due to budgetary limitations.

3. Training of teachers at the tertiary levels (c/o the Commission on Higher Education, or CHED): no information obtained from CHED.

***Workplace HIV/AIDS Control:
HIV/AIDS workplace policies and programs***

1. Enterprises with HIV/AIDS workplace policies and programs

Data from the Department of Labor-Occupational Safety and Health Center (DOLE-OSHC) Survey on Workplace-based STD/HIV Activities (two surveys: one in 2004, and one covering January to June 2005) showed the following percentages (%) of large, medium and small-scale enterprises that have HIV/AIDS workplace policies and programs:

Large-scale enterprises: 11% in 2004; 32% for January to June 2005
 Medium-scale enterprises: 9% in 2004; (no figures provided for 2005)
 Small-scale enterprises: 27% in 2004; 16% for January to June 2005

Table 6. % of Employers with HIV/AIDS Workplace Policies and Programs

Type	2004	Jan-Jun 2005
	%	%
Large-scale	11	32
Medium-scale	9	--
Small-scale	27	16

Source: DOLE-OSHC 2004 and 2005 Surveys

Note: based on surveyed employers/companies only: N=87 in 2004; N=35 for Jan-June 2005

2. Employers with accepting attitudes towards PLWHA employees

The DOLE-OSHC Survey also cited percentages (%) of employers with accepting attitudes towards PLWHA employees: nine percent (9%) in 2004 specified in their company policy their commitment to employment of persons regardless of HIV status. The figure for 2005 (January to June) is 40%.

When disaggregated according to urban and rural areas, the data showed that 38% of employers in urban areas had accepting attitudes towards PLWHA employees. The figure was 50% for rural areas.

3. Employers with accepting attitudes towards PLWHA

The same DOLE-OSHC Surveys revealed that 56% of employers surveyed in 2004 had accepting attitudes towards PLWHA. The figure is 40% for January to June 2005.

When disaggregated according to urban and rural areas, the 2005 data showed that 38% of employers in urban areas had accepting attitudes towards PLWHA while the figure was 50% for rural areas. The 2004 data did not include disaggregated figures for urban and rural areas.

Table 7. % of Employers with Accepting Attitudes towards PLWHA Employees and PLWHA in general; in rural and urban areas

Description	2004	Jan-June 2005
	%	%
With accepting attitudes towards PLWHA employees	9	40
Urban	no data	38
Rural	no data	50
With accepting attitudes towards PLWHA	56	40
Urban	no data	38
Rural	no data	50

Source: DOLE-OSHC 2004 and 2005 Surveys

Note: based on surveyed employers/companies only: N=87 in 2004; N=35 for Jan-June 2005

National Knowledge and Behaviour

National knowledge and behaviours at a glance

1. Knowledge: Most-at-Risk Populations

% of most-at-risk populations (PIP, MSM, IDU) who can correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission⁴¹

PIP: RFSW: 66%, FLSW: 55%

MSM: 61%

IDU: 49%

2. Behaviour: Most-at-Risk Populations

% of most-at-risk populations (PIP, MSM, IDU) reporting use of condom with their most recent client

PIP: female sex workers: 67% (2,894 respondents who reported that a condom was used with their most recent client out of 4,322 who reported having commercial sex in the last 12 months)
Location: 100% urban⁴² (data from LEAD Project citing 2005 IHBSS)

PIP: male sex workers: 45% (138 reported that condom was used with their most recent client out of 304 who reported having commercial sex in the last 12 months) Location: 100% urban⁴³

PIP: 70% (1,679 PIP who reported that a condom was used with their most recent client out of 2,400 who have reported having commercial sex in the last 12 months) (data from BSS 2003 - supplied by NEC)

MSM: 20% (170 respondents reported that a condom was used with their last male partner in the last 6 months out of 840 respondents who reported having had anal sex with a male partner in the last 6 months (data from NEC - citing 2003 BSS)

% of PIP who consistently used a condom in the last month

Female sex workers: 57% reported consistent condom use (1937 out of the 3,402) - time frame is the past week

Male sex workers: 27% reported consistent condom use (82 out of 304) – time frame is past week (data from LEAD Project)

% of IDU who have adopted behaviours which reduce the transmission of HIV

7% (8 respondents who report having never shared injecting equipment during the last month and who reported that a condom was used the last time they had sex, out of 120 respondents who report injecting drugs and having sexual intercourse in the last month) (data from NEC - citing 2003 BSS)

0.2% (24 IDU who used a condom during last sexual encounter, out of 120 IDU who reported having had sex during the last three (3) months) (data from NEC - citing 2003 BSS; note: the question asked “last 3 months” and not last month)

3. Knowledge: Young People

% of people 15-24 years of age who can correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission⁴⁴:

76.8% of young people agreed that condoms can prevent STI/AIDS if used properly

35% of young females and 28.5% of young males correctly rejected the two misconceptions that AIDS can be transmitted by mosquito bites and by sharing food with persons with AIDS.

39.4% of young females and 51.7% of young males correctly answered that condoms and limiting sex to one uninfected partner can reduce the risk of HIV transmission

4. Behaviour: Young People

% of people 15-24 years of age reporting use of condom during sexual intercourse with non-regular partner:

12.6% of young people who had experience with sex reported use of a condom during sexual intercourse with a non-regular partner (the term “casual partner” was used in the 2002 YAFS)

26.8% among those who reported having had a sexual encounter with a PIP said they used condom every time they paid for sex

10.4% said they used condom when paid for sex

1. Knowledge among Most-At-Risk Populations: PIP, MSM, IDU

To determine level of knowledge on HIV and AIDS, the UNAIDS provided a criteria that respondents should “correctly identify five ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.” While the surveillance surveys did not include all the five questions prescribed in the *UNAIDS Guidelines for Construction of Core Indicators*, the available data can still give valuable insights about the level of knowledge on STI, HIV and AIDS among most-at-risk populations.

As knowledge indicator for most-at-risk populations, the 2003 NHSS obtained the proportion of HRGs who knew of three correct ways to prevent HIV transmission. These three are: 1) being faithful to one faithful partner; 2) consistent and correct condom use; and 3) non-sharing of injecting equipment.

The 2003 *NEC Technical Report* cited that “per site analysis, [the] 2003 BSS showed that the proportion of study participants who knew of three correct ways of preventing HIV transmission in all cities decreased. Exemptions would include Angeles, Iloilo and Zamboanga for RFSW, Angeles, Baguio and Iloilo for FLSW and Zamboanga for MSM.”⁴⁵

The figures for each group are as follow:

Table 8. Proportion of Most-at-Risk Populations Knowledgeable on HIV

High-risk Group (HRG)	Proportion Knowledgeable* on HIV	
	2002	2003
PIP: RFSW	74%	66%
PIP: FLSW	61%	55%
MSM	64%	61%
IDU	54%	49%

Source: 2003 NEC Technical Report

*Knowledgeable on HIV – those who can correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission

Figures from the 2005 IBHSS are not yet available as of the time of writing of this Country Report.

2. Sexual Behaviour: Number of Sex Partners and Reported Consistent Condom Use among Most-At-Risk Populations

Consistent condom use was generally low (<30%) among the HRG in 2003. The only improvement was posted among MSM from 2002-2003.⁴⁶

- *Number of Sex Partners and Reported Consistent Condom Use among PIP*

The 2003 NEC Technical report cites that the number of sex partners of female sex workers vary from one to 80 per week; median was two (2) per week for RFSW and four (4) per week for FLSW.

The 2003 BSS showed that condom use by female sex workers with their non-regular partners was higher compared to condom use with their regular-paying and regular non-paying partners.⁴⁷ However, the percentages for RFSW fell from 30% in 2002 to 28% in 2003. For FLSW, the percentages were 30% in 2002 and 26% in 2003.

- *Percentage of PIP who reported consistent condom use in the last month:*

Data from LEAD Project:

Female sex workers: 57% reported consistent condom use (1937 out of the 3,402) - time frame is the past week

Male sex workers: 27% reported consistent condom use (82 out of 304) – time frame is past week

- *Percentage of most-at-risk populations (PIP, MSM, IDU) reporting use of condom with their most recent client*

Data from LEAD Project (citing 2005 IHBSS):

PIP – female sex workers: 67% (2,894 respondents who reported that a condom was used with their most recent client out of 4,322 who have reported having commercial sex in the last 12 months). Location: 100% urban⁴⁸

PIP – male sex workers: 45% [138 reported that condom was used with their most recent client out of 304 who reported having commercial sex in the last 12 months]. Location: 100% urban

Data from BSS 2003 (supplied by NEC):

70% (1,679 PIP who reported that a condom was used with their most recent client out of 2,400 who have reported having commercial sex in the last 12 months).

- *Number of Sex Partners and Reported Consistent Condom Use among MSM*

The 2003 NEC data showed that some MSM reported as many as 55 sex partners per month. The norm however, is two (2) per month.

Data show that MSM practiced anal sex more with their regular non-paying partners (51%) while they practiced oral sex more with their non-regular partners (53%) and regular paying partners (40%). As for condom use, the 2003 BSS revealed that among HRG, only MSM posted improvement from 12% in 2002 to 19% in 2003.

Figures from the 2005 IBHSS are not yet available as of the time of writing of this Country Report

• *Number of Sex Partners, Safe Use of Injecting Equipment and Reported Consistent Condom Use among IDU*

The median number of sex partners per month for IDU was one according to the 2003 NEC data.

The 2004 NHSSS indicated that while most surveillance sites reported use of prohibited drugs by HRG, few are cases of injecting drug use. However, although the proportion of IDU sharing injecting equipment has been decreasing, the use of bleach and water in cleansing equipment has been decreasing since 2002.

For IDU, consistent condom use decreased from 3% in 2002 to 2% in 2003.

For the indicator on percentage of injecting drug users who have adopted behaviors which reduce the transmission of HIV, the NEC (citing 2003 BSS) had the following figures: 7% (8 respondents who report having never shared injecting equipment during the last month and who reported that a condom was used the last time they had sex, out of 120 respondents who report injecting drugs and having sexual intercourse in the last month)

Data from NEC (citing 2003 BSS; note: the question asked “last 3 months” and not last month) reflected the following figures: 0.2% (24 IDU who used a condom during last sexual encounter, out of 120 IDU who reported having had sex during the last three (3) months)

Figures from the 2005 IBHSS are not yet available as of the time of writing of this Country Report

Table 9. Summary of Number of Sex Partners and Reported Consistent Condom Use among Most-at-Risk Populations (High Risk Groups)

High-risk Group (HRG)	Median Number of Sex Partners Per Month		Reported Consistent Condom Use	
	2002*	2003	2002	2003
PIP: RFSW	-	2	30%	28%
PIP: FLSW	-	4	30%	26%
MSM	-	2	12%	19%
IDU	-	1	3%	2%

Source: 2003 NEC Technical Report

*Data not supplied

STI Incidence among Most-At-Risk Populations

Proportion of Most-At-Risk Populations Who Reported Signs and Symptoms of STI

The 2003 NEC technical report revealed that female sex workers (RFSW and FLSW) reported signs and symptoms of STI more often than MSM. There was a 50% increase of IDU reporting signs and symptoms of STI in 2003 compared to 2002. Breakdown of the figures is as follow:

Table 10. STI Incidence among Most-At-Risk Populations (High Risk Groups)

	Reported Signs and Symptoms of STI	
	2002	2003
PIP: RFSW	24%	22%
PIP: FLSW	18%	24%
MSM	7%	8%
IDU	5%	10%

Source: 2003 NEC Technical Report

Table 11. Summary Table for Knowledge and Behaviour and STI Incidence among Most-at-Risk Populations

High-risk Group	Proportion Knowledgeable* on HIV		Reported Consistent Condom Use		Median No. of Sexual Partners per Month		STI Incidence	
	2002	2003	2002	2003	2002	2003	2002	2003
PIP: RFSW	74%	66%	30%	28%	-	2	24%	22%
PIP: FLSW	61%	55%	30%	26%	-	4	18%	24%
MSM	64%	61%	12%	19%	-	2	7%	8%
IDU	54%	49%	3%	2%	-	1	5%	10%

Source: 2003 NEC Technical Report

*Knowledgeable on HIV – those who can correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission

Reported STI Cases among Male and Female Consultations

Data cited in the 2005 Philippine HIV and AIDS Country profile show that nine percent (9%) of 213,864 females and eight percent (8%) of 15,284 males consulting for STI signs and symptoms were diagnosed as STI cases.

Table 12. Reported STI cases among male and female consultations SSESS 2003

	Number of consultations	STI cases (number)	STI cases (in percent)
Female	213,864	19,829	9
Male	15,284	1,154	8

Source: 2003 HIV/AIDS Technical Report, as cited in 2005 Philippine HIV and AIDS Country Profile

3. Young People's and the General Population's Knowledge about STI, HIV and AIDS

The 2003 NDHS figures on Table 13 below indicate high levels of awareness about AIDS, e.g., who have heard of AIDS and who believe there is a way to avoid HIV/AIDS, across the age groups from 15-54 years, among those residing in urban and rural areas.

Table 13. Knowledge of AIDS: Percentage of women and men who have heard of AIDS and who believe there is a way to avoid HIV/AIDS, by background characteristics. Philippines 2003

Background characteristic	Women			Men		
	Has heard of AIDS	Believes there is a way to avoid HIV/AIDS	Number of women	Has heard of AIDS	Believes there is a way to avoid HIV/AIDS	Number of men
Age						
15-19	93.1	83.6	2,648	93.3	84.7	918
20-24	95.3	90.0	2,209	96.4	90.9	785
25-29	95.6	90.5	2,034	96.6	91.9	647
30-39	96.5	90.0	3,827	96.3	91.0	1,179
40-49	95.1	87.3	2,915	96.0	88.6	899
50-54	na	na	0	95.2	88.6	338
Residency						
Urban	96.6	90.8	7,877	96.9	92.7	2,553
Rural	93.3	84.8	5,756	94.2	85.4	2,213

Source: Philippines National Demographic and Health Survey 2003

However, this high level of awareness does not necessarily translate to high levels of knowledge as misconceptions still abound as shown by the 2003 NDHS figures on Tables 14.

Table 14. Beliefs about AIDS: Percentage of women and men aged 15-49 who, in response to a prompted question, correctly rejected local misconceptions about AIDS transmission or prevention, by background characteristics, Philippines 2003

Background characteristic (Age)	Percentage of respondents who know that:									
	AIDS cannot be transmitted by mosquito bites		AIDS cannot be transmitted by supernatural means		A person cannot become infected by sharing food with PWA		Percentage who correctly rejected the two* most common misconceptions		Number of women and men	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
15-19	58.1	55.3	75.4	76.2	45.6	39.8	33.7	26.0	2,648	918
20-24	62.2	60.9	83.0	84.4	56.8	46.2	36.8	31.5	2,209	785
25-29	62.6	62.1	84.0	85.7	57.6	47.5	39.6	34.0	2,034	647
30-39	59.3	56.0	81.1	81.2	55.8	45.6	37.6	30.0	3,827	1,179
40-49	58.5	56.8	76.3	78.9	51.6	44.1	33.3	29.9	2,915	899
15-24	60.0	57.9	78.8	80.0	50.7	42.8	35.1	28.5	4,856	1,702

Source: Philippines National Demographic and Health Survey 2003

*The two most common local misconceptions involve transmission by mosquito bites and by sharing food with a person who has AIDS (both country specific)

To determine level of knowledge on HIV and AIDS, the UNAIDS provided a criteria that respondents should “correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.” Five questions were prescribed by UNAIDS for this indicator. While the 2002 Young Adult Fertility and Sexuality Survey (2002 YAFS) did not ask all five questions and most of the questions were phrased differently, the following data can also give insights about the level of awareness and knowledge on STI, HIV and AIDS among the more than 16,000 surveyed about knowledge and behavior on HIV, AIDS and STI.

Table 15. Trends in awareness and knowledge of HIV/AIDS, by sex and age: 2002

Sex and age	Knew STD	Heard of AIDS	Thought that AIDS is curable	Thought that there is no chance of them getting AIDS
Males	69.8	94.9	30.1	72.3
15-19	65.5	93.6	30.4	71.3
20-24	76.9	97.0	29.6	74.0
Females	62.5	95.3	25.7	74.3
15-19	60.9	94.8	25.9	73.9
20-24	64.8	96.1	25.5	74.9
Both sexes	65.9	95.1	27.8	73.4
15-19	63.1	94.2	28.1	72.6
20-24	70.2	96.5	27.4	74.5
N Cases	16,235	16,210	13,837	13,533

Source: *Youth Sex and Risk Behaviors in the Philippines 2004*

Further, the *2004 Youth Sex and Risk Behaviors in the Philippines* cites the following findings:

- 76.8% of young people agreed that condoms can prevent STI/AIDS if used properly
- 35% of young females and 28.5% of young males correctly rejected the two misconceptions that AIDS can be transmitted by mosquito bites and by sharing food with persons with AIDS
- 39.4% of young females and 51.7% of young males correctly answered that condoms and limiting sex to one uninfected partner can reduce the risk of HIV transmission.

Data from the above study likewise reflect that those surveyed had a higher awareness about AIDS while knowledge on both STI and AIDS were low. More than a quarter of those surveyed still thought that AIDS is curable and more than 70% of males and females aged 15-24 thought that there was no chance for them to get AIDS.

4. Young People’s Sexual Behaviour

Young people’s sexual initiation

Data from the 2002 YAFS indicate that the median age at first penetrative sexual intercourse among 15-24 years old was 18 for both sexes. The median age was 17 years old for males and 18 years old for females.

The figures in Table 16 below provide insights into the sexual behavior of young people between the ages of 15-24. It is important to note that more than 20% of respondents said that for their first sexual intercourse they did not want this to happen but that they went along with it. Another 32% said that they did not plan on having sexual intercourse but it happened anyway. Four percent (4%) of the females in this survey said that sexual intercourse was something that happened against their will.

Table 16. Youth risk behavior among young adults aged 15-24

	Male	Female	Both
Ever had sex	31.3	15.7	23.1
First sexual intercourse was something...			
Wanted to happen	46.0	34.9	42.1
Did not want but went along	21.3	27.3	23.4
Did not plan but happened anyway	31.8	33.7	32.5
Happened against will	(1.0)	4.0	2.0
Practiced contraception			
During first sexual intercourse	27.5	14.9	21.0
During last sexual intercourse	26.6	21.8	24.8
Used condom...			
During first sexual intercourse	43.0	38.0	40.5
During last sexual intercourse	45.2	23.3	38.2
Had sex with more than one partner	48.9	10.6	34.8

Source: Philippines National Demographic and Health Survey 2003, as cited in the 2005 Philippine HIV and AIDS Country Profile

Young People's Condom Use with Non-Regular Partner

About 12.6% of young people reported use of a condom during sexual intercourse with a non-regular partner (the term "casual partner" was used in the 2002 YAFS).

Among those who had sexual encounter with a PIP, 26.8% said they used condom every time they paid for sex. About 10.4% said they used condom when paid for sex.

All of the above data highlight the need for intensified information and education activities to reduce and minimize - if not eliminate - major misconceptions. Efforts in these areas need to be doubled to help people prevent HIV transmission by encouraging the limiting of the number of sexual partners, increasing the practice of correct and consistent condom use, and improving health-seeking behavior for timely and appropriate STI diagnosis and treatment.

D. Impact

Impact
<i>% of most-at-risk-populations who are HIV infected (2003 estimate)</i>
PIP: <1%
MSM: <1%
IDU: <1%
<i>% of general population 15-49 years old who are HIV infected (2001 estimate)</i>
General Population 15-49 years old: 0.001% (<0.1)
<i>Sources: 2003 NEC Technical Report, 2002 Consensus Report on STI, HIV and AIDS Epidemiology</i>

No official estimates for total population sizes of PIP, MSM, IDU were available for 2003, 2004 and 2005, making computing for percentages difficult. The data obtained mainly came from surveillance reports that included sampling sizes of 3,000 each for PIP and IDU.

Further, no HIV Serologic Surveillance (HSS) was conducted in 2004 due to logistical constraints.

E. Care, Support and Treatment

Care, Support and Treatment
<i>% of patients with STI at public and private healthcare facilities who are appropriately diagnosed, treated and counseled</i>
9% (20,983 patients with STI at public healthcare facilities who are appropriately diagnosed, treated and counseled out of 229,148 patients who went to public health facilities for STI screening) (data from NEC-DOH, 2003 SSESS)
23,372 in social hygiene clinics (SHC) and regional health clinics (RHC) in 11 sites; data collection started August 2005 (data from GFATM project)

% of PLWHA receiving prophylaxis treatment

53 out of 132 PLWHA documented by PAFPI (data from PAFPI)

% of PLWHA receiving OI treatment

53 out of 132 PLWHA documented by PAFPI (data from PAFPI)

E. Care/Treatment Programmes***STI Cases: Appropriate Diagnosis, Treatment and Counseling***

For this indicator, the following numerators and denominators were used to compute for the percentages: number of patients with STI at public healthcare facilities who are appropriately diagnosed, treated and counseled out of number of patients who go to public health facilities for STI screening.

The SSESS 2003 data (supplied by the NEC), gave a figure of nine percent (9%). There were 20,983 of patients with STI at public healthcare facilities who were appropriately diagnosed, treated and counseled out of 229,148 patients who went to public health facilities for STI screening in 2003.

Data cited in the 2005 Philippine HIV and AIDS Country profile show that 9% of females and 8% of males consulting for STI signs and symptoms were diagnosed as STI cases.

Table 17. Reported STI cases among male and female consultations SSESS 2003

	Number of consultations	STI cases (number)	STI cases (in percent)
Female	213,864	19,829	9
Male	15,284	1,154	8

Source: 2003 HIV/AIDS Technical Report, as cited in 2005 Philippine HIV and AIDS Country Profile

Another data source, the Global Fund Project, counted 23,372 patients in SHC and RHC in 11 sites as of October 2005 (data collection started in August 2005). No denominators were provided.

HIV Treatment

No percentage figures were available for this indicator at the time of writing of this Country Report. However, data supplied by Positive Action Philippines Foundation, Inc. (PAFPI), an NGO providing care and support for People Living with HIV and AIDS (PLWHA) list the following:

PLWHA receiving prophylaxis treatment: 53 (out of 132 PLWHAS documented by PAFPI)

PLWHA receiving OI treatment: 53 (out of 132 PLWHAS documented by PAFPI)

The *2005 Philippine HIV and AIDS Country Profile* notes that “access to treatment among HIV Filipinos remains low” due to the high costs of medicines, particularly antiretroviral drugs.

The Global Fund Project estimated that there are about 6,000 PLWHA by 2004. By 2006, more PLWHA will be reached with care and treatment programs due to expansion of the Project’s coverage and arrival of pharmaceutical products to be used for treatment and therapy.

IV. Major Challenges Faced and Action Needed to Achieve the Goals/Targets

As results of the Behavioral Sentinel Surveillance (BSS) showed that “consistent condom use among the most-at-risk populations (PIP, MSM, IDU) as well as among the vulnerable populations (OFW, young people) was low, most IDU still shared injecting equipment, only a small proportion of ‘sharers’ used bleach and water to share injecting equipment, and that health-seeking behavior for STI was still far from ideal, particularly among the MSM,”⁴⁹ the Philippines faces many challenges that need urgent action if the country is to get a step ahead and gain a foothold in preventing the escalation of the epidemic.

Many of the challenges identified in the *2003 Country Report* remain to be challenges identified in this 2005 report. The *2003 NEC Technical Report*, *AMTP III* and *AMTP IV Plan* have likewise identified major challenges. Participants to the two NGO consultation meetings and the November 2005 validation meeting have also contributed their perspectives and recommendations. Specifically, these combined challenges and recommendations to address these challenges are:

A. Setting-up and Strengthening of Monitoring and Evaluation Systems (M & E)

1. Convincing and training key stakeholders to systematically undertake M&E, collect the necessary data, make data accessible and user-friendly, adopt systems where raw data may be summarized for easier and faster data collection.
2. Getting the cooperation and commitment of government agencies, LGUs, and NGOs to allocate and mobilize resources (financial, human, infrastructure, systems) for HIV and AIDS programs, including for M&E activities.
3. Developing and sustaining support for champions and focal persons for M&E within each government agency, in the LGUs, as well as in the legislative chambers.

B. Strengthening HIV and AIDS Education

4. Implementing School-based HIV and AIDS education by strengthening curriculum development and training of teachers, getting teachers to actually teach the students using life-skills based approach about HIV and AIDS in an age-appropriate, gender sensitive and gender-responsive manner.
5. Strengthening community-based HIV and AIDS education among young people, including out-of-school youth (OSY) and among street children. While these groups have been identified as among the vulnerable members of the population, few interventions are still being undertaken to address their needs.

C. Strengthening Promotion of Correct and Consistent Condom Use and Ensuring Supplies Are Available

6. Increasing and strengthening promotion of correct and consistent condom use since correct and consistent condom use is still low and has been decreasing in recent years. There is a need to increase access to information and resources to enable individuals to consistently and correctly use condoms as a means of protecting themselves and others from HIV transmission as well as from other sexually transmitted infections. Communication campaigns also need to be undertaken and continuously assessed/evaluated to counter existing misconceptions about condom use and HIV prevention.

There is a need to look into factors that have contributed or led to decreases in knowledge of correct ways of preventing HIV transmission.

7. Ensuring access of individuals to reliable and continuous supply of condoms. There is a need to look into factors that have contributed or led to decreases in condom use among most-at-risk populations in the past years. A review of government policies on condom procurement and distribution needs to be undertaken. The impact of non-promotion of condoms for family planning purposes and non-allocation of government resources for condom procurement also need to be looked into.

D. Institutionalizing AIDS in the Workplace Programs

8. Expanding and sustaining AIDS in the workplace programs to cover more areas and individuals.

E. Improving Access to Care, Support and Treatment

9. Improving access to care, support and treatment of PLWHA, including care and treatment of children affected by HIV and AIDS

10. Providing for the needs of children affected by HIV and AIDS (HIV+ children, children orphaned by HIV/AIDS, children living with HIV+ parent(s) and/or HIV+ family member(s): psycho-social support, family or other alternate parental care (whichever is appropriate), pediatric ARV therapy, support to help affected children stay in school, other needs, utilizing the Convention on the Rights of the Child and the Child 21 framework.

F. Developing and Maintaining Databases for Most-at-Risk and Vulnerable Populations for More Effective Policymaking and Programming on HIV and AIDS

11. Developing a database for PIP, MSM and IDU for improved programming for most-at-risk populations. Currently it is difficult to get percentage figures for some of the indicators due to the lack of official and updated estimates regarding population sizes of the above groups. According to the National Epidemiology Center (NEC), they are now in the process of updating previous estimates of population sizes for the said groups. Official estimates are hoped to be released in 2006.

12. Developing a database for children affected by HIV and AIDS. Currently, there is no existing database for children affected by HIV and AIDS. A project called "Crossing Borders" is being developed by Precious Jewels Ministry in cooperation with the Department of Health and three hospitals (Philippine General Hospital, San Lazaro Hospital and the Research Institute for Tropical Medicine). This joint initiative will include building a comprehensive database for children affected by

HIV and AIDS as a major output, the first results of which will be available by December 2006, and thereafter. This database is expected to help provide critical data for improved programming for children affected by HIV and AIDS.

G. Increasing Civil Society Involvement and Participation

13. Increasing involvement and participation of civil society, including NGOs, private agencies, professional organizations, and faith-based organizations, in:

- reviewing existing laws and policies, formulation of new ones, and repealing certain discriminatory provisions of existing laws and policies, towards making laws and policies more sensitive and responsive to the current as well as the changing needs; and
- planning, implementation, monitoring and evaluation of national and local level programs.

H. Strengthening Monitoring of Human Rights Issues

14. Strengthening 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.

I. Ensuring Quality Assurance in HIV Testing

15. Ensuring quality assurance for all clinical laboratories providing HIV testing. The Department of Health has issued an Administrative Order (series 2005) titled, "Guidelines of the National Reference Laboratory on the Quality Assurance Program (QAP) for All HIV Clinical Laboratories in the Philippines." This is being implemented by the NRL-SACCL and involves providing measures "to improve laboratory efficiency and effectiveness, for maximum benefit of the people with minimal risk to laboratory personnel." It seeks to "ensure that test results provided are accurate and reliable as possible for all persons being tested." The QAP will regulate and monitor all accredited HIV testing laboratories nationwide (about 500 HIV laboratory facilities and 2,000 clinical laboratories).

J. Sustaining PNAC and the PNAC Secretariat

16. Sustaining the work of the PNAC. The PNAC Secretariat itself lacks technical staff. Many of those that had been trained in the past had left. Moreover, staffing complement was also trimmed down and while RA 8504 provides for budget allocation for PNAC each year, the full and legislated budget amount for PNAC operations and activities has not been allocated by the national government in recent years. This trend in reduced funding will likely continue as the national government tightens its belt and cuts down on spending due to its huge fiscal deficit.

It is asserted, however, that if government is intent on and committed to addressing the HIV and AIDS epidemic, it needs to invest more resources (financial, human, infrastructure and systems) to prevention, care and treatment programs. At this juncture in the nation's history, critical efforts to afford the Philippines the opportunity to avert an explosive HIV epidemic cannot be sacrificed by belt-tightening measures. For the meantime, this low budget allocation may be supplemented by resource inputs from donor agencies and by private agencies.

V. Support required from the country's development partners

To enable it to continue its programs and strategies to address the HIV/AIDS epidemic more systematically and effectively, the Philippines needs sustained support from its development partners.

Specifically, support is needed for the following:

1. Setting-up of coordinated and concerted monitoring and evaluation (M&E) systems that will function at the local and national levels on a per agency scale involving government agencies, NGOs, public and private clinics/facilities, academe and research institutions, professional organizations, other civil society entities, including faith-based groups.

These coordinated and concerted M&E activities should be designed to make data collection more efficient, with outputs made accessible and utilized for improved national and local level policymaking and programming.

2. Sustaining the activities of stakeholders, specifically the concerned government agencies, NGOs, and other civil society entities working on HIV and AIDS.

3. Sustaining and expanding PNAC activities. There is a need to provide additional financing for PNAC Secretariat activities (including support for additional technical personnel) in order for it to be able to do its work more effectively.

VI. Monitoring and Evaluation Environment

In 2004, a monitoring and evaluation working group (MEWG) was constituted, with funding and technical support from UNAIDS. The MEWG, which continues to meet, is tasked to come up with the following:

- identify and adopt core indicators and country-specific indicators, taking into account the situation of HIV and AIDS in the country;
- develop an M&E manual approved by PNAC;
- train key representatives from government, NGOs, and private agencies on how to use the manual and collect data using the manual; and
- print and circulate copies of the M&E manual to identified agencies and individuals.

As of reporting date, the draft of the M&E manual was still undergoing revision based on recommendations during a MEWG workshop in October 2005. Training of data collectors on the use of the manual will be conducted during the first quarter of 2006. It is hoped that trained data collectors from each of the key agencies will start and will continue to systematically collect data. It is anticipated that with an M&E system in place by early- or mid-2006, data collection for the CRIS and for the 2007 Country Report will be better facilitated.

The above activities are being undertaken by the PNAC-DOH and the UNAIDS. Coordination and documentation of activities are being undertaken by the Women's Health Care Foundation (WHCF), PNAC's and UNAIDS' NGO partner for the M&E project.

Needs for M & E Technical Assistance

For monitoring and evaluation (M&E), the following support is needed:

1. Technical assistance for

- training of key people from the DOH and NGO focal point on maintaining the CRIS database; and
- training of representatives from key government agencies, NGOs, LGUs, and private agencies on how to systematically collect data (disaggregated according to gender, age and location) and package these for utilization such as in Country Reports. It was observed that while data is generated by and lodged in these agencies, many remain as raw data. There was difficulty encountered in getting summarized or packaged data even from the main data sources.

2. Forging of cooperative agreements between national agencies and local government agencies

Most of the data are lodged in the LGUs since program and activity implementation is now the domain of LGUs. However, under the devolution of government functions, LGUs are not required to submit reports to the national agencies. Hence, there was difficulty in obtaining the needed data.

Remedial Action: Recommendations for future reporting (2007 Reporting)

To address gaps observed in the period reviewed, the following should have been undertaken and achieved in 2006 and sustained onwards:

1. Collection of Data Disaggregated According to Gender, Age, Location

Data sources – government agencies, LGUs and NGOs – should have ensured that data disaggregated according to gender, age and location are collected for all indicators and that the data remains disaggregated even as it is transmitted from the local to the national level.

2. HIV Education in Primary, Secondary, Tertiary and Technical/Vocational Levels

Modules should have been pre-tested, finalized, printed, distributed and used for training teachers at all levels nationwide.

The Department of Education (DepEd), the Commission on Higher Education (CHED) and the Technical Education and Skills Development Authority (TESDA) should have started training teachers to teach life skills in the schools (primary, secondary, tertiary and technical/vocational schools). These teacher training activities should be done on a yearly basis due to the rapid turnover of teaching staff. Moreover, there should also be a trained core group of teachers (pool of teachers) in each school such that even if others leave, there will always be teaching staff left to continue the program.

Trained teaching staff should have started teaching life skills in their respective schools by mid-2006 and all of these trainings should have been documented.

3. Inventory and Monitoring of HIV/AIDS Core Teams (HACT) and Local AIDS Councils (LAC)

By 2007, there should have been an inventory of HIV/AIDS Core Teams (HACT) and Local AIDS Councils (LAC) in order to obtain information on whether these are still functional. For this undertaking, the concerned DOH agencies and the Department of the Interior and Local Government (DILG) need the cooperation of local government units and the local agencies.

4. Inventory and Monitoring of Public and Private Clinics/Facilities Providing VCT and those Providing STI Diagnosis, Treatment and Counseling

By 2007, there should have been an inventory of public and private clinics/facilities providing VCT and those providing STI diagnosis, treatment and counseling to ensure that these are functional, are able to meet the needs of concerned people, and adhere to set standards and ethical principles and guidelines. For this undertaking, the concerned DOH agencies need the cooperation of both private and public facilities in rural and urban sites, at all levels, in all regions.

5. Identifying and Developing Uniform Indicators for National Surveys

Uniform indicators and standardized questions for national surveys should have been identified to help facilitate faster and more efficient data collection and harmonization. For the past years, different surveys have asked different questions pertaining to knowledge and behaviors making it harder to harmonize the data and summarize these in national reports. For example, the 2003 NDHS, 2002 YAFS, 2003 IHSS and the 2005 IHBSS satisfy only 3 to 4 out of the required 5 questions in the UNGASS guidelines even if more than five questions had been fielded in some of these surveys. This is understandable as these surveys preceded the release of the UNGASS guidelines. It is hoped that UNAIDS, PNAC and other concerned government agencies and NGOs will be able to successfully negotiate for all the five indicators to be included in the next round of surveys.

6. Summarizing and Packaging of Data for Easier Collection and Utilization

Representatives from key government agencies, NGOs, LGUs, and private agencies should have been trained on how to systematically collect and summarize data and package these for utilization. It was observed that while data exists in these agencies, many remain as raw data. It was difficult to get summarized or packaged data even from main data sources.

7. Forging and Ensuring Cooperation between Agencies

Cooperation between national agencies and local government agencies should have been forged and ensured through policies and memoranda of agreement (MOA). Currently, most of the data are lodged in the LGUs since program and activity implementation is now the domain of LGUs. However, under the devolution of government functions, LGUs are not required to submit reports to the national agencies. Hence, there was difficulty in obtaining the needed data for this 2005 Country Report.

Data Collection Plan***For the 2007 Reporting, the following major data sources can be utilized***

Data collection plan (for 2008 reporting)	2006	2007
Household Surveys	NDHS held every 5 years: next round in 2008; the last survey was in 2003	NDHS held every 5 years: next round in 2008; the last survey was in 2003
Health Facility Surveys	yearly	yearly
School-based Surveys	The conduct of surveys depend on whether there are available funds. A KAP survey will be conducted in 2006	Depending on availability of funds. However, a KAP survey will be conducted in 2006 and results of these can be used in the 2008 UNGASS reporting
Workplace Surveys	yearly	yearly

ENDNOTES

¹ Surveys (BSS 2003) for this population included at most only 3 out of the 5 questions prescribed by UNAIDS for this indicator. The 2005 IHBSS has been conducted. However, official results have not yet been released as of submission of this Country Report. In the 2005 IHBSS round, only 3 out of the 5 questions prescribed by UNAIDS have been asked, plus 4 new questions were included to measure knowledge about HIV prevention.

² Surveys (BSS 2003) for this population included at most only 3 out of the 5 questions prescribed by UNAIDS for this indicator. The 2005 IHBSS has been conducted. However, official results have not yet been released as of submission of this Country Report. In the 2005 IHBSS round, only 3 out of the 5 questions prescribed by UNAIDS have been asked, plus 4 new questions were included to measure knowledge about HIV prevention.

³ Surveys (BSS 2003) for this population included only at most 3 out of the 5 questions prescribed by UNAIDS for this indicator. The 2005 IHBSS for IDU has not yet been conducted as of submission of this Country Report.

⁴ Only males 15-24 year olds were asked this question in the 2002 YAFS. Overall, six questions were asked related to this.

⁵ Data available is for 2003 only. According to the LEAD Project, 4,000+ samples coming from nine (9) sentinel sites have been completed in 2005. However, official results have not yet been released by NEC as of the time of submission of this Country Report.

⁶ 2003 HIV Serologic Surveillance (as reported in the 2003 National Epidemiology Center (NEC) Technical Report).

⁷ Percentages were computed based on BSS sample size of 300 PIP tested for HIV per sentinel site x 10 sentinel sites = 3,000 PIP tested for HIV. Official estimates for population size of PIP are still not available. However, the 2002 Consensus Report on STI, HIV and AIDS Epidemiology placed the population size at 540,000 for 2001.

⁸ 2003 HIV Serologic Surveillance (as reported by the National Epidemiology Center (NEC)).

⁹ Percentages were computed based on BSS sample size of 300 MSM tested for HIV per sentinel site x 10 sentinel sites = 3,000 MSM tested for HIV. Official estimates for population size of MSM are still not available.

¹⁰ No percentages were computed due to absence of official estimate for population size of IDU. However, the 2002 Consensus Report on STI, HIV and AIDS Epidemiology placed the population size at 10,000 in 2001.

¹¹ No percentages were computed due to absence of official estimate for population size of OFW.

¹² Available data from the HIV/AIDS registry as of September 2005 is for 10-19 and 20-29 year old. Not in percentage but in actual numbers. Figures provided are cumulative from 1987 to September 2005.

There were 13 males aged 10-19 years old and 334 males aged 20-29 years old documented to have HIV. There were 31 females aged 10-19 and 365 females aged 20-29. Overall, the totals are 44 cases for age 10-19 and 699 for ages 20-29.

¹³ HIV/AIDS Country Profile PHILIPPINES 2002, p. 9

¹⁴ 2002 Consensus Report on STI, HIV and AIDS Epidemiology. World Health Organization and Department of Health, Philippines 2002, pp. 23-24.

¹⁵ HIV/AIDS Country Profile PHILIPPINES 2002, p.2

¹⁶ 2002 Consensus Report on STI, HIV and AIDS Epidemiology. World Health Organization and Department of Health, Philippines 2002, p. 24

¹⁷ 2003 NEC Technical Report, p.4.

¹⁸ AMTP III, pp. 2-4

¹⁹ AMTP IV, Foreword by the Department of Health Secretary

²⁰ 2002 Consensus Report on STI, HIV and AIDS Epidemiology. World Health Organization and Department of Health, Philippines 2002, p. 22

²¹ AMTP III, p. 14

²² Loc. Cit. p. 7-8

²³ AMTP IV, p. 3

²⁴ AMTP IV, p. 17

²⁵ 2002 HIV/AIDS Country Profile PHILIPPINES, p. 8

²⁶ 2003 NEC Technical Report, p. 8

²⁷ AMTP III, page 5.

²⁸ 2002 HIV/AIDS Country Profile PHILIPPINES, p.2

²⁹ Ibid.

³⁰ Guidelines on Construction of Core Indicators for the 2006 Report to the United Nations General Assembly Special Session (UNGASS 2006 Report)

³¹ Ibid.

³² The Consensus Report on STI, HIV and AIDS Epidemiology in 2002 placed the PIP population size at 540,000 for 2001. No new official estimates, however, were obtained for 2003, 2004 and 2005 as of writing of this Country Report.

³³ Data is for female freelance sex workers coming from seven (7) sentinel sites. Cumulative LEAD HIV/AIDS SIOs Numerical Report for the period February to September 2005. Also from Size Estimation Workshop held on September 12-15, 2005, Cebu City.

³⁴ Cumulative LEAD HIV/AIDS SIOs Numerical Report for the period February to September 2005. Also from Size Estimation Workshop held on September 12-15, 2005, Cebu City.

³⁵ Cumulative LEAD HIV/AIDS SIOs Numerical Report for the period February to September 2005. Also from Size Estimation Workshop held on September 12-15, 2005, Cebu City.

³⁶ The 2002 Consensus Report on STI, HIV and AIDS Epidemiology placed the PIP population size at 540,000 for 2001.

³⁷ Cumulative LEAD HIV/AIDS SIOs Numerical Report for the period February to September 2005. Also from Size Estimation Workshop held on September 12-15, 2005, Cebu City.

³⁸ Cumulative LEAD HIV/AIDS SIOs Numerical Report for the period February to September 2005. Also from Size Estimation Workshop held on September 12-15, 2005, Cebu City.

³⁹ The 2002 Consensus Report on STI, HIV and AIDS Epidemiology in 2002 placed the IDU population size at 10,000 in that year.

⁴⁰ Cumulative LEAD HIV/AIDS SIOs Numerical Report for the period February to September 2005. Also from Size Estimation Workshop held on September 12-15, 2005, Cebu City.

⁴¹ 2003 NEC Technical Report. Survey included three questions regarding major misconceptions.

⁴² 2005 IHBSS; Data supplied by LEAD Project

⁴³ Ibid.

⁴⁴ Surveys (2002 YAFS) for this population included only 4 out of the 5 questions prescribed by UNAIDS for this indicator. No combined total percentages for the four questions provided.

⁴⁵ 2003 NEC Technical Report, p. 18

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ 2005 IHBSS; Data supplied by LEAD Project

⁴⁹ 2003 NEC Technical Report, p.4.

REFERENCES

Health Action Information Network. *HIV/AIDS Country Profile Philippines 2002*. Quezon City: 2003.

Health Action Information Network. *2005 Philippine HIV and AIDS Country Profile*. Quezon City: 2005

Joint United Nations Programme on HIV/AIDS (UNAIDS). *2004 Report on the Global AIDS Epidemic: 4th Global Report*. Geneva: 2004.

Lunduyan para sa Pagpapalaganap, Pagtataguyod, at Pagtatanggol ng Karapatang Pambata Foundation, Inc. and United Nations Children's Fund (UNICEF). *A Deafening Silence: The Situation of Filipinos Affected by HIV and AIDS: A Preliminary Assesment*. Manila: 2005

National Statistics Office. *National Demographic and Health Survey 2003*. Manila: 2004

Philippine National AIDS Council. *4th AIDS Medium Term-Plan 2005-2010 Philippines*. [s.l.: 2005].

Philippine National AIDS Council. *Seizing the Opportunity: The 2000-2004 Medium Term-Plan for Accelerating the Philippine Response to HIV/AIDS (AMTP)*. [s.l.: 2004].

Republic of the Philippines. *Second Philippines Progress Report on the Millennium Development Goals*. Manila: 2005.

Sobritchea, C.I. and F.M. Tadiar. *A Report on the Review of Philippine Policies and Programs Related to Migration and HIV/AIDS*. [s.l.: 2004].

University of the Philippines Population Institute. *Youth Sex and Risk Behavior: 2002 Young Adult Fertility and Sexuality Survey (YAFS 3)*. Quezon City: 2004.

GUIDE TO ACRONYMS USED

AIDS – Acquired Immune Deficiency Syndrome
AMTP – AIDS Medium Term Plan
ASEP – AIDS Surveillance and Education Project
BSS – Behavioral Sentinel Surveillance
CHD – Center for Health Development
CHED – Commission on Higher Education
CRIS – Country Response Information System
DepEd – Department of Education
DILG – Department of Interior and Local Government
DOH – Department of Health
DOLE – Department of Labor and Employment
DSWD – Department of Social Welfare and Development
FHI – Family Health International
FFSW – Female Freelance Sex Worker
GFATM – Global Fund to Fight AIDS, Tuberculosis and Malaria
GO – Government Organization
HACT – HIV/AIDS Core Team
HIV – Human Immunodeficiency Virus
HRG – High Risk Group
HSS – HIV Serologic Surveillance
IDU – Injecting Drug Users
KAP – Knowledge, Awareness and Practice
LAC – Local AIDS Council
LGU – Local Government Unit
M & E – Monitoring and Evaluation
MEWG – Monitoring and Evaluation Working Group
MOA – Memoranda of Agreement
MSM – Men who have Sex with Men
MSW – Male Sex Worker
NCPI – National Composite Policy Index
NDHS – National Demographic and Health Survey
NEC – National Epidemiology Center
NEDA – National Economic and Development Authority
NGO – Non-Government Organization
NHSS – National HIV/AIDS Sentinel Surveillance System
NRL-SACCL – National Reference Laboratory- STI/AIDS Cooperative Central
Laboratory
OFW – Overseas Filipino Worker
OI – Opportunistic Infections
OSHC – Occupational Safety and Health Center
OSY – Out-of-School Youth
PAFPI – Positive Action Philippines Foundation, Inc.
PIP – People in Prostitution
PLWHA – People Living with HIV/AIDS

PNAC – Philippine National AIDS Council
QAP – Quality Assurance Program
RA – Republic Act
RFSW – Registered Female Sex Worker
RHC – Regional Health Clinics
RITM – Research Institute for Tropical Medicine
SACCL – STI/AIDS Cooperative Central Laboratory
SHC – Social Hygiene Clinic
SSESS – Sentinel STI Etiologic Surveillance System
STI – Sexually Transmitted Infection
TESDA – Technical Education and Skills Development Authority
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
WHCF – Women’s Health Care Foundation, Inc.
WHO – World Health Organization
YAFS 3 – Young Adult Fertility and Sexuality Survey 3