Republic of the Philippines
Philippine National AIDS Council

Mid-Term Review Report – Fourth AIDS Medium Term Plan 2005-2010

December 2008

UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK
tsf TECHNICAL SUPPORT FACILITY Southeast Asia and the Pacific

Acknowledgement

The review team members wish to express their sincere thanks and gratitude to the Government of Philippines and in particular, the members of the Philippines National AIDS Council and Secretariat for making possible this mid-term review. Throughout the review, the PNAC Secretariat worked tirelessly to make sure all aspects of the review proceeded smoothly and to provide the team with any help and guidance needed along the way. The review team consisted of major players within the national AIDS program like PNAC Secretariat, Department of Health, National AIDS and STI Prevention and Control Program, National Epidemiology Center, UNAIDS, WHO and the Tropical Disease Foundation. Similarly, representatives of implementing partner organisations took time to present their programme activities, provide thoughtful answers to the review team's questions, and in some cases to facilitate and accommodate visits to activity sites. Special thanks to the Technical Support Facility, South East Asia and Pacific without whose support this review would not have happened. This midterm review would not have been completed without the full cooperation and invaluable insights of all concerned.

Dr Angela Chaudhuri
Team Leader
Swasti- Health Resource Center
Technical Support Facility- South East Asia and Pacific

List of abbreviations

AMTP	**AIDS Medium Term Plan**
ARV	**Anti-retroviral drugs**
CRIS	**Country Response Information System**
CHED	**Commission of Higher Education**
DDB	**Dangerous Drugs Board**
DOH	**Department of Health**
DOLE	**Department of Labor and Employment**
GIPA	**Greater involvement of persons with HIV and AIDS**
HACT	**HIV AIDS Core Teams**
HRG	**High Risk Group**
IDU/s	**Injecting drug users**
IHBSS	**Integrated HIV Behavioral Serologic Surveillance**
LAC	**Local AIDS Council**
LGU	**Local Government Unit**
MARP/s	**Most-at-Risk Population/s**
MDG/s	**Millennium Development Goals**
MSM/s	**Males having sex with Males**
MTPDP	**Medium Term Philippine Development Plan**
NASPCP	**National AIDS STI Prevention and Control Program**
NEC	**National Epidemiology Center**
NEDA	**National Economic and Development Authority**
NGOs	**Non-Government Organizations**
NHSSS	**National HIV and AIDS Sentinel Surveillance System**
OFW	**Overseas Filipino Worker**
OSY	**Out-of-School Youth**
PIP/s	**People in prostitution**
PLHIV/s	**People Living with HIV**
PNAC	**Philippine National AIDS Council**
RA 8504	**Republic Act 8504, The Philippine AIDS Prevention and Control Act of 1998**
SHC	**Social Hygiene Clinic**
SSESS	**Sentinel STI Etiologic Surveillance System**
STI	**Sexually Transmitted Infections**
UNGASS	**UN General Assembly Special Session on HIV and AIDS**
VCT	**Voluntary Counselling and Testing**

Table of contents

1 Executive Summary

The AIDS Medium Term Plan IV of the Philippines was conceptualized and prepared through a robust and wide consultative process which was inclusive of civil society, different agencies of the government, multi lateral and bilateral agencies as well as corporates. The period of this plan is from 2005 to 2010. The Philippine National AIDS Council is responsible for overseeing the program implementation plan of the country. In this regard, the PNAC commissioned a mid term assessment of the plan in order to draw lessons from the first half of the plan, and to apply these in the second half of the plan i.e. 2009 and 2010. The assessment will also look into the performance of the council, and suggest improvements for the same.

Broadly the plan addresses the drivers of the epidemic, the trend of the epidemic and how they have been able to cap the increasing trend of HIV, to a limited extent. The country has indeed identified the focal points of the epidemic, and has programs in place to address these populations. However, the scale of programs has been far from sufficient. The current prevalence, although low, has proved to be a deterrent towards accessing or gaining funds for HIV interventions.

Local initiatives show a mixed response. Where there is funding from external donors like Global Fund, it seems there is impetus to push for adoption of a local AIDS council. Success stories are seen in areas where there seems to be an external push to the programs and high levels of advocacy with the Local Government Units. There have been examples of functioning LACs without Global Fund grants, however these are few. Local response has been plagued with issues of opposing political and religious views as well as an insufficient budget. The sustainability of the local response also seems to hinge on a few well meaning dedicated individuals rather than a systemic or institutional model of sustainability.

The financial requirement for 2007 and 2008 is about Php 849 million (UNGASS 2008). Given the average total spending of about Php 311 million per year, there is a funding gap of about Php227 million or Php113.5 million per year. There are contributions from external agencies like Global Fund through its two rounds for HIV (Round 5 and Round 6), however these are insufficient. The national budgetary commitments are insufficient, although a precise amount has been difficult to determine, since unit costings were not available.

The Philippines National AIDS Council is responsible for policy making and overseeing the program. Therefore, its performance is critical to outputs and outcomes of the program. The multi- sectoral dimensions of the council have led credence to the value of multi- pronged multi- dimensional nature of the national HIV program. However, there have been several issues that have plagued the PNAC, particularly, the slow decision- making processes of the council. The acceleration needed for the national program has largely remained unachieved because of this very reason.

Areas that need focus for the next two years include geographical mapping of the 'Most at risk' populations, since it seems, from the assessment, that the numbers have been by and large under-estimated. Unit costing and costing guidelines need to be defined, so as to be able to plan appropriately for the program and estimate the funding gaps. There have been a couple of capacity assessments done for the PNAC. Both the assessments have similar and sound recommendations for improved functioning of the PNAC, and these needs to be followed up strongly. Program areas that need strengthening include nuancing and categorization of migrant workers, the program monitoring and evaluation systems, packaging the services as an essential package of services along with operational guidelines.

In summary, the national HIV response has managed to maintain the low prevalence of the epidemic and now needs to focus on enhancing and improving the quality of the programs on ground, enhanced speed of direction and policy making, as well as institutional strengthening- both locally and national- in order to make the necessary impact.

2 Introduction

2.1 Background

The Philippine National AIDS Council (PNAC) was created in 1992 by Executive Order No. 39 as an advisory body to the Office of the President on all matters related to AIDS. It was reconstituted by virtue of Republic Act 8504 as the central advisory, planning and policy making body on the prevention and control of HIV and AIDS in the country. Made up of 26 members from the government, civil society and organization of people living with HIV, the Council envisions a fully empowered national coordinating body where different individuals and sectors work in partnership to prevent the transmission of the virus and lessen its impact on the affected persons in particular and society in general.

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

The mid-term assessment of the 4th AIDS Medium Term Plan (AMTP IV), due in 2008, was endorsed by the PNAC during its plenary in April 2007. The PNAC Secretariat approached the Technical Support Facility of the South East Asia Pacific for funding and technical support to lead the assessment. TSF-SEAP approached Swasti- a health resource center for this purpose.

This is the mid term assessment report of the AIDS Medium Term Plan IV of the Philippines.

2.2 Objectives and Scope of the review

A Mid-Term Assessment of AMTP IV is being conducted in order to review achievements and lessons from the first half of the program, so as to inform the second half of the program and provide guidance towards the development of a subsequent medium term plan. The primary purpose of this assessment is to determine the AMTP IV accomplishments to date, the status of achieving its targets, the relevance and adequacy of current strategies, and to develop recommendations to address identified data and response gaps. In the same manner, good practices and successful strategies will be highlighted in this assessment. Further, the mid-term assessment will determine how the AMTP IV responds to international and regional commitments like Global Campaign Unite for Children, Unite against AIDS, Millennium Development Goal (MDG) and Association of Southeast Asian Nation (ASEAN) Declaration, principles and framework like the “Three Ones” and “Universal Access” and other new international guidance, and how to incorporate these. Finally the findings of this

assessment will provide or guide PNAC in the conduct of the end-term assessment of AMTP IV in 2010. The period assessed includes 2005 to 2008 (June).

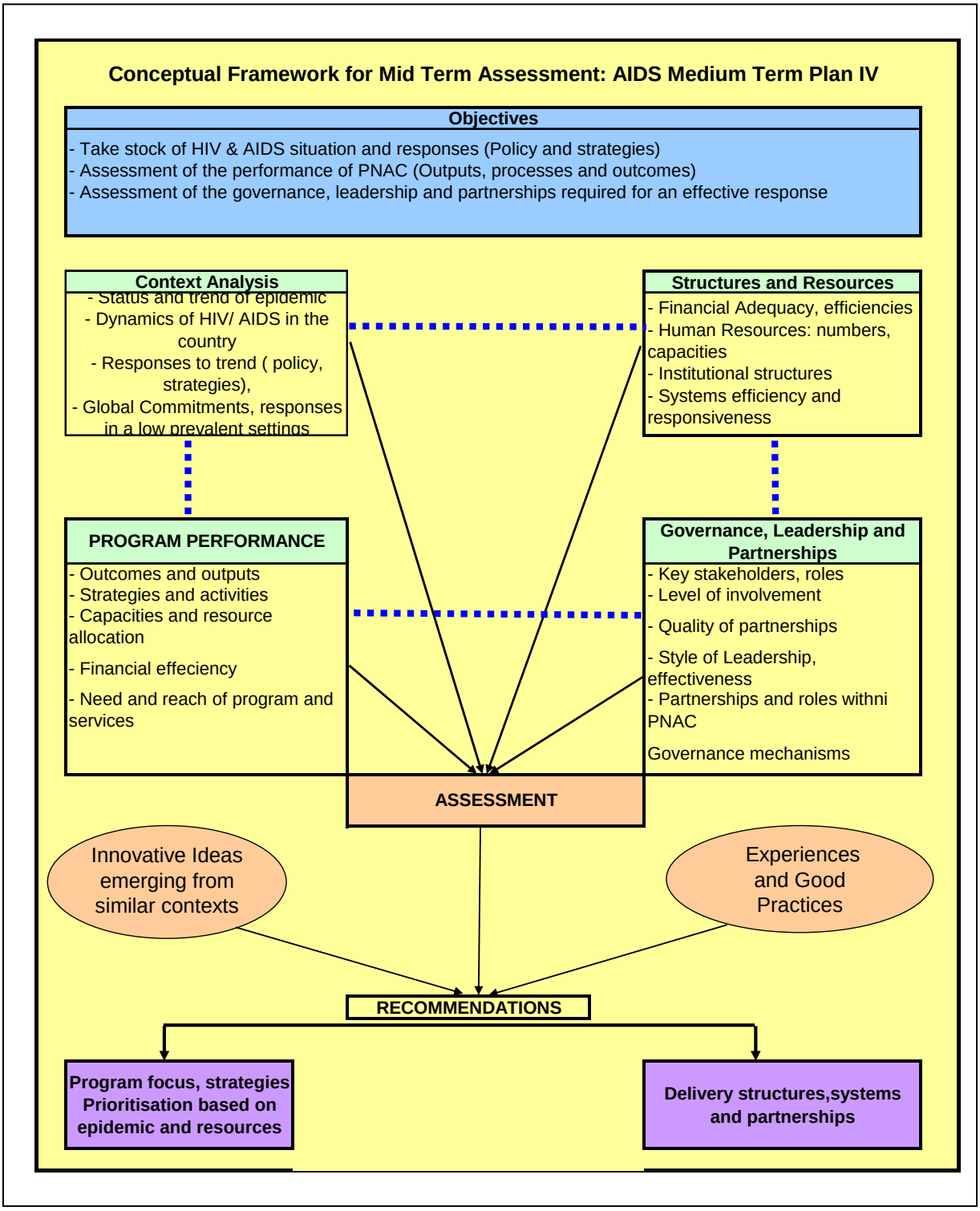
The outputs of the Assessment include:

1. Evaluation Framework and Tools (attached as annexure to the report)
2. Inception Report (attached as annexure to the report)
3. Assessment Report, with key recommendations for the second phase of AMTP IV

2.3 Assessment Framework

According to the Terms of Reference, the review looks at the AMTP IV for relevance, appropriateness, responsiveness, extent of coverage and quality with respect to implementation of the country program. The review also assesses PNAC's performance and effectiveness of governance, partnerships and leadership in the context of implementing the AMTP IV.

The assessment framework provides a lens for assessment, a structure for analysis and reporting, with a perspective for future action. The framework structures the issues and questions as indicators that can be gauged during the assessment. It also identifies the range of documents to be reviewed and key informants to be interviewed for each question. This framework is an important part of the assessment process and not an end-product and has been finalized along with the assessment team and presented to various key stakeholders.


Conceptual Framework for Mid Term Assessment: AIDS Medium Term Plan IV
Objectives
- Take stock of HIV & AIDS situation and responses (Policy and strategies)
- Assessment of the performance of PNAC (Outputs, processes and outcomes)
- Assessment of the governance, leadership and partnerships required for an effective response
Context Analysis
- Status and trend of epidemic
- Dynamics of HIV/ AIDS in the country
- Responses to trend (policy, strategies),
- Global Commitments, responses in a low prevalent settings
Structures and Resources
- Financial Adequacy, efficiencies
- Human Resources: numbers, capacities
- Institutional structures
- Systems efficiency and responsiveness
PROGRAM PERFORMANCE
- Outcomes and outputs
- Strategies and activities
- Capacities and resource allocation
- Financial effeciency
- Need and reach of program and services
Governance, Leadership and Partnerships
- Key stakeholders, roles
- Level of involvement
- Quality of partnerships
- Style of Leadership, effectiveness
- Partnerships and roles withni PNAC
Governance mechanisms
ASSESSMENT
Innovative Ideas emerging from similar contexts
Experiences and Good Practices
RECOMMENDATIONS
Program focus, strategies Prioritisation based on epidemic and resources
Delivery structures,systems and partnerships

2.4 Guiding Principles

Guiding Principles used in the assessment include:

1. Driven on country's needs
2. Participatory in nature, including field level implementers
3. Appreciative enquiry
4. Collective learning approach
5. Data collection based on standardized methodologies
6. Tools developed collectively in consultation with assessment team which included key staff at the PNAC, National Epidemiology Center (NEC), UNAIDS and Department of Health (DOH).
7. Criteria for site selection - nine sites, proposed
8. Differentiation of information-- fact and perception

2.5 Methodology

The assessment framework provides a basis for development of interview questions. By matching questions to sources of data from framework tables, respondents or documents, the review team prepared interview guides for specific individuals and organisations such as Focal Point for surveillance (NEC), Program Director of National AIDS and STD Control Program (NASCP), local chief executives, and other key informants etc.

The review methodology comprises a mix of site visits and observation, telephone and face-to-face interviews, discussion groups, desk-based research and review of existing reports and secondary data.

2.5.1 Methods

Document review against structured checklist
These were used to help analyse the content of key documents such as policies, strategies, annual work plans, surveillance reports, progress reports and evaluation reports. Checklists help to ensure comprehensive coverage against the evaluation questions and a consistent approach to document review.

Policy/Decision making timeline
This is a visual means of recording and presenting key events in the evolution and implementation of a decision or policy. PNAC being a large committee with a multitude of stakeholders, it becomes particularly important to assess the quality of PNAC meetings particularly in decision-making and policy development and implementation. The 'minutes' of the last five meetings have been used for analysis, wherein two decision-making topics were taken and these were followed for action and implementation.

Semi-structured interview guides
Interview guides will be developed prior to discussions to help ensure systematic coverage of questions and issues by smaller teams/team members working individually. The topics have been developed around the assessment questions, but grouped and focussed according to the organisation or individual being interviewed. The semi-structured nature of the interviews and discussions allows

the assessment team to probe further and explore deeper avenues of enquiry as issues arise through the discussions.

Appreciative enquiry
An approach that seeks to explore successes and positive experiences, in dialogue with individuals and groups of individuals or organizations, in order to record and deepen the understanding of why something worked well, and how the good practice may be adapted and applied elsewhere.

Workshops
This is an approach allowing stakeholders to gain from cross discussions particularly when assessing their own capacities, progress against plans, partnerships and collaborative efforts. Two such workshops were planned and conducted: the first one was to disseminate the inception report, evaluation framework and assess PNAC's capacities as well as to make a data procurement plan. The second workshop involved collation of all data, presentation of the findings and sharing of experiences.

2.5.2 Site Visits: Selection and Preparation

The selection of sites was based on specific criteria:

1. **Presence of Local AIDS Council:** present and active, present and non functional, and absence of LAC
2. **Distance from Capital:** Distant (More than 6 hours by road or more than one hour by flight), and near (less than 6 hours by road or less than one hour by flight).
3. **Socio economic status:** Urban and Rural
4. **All sites selected covered all the identified MARPs and vulnerable groups**
5. **All sites totally covered prevention and care and support programs**

Table 1 : Sites Selected for the Assessment

SITE	STI	Enabling Environment (Presence of LAC)	Target Population	Urban/ Rural	Distance from Capital/City
Cebu	19.5	Old	IDUs	U	Far
Laoag	9.6	Old	PIP	U	Far
Legaspi	23.94	No	MSM, PIP, IDU	Mixed	Far
Cagayan De Oro	8.76	New	MSM, PIP, IDU	U	Far
Dumaguete	No data	No	MSM, PIP, IDU	U	Near
Kalibo (Aklan)	No Data	No	MSM, PIP, IDU	R	Near
Numancia (Aklan)	No data	No	MSM, PIP	R	Near
Daraga	27.83	New	MSM, PIP, IDU	R	Far
Bocaue	0	No	TCS	R	Near

Considerations of ease of travel, costs, time and also the weather, (this being a season for typhoons), were made.

2.6 Factors Affecting Assessment

Some of the key factors affecting the assessment are:

1. Participation of key stakeholders at consultations and workshops
2. Availability of key information needed for analysis
3. Weather: During the time of this review, Philippines was going through the typhoon season which affected the site visits as well as the availability of people to be interviewed.

2.7 Team

The assessment team has a strong national and local expertise and perspective, good gender balance and sound technical expertise in planning, evaluation, HIV and AIDS and health systems. The team consists of members of PNAC Secretariat, NEC, NASPCP, UNAIDS, WHO, Tropical Disease Foundation or TDF (one of the largest HIV program implementers), an independent local consultant, the team leader, an international consultant identified by Technical Support Facility-- South East Asia Pacific from Swasti-Health Resource Center (based in India) which is a leading international agency on programme evaluations particularly in HIV and health systems.

The review team comprised of nine part-time team members, led by Dr Angela Chaudhuri. The local counterpart -- Ms. Noemi B. Leis -- was contracted during the latter half of the assessment. The team worked closely with the Director of the PNAC Secretariat, Dr. Ferchito Avelino and the M and E officer from the Secretariat, Dr. Jessie Fantone. The list of members is in Annex B

The team:

- Established the review design and framework
- Conducted a desk review of relevant reports and documents, including the AIDS Medium Term Plan IV Strategy Document and budgeted an operational plan; UNGASS 2008 including NASA 2005-2007 report; Global Fund Round 5 HIV Phase I Evaluation report; RA 8504 document; capacity assessment reports by Pilar and Gerochi etc.
- Reviewed the field sites through observation and interviews
- Conducted a policy and decision making timeline analysis by analysing the minutes of the last five plenary meetings
- Conducted two consultative meetings of PNAC members and large implementers, where the capacity assessments of PNAC were discussed and outputs and progress against plans were captured.
- Held extensive internal discussions with key members like PNAC Secretariat, NEC, DOH, NASPCP, and UNAIDS.
- De-briefed the Director, PNAC Secretariat, and the Secretary of Health, chair of the PNAC on the findings with recommendations for the future.
- Made a presentation to the plenary on the findings and recommendations.
- Prepared this report

The findings in this report are presented across four chapters.

- Chapter 2: Situation and Context of the Epidemic
- Chapter 3: Findings
- Chapter 4: Recommendations and Ways Forward

3 Findings

3.1 Situation and Context

3.1.1 HIV and AIDS Situation in Philippines

The Republic of Philippines is known to be a low HIV prevalence country. However, there is an increasing cause for concern that the disease could grow at an exponential rate. Since 1984 cumulatively there were 3,456 registered HIV patients.

Like in most countries, HIV affects Filipino adults during their peak economically productive years (58% of the registered cases were aged 25-39 years old[1]). Current data indicates that young adults, men who have sex with men (MSMs), people in prostitution (PIPs), injecting drug users (IDUs), overseas Filipino workers (OFWs) and the partners of all these groups are particularly vulnerable to HIV infection.

Compared to the monthly average registration in the last five years (2003-2007) which was 20 per month, the AIDS Registry showed an average of 29 new HIV cases per month for 2007. The first and second quarter of 2008 had an average of 40-50 new cases/month. This has surpassed the total number of HIV cases annually since the AIDS registry started. The numbers obtained in October 2008 – 59 cases, were the highest ever recorded in the Registry. However, national adult HIV prevalence remains under 0.1%.

Drivers of the Epidemic

HIV prevalence among the most-at-risk-populations (MARPs) remains below 1%;. The general low prevalence in Philippines leaves no room for complacency since the rate of new cases per month is increasing in trend. Among the transmission modes that have been reported, sexual transmission is the most common (88%). Condom use among MARPs (e.g. FSW: 65%; MSM: 32%) is below universal access (UA) targets (80%) and lower still among the general population.

According to 2007 estimates, there are 7,490 adults (15-49) living with HIV, of which 24 % are women. Prevalence is currently at 0.0168%. Most recent estimates of the Most at risk and vulnerable populations were arrived at after a series of workshops from September to December 2007. Estimates of the number of PLHIVs were arrived at during a National Consensus Meeting held on November 22, 2007. The AIDS Medium Term Plan (AMTP) IV categorizes the OFWs as vulnerable population. Of the 8 to 12 million OFWs, it is estimated that 883,897 are deemed at most risk due to their work situation and behavior. The following table (Table 1) lays out critical data on Most at risk populations, from the latest estimates in 2007.

[1] Cumulative figure

MARPs	Population Estimates in 2007			
	Low (in nos.)	High (in nos.)	Estimate HIV prevalence in various sites	
			Low	High
• Female Sex Workers	139,999	180,001	0.02%	0.23%
• Men who have sex with men	223,042	669,323	0.07%	1.02%
• Injecting Drug Users	9,984	20,316	0.01%	0.85%
• Male Clients of female sex workers	892,165	1,561,290	0.01%	0.10%
Vulnerable Populations				
Migrant Workers (OFWs: only those deemed vulnerable and who returned to the country)				
• Current OFW	883,897	883,897	0.l0%	0.26%
• Former OFW	1,700,000	1,700,000	0.05%	0.13%
Total	**3,849,385**	**5,014,427**		
• Out of school youth	11.6 M *(Source: 2003 Functional Literacy, Education and Mass Media Survey FLEMMS)*		Not Available	
• Street children	224,417 *(Source: http://www.streetchildren.org.uk/reports/southeastasia.pdf - 2003)*		Not Available	

Source: 2007 Estimates of Adults Living with HIV in the Philippines. DOH, [2008]
Note: MARPs estimates are based on situations prevailing in the 10 sentinel sites: Cities of Pasay, Quezon, Baguio, Angeles, Cebu, Iloilo, Cagayan de Oro, Davao, General Santos, and Zamboanga.

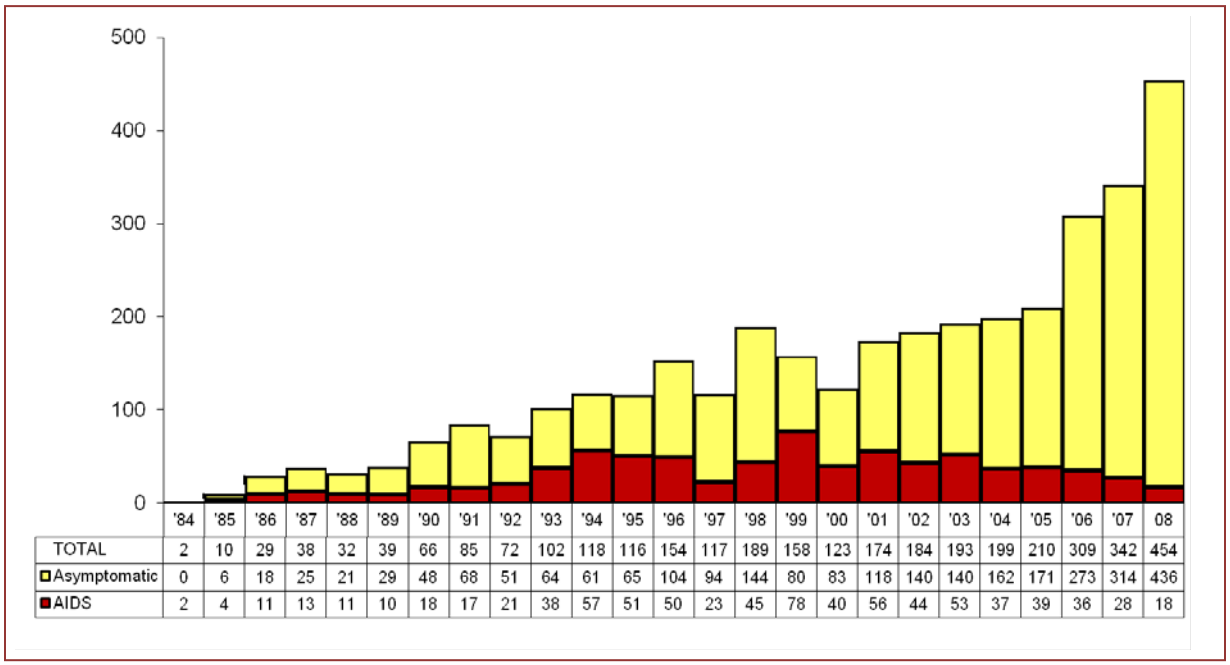
Dynamics of the Epidemic

The AIDS Registry reports that for the last three years (2005-2007), and up to the third quarter of 2008, there has been a significant increase in the number of new cases. In 2005, 210 new cases were reported; there were 309 in 2006, 342 in 2007 and 395 in the third quarter of 2008.[2] Majority of the reported cases are males. The Registry also showed that reported cases amongst MSMs are steadily climbing with a sharp increase in 2007. Overseas Filipino Workers (OFWs) consistently comprise 34% of all reported cases and the majority are males. It should be noted that OFWs are subjected to compulsory testing prior to employment. It was observed in 2007 that more and more young people were

[2] Philippine HIV and AIDS Registry, September 2008.

getting HIV[3]. The HIV prevalence among MARPs remains at 0.08% and is disaggregated - MSMs 0.28%, IDUs 0.13% and FSW at 0.06%.[4]

Figure 1. New Cases of HIV from January 1984 -October 2008



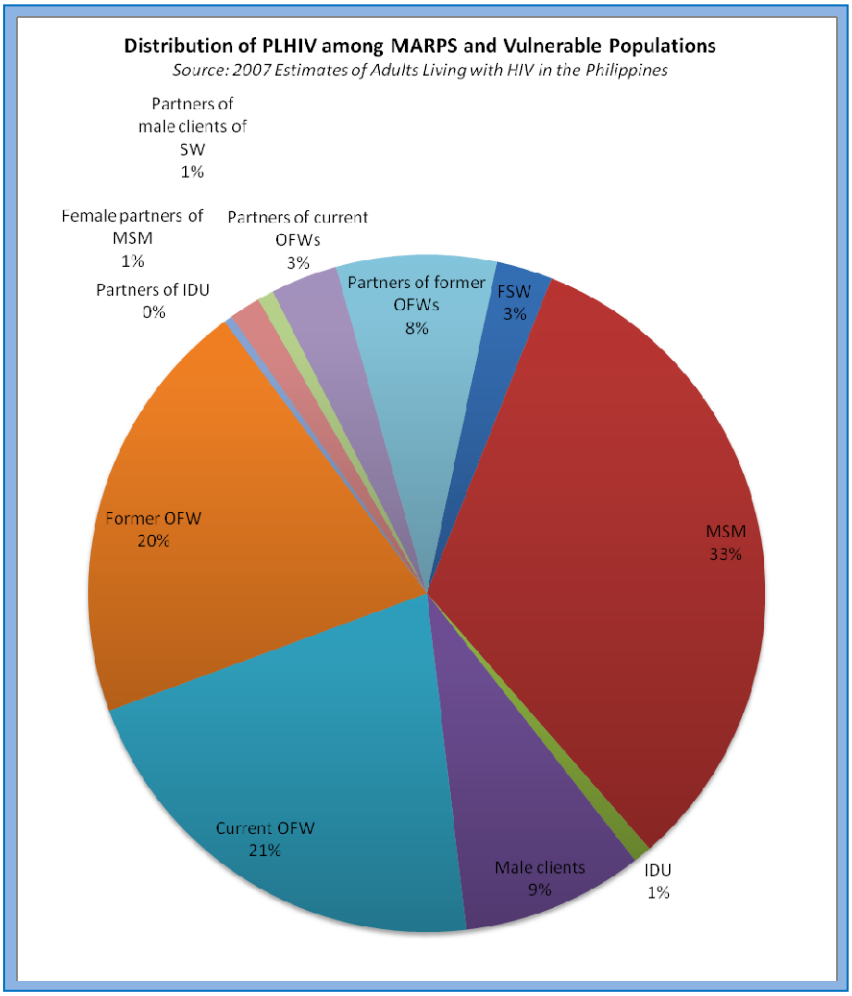
	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	08
TOTAL	2	10	29	38	32	39	66	85	72	102	118	116	154	117	189	158	123	174	184	193	199	210	309	342	454
Asymptomatic	0	6	18	25	21	29	48	68	51	64	61	65	104	94	144	80	83	118	140	140	162	171	273	314	436
AIDS	2	4	11	13	11	10	18	17	21	38	57	51	50	23	45	78	40	56	44	53	37	39	36	28	18

The AIDS Registry shows that new cases of HIV is significantly increasing every year with an average of 2 cases being reported daily in 2008 (till Sep 2008). This is indeed an alarming trend, since AMTP IV has been implemented since 2005, and the trend of the epidemic seems to be rising sharply. The outcome of the national HIV program needs to be questioned.

[3] Proceedings of the National Dissemination Forum, 2008.

[4] Philippine UNGASS Report on HIV and AIDS, 2008

Figure 2. Distribution of PLHIV among MARPS and vulnerable populations



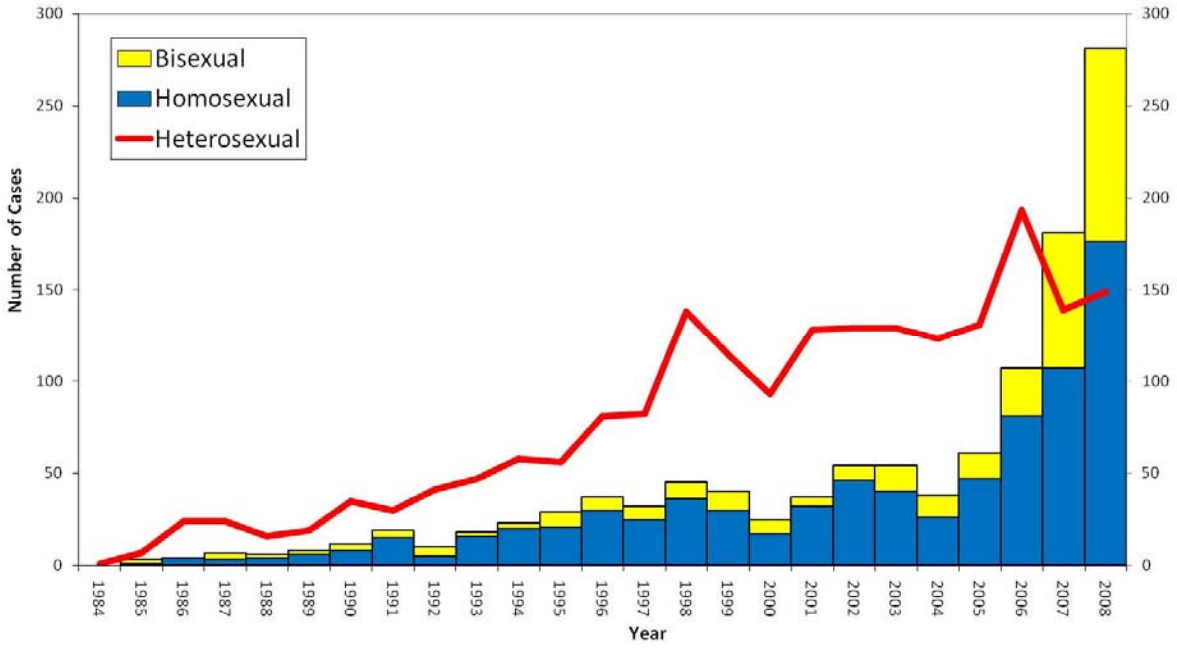
Based on the estimated number of MARPs, MSMs had the highest proportion of HIV infections in 2007.

Mode of Transmission

The main mode of HIV transmission is primarily through sexual contact: heterosexuals-- through paid sex, homosexuals practicing anal sex, and some reported bisexual. Among OFWs, a substantial number reported homosexual or bisexual transmission. The Registry showed that "MSMs present the biggest threat of an accelerated growth in the spread of HIV in the country."[5]

[5] Natividad, JN, [et al.]. The HIV/AIDS Situation in the Philippines: Final Report, 2008.

Figure 3. Sexual Transmission Routes from January 1984 to October 2008



The table above suggests the predominantly heterosexual routes of transmission. There was however an increase in homosexual and bisexual transmission in 2007, whereas by 2008, heterosexual to homosexual and bisexual activity was more by 50%.

Vulnerabilities

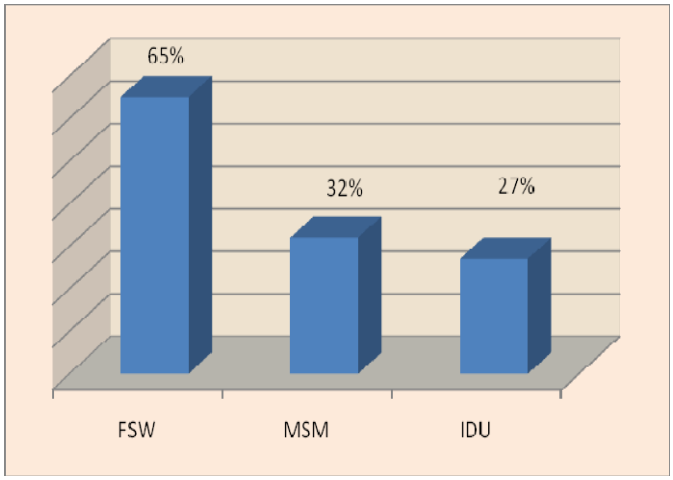
Lack of awareness, education etc leads to risky behaviour that increases vulnerability to HIV. IHBSS 2007 results show that HIV knowledge among MARPs is extremely low – FSW 2%, MSM 10%, and IDU 26%. Data from OFWs are not captured in IHBSS but studies have shown that HIV information given in PDOS (Pre-Departure Orientation Seminar) is minimal and probably insufficient to gain adequate knowledge and skills to understand their risks and to protect themselves from possible infection. In addition, prolonged isolation from normal social situations and lack of awareness about local cultures of countries of destination are factored in to their vulnerability.[6]

Condom use among MARPs is dismally low. According to the IHBSS 2007 report, 20% of MSMs who practice anal sex report a low percentage (32%) of condom use; IDUs report 27%. Condom use among FSW is 65%. In addition, 48% of IDUs used sterile injecting equipment the last time they injected.[7]

[6] Ibid

[7] UNGASS Report 2008.

Figure 4. Condom Use among MARPs 2007



In summary, vulnerabilities of these populations are high due to almost negligible HIV awareness, low utilization of condoms and occupational environment like in the case of OFWs. The data shows that there is an increasing trend of new cases, awareness is low among the MARPs and vulnerable populations and the behaviours remain risky exhibiting the less than optimal performance of the National HIV program.

3.1.2 Policy Environment and institutional responses:

The policy and programmatic anchor of the national response to AIDS is the Republic Act 8504, also known as the Philippine AIDS Prevention and Control Act of 1998. The Philippine AIDS law, enacted in 1998, recognized AIDS as a development issue and mandated "strong State action" in response to the "threat" of AIDS. It reversed the long established policies of mandatory testing and termination from work when one was suspected to have an incurable infectious disease. The law requires that the State shall promote public awareness about the causes, modes of transmission, consequences, and means of prevention and control of HIV through a comprehensive nationwide educational and information campaign. It further mandates that the state shall extend, to every person suspected or known to be infected with HIV, full protection of his/her human rights and civil liberties; shall promote utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission; shall positively address and seek to eradicate conditions that aggravate the spread of HIV infection, including but not limited to, poverty, gender inequality, prostitution, marginalization, drug abuse and ignorance; and shall recognize the potential role of affected individuals in propagating vital information and educational messages about HIV and shall utilize their experience in prevention programmes.

To provide clear guidelines and direction towards a national response to HIV and AIDS, the Philippine National AIDS Council approved its 4th AIDS Medium Term Plan (AMTP-IV) for 2005-2010. The goals of the AMTP-IV are echoed in the Philippine Millennium Development Goals Plan (MDGP) and the Medium-

Term Philippine Development Plan (MTPDP). The AMTP-IV has identified strategies and key result areas that will provide a unified effort addressing the rise of HIV in the Philippines.

The Principle of "Three Ones" is implemented by the country, with the national response having:

1. **One National AIDS Coordinating Authority** – *Philippine National AIDS Council (PNAC*) was constituted in 1992 and has set the policy direction in implementing AIDS Medium Term Plan IV

2. **One Agreed Strategic Framework -** The national response to the AIDS epidemic of the country, which is endorsed and serves as the overall plan - the *AIDS Medium Term Plan IV (2005-2010).*

3. **One Agreed National Monitoring and Evaluation System** – Is being put in place.

Efforts to set up a national HIV and AIDS M & E system began in 2003 and are yet to be completed. The process involved strong participation of different sectors. The institutionalization of the M & E system up to the level of the Local Government Unit (LGU) looks promising, although confronted by several challenges including structural, logistical, technological and sometimes political constraints at almost every level. This is still work in progress and a full system is likely to be operationalised in 2010. A core group of stakeholders from both government and civil society remain active in the process of planning and implementation of the M & E System. Till the M and E system is fully implemented, data particularly baseline data is likely to be less than accurate and with gaps in some areas.

The Philippine Government, through its various departments is implementing AIDS information and advocacy programs. The Department of Labor and Employment (DOLE) has in place policies and strategies for dealing with people who have sexually transmitted infections (STIs) and AIDS in the workplace. The Department of Foreign Affairs (DFA), the Philippine Overseas Employment Administration (POEA) and the Overseas Workers Welfare Administration (OWWA) has programs that address the HIV and AIDS information and services needs of overseas Filipino workers. LGUs have been tasked to implement Republic Act 8504.

In terms of direct health services and surveillance, the Department of Health (DOH) is the lead agency that oversees and coordinates HIV and AIDS program implementation. Such programs deal either solely with HIV and AIDS (i.e. the Global Fund project) or are HIV interventions incorporated as part of reproductive health and other health concerns. The DOH has organized HIV and AIDS Core Teams in hospitals in key cities throughout the country to respond to the needs of people living with HIV (PLHIV), a program on providing care, support and treatment in partnership with non-governmental organizations (NGOs) of PLHIV. The World Health Organization (WHO) has provided program support to the DOH; in particular it has developed policy guidelines as well as provided training on 100% Condom Use Programme (100% CUP), developed policy guidelines on Post-Exposure Prophylaxis for HIV and other blood-borne diseases, technical assistance on surveillance and data estimates,

interventions for injecting drug users (IDUs), and on procurement and supply of antiretroviral drugs (ARVs). There was a review of the progress of the MDGs in 2007. According to the review report, the target was to maintain HIV prevalence to below 1%. It is currently 0.016 % of the general population.

In summary, the AIDS Medium Term Plan is aligned to the Development plans of the country, the strategic directions for becoming a low prevalent country and other development plans. Besides that the policy environment promotes the care and support of PLHIVs along with prevention care for the vulnerable through the Republic Act 8504.

3.2 The Plan and its Relevance

This section will concentrate on how the AIDS Medium Term Plan IV has responded to the HIV situation of the country, and whether the plan is relevant, appropriate and adequate.

3.2.1 What is the AIDS Medium Term Plan?

The AIDS Medium Term Plan IV is a six year strategic plan, with a two-year budgeted operational plan which attempts to fill the gaps of the previous AIDS Medium Term Plan.

The Goal of the Program is: To prevent the further spread of HIV infection and reduce the impact of the disease on individuals, families and communities.

The objectives of the plan are:

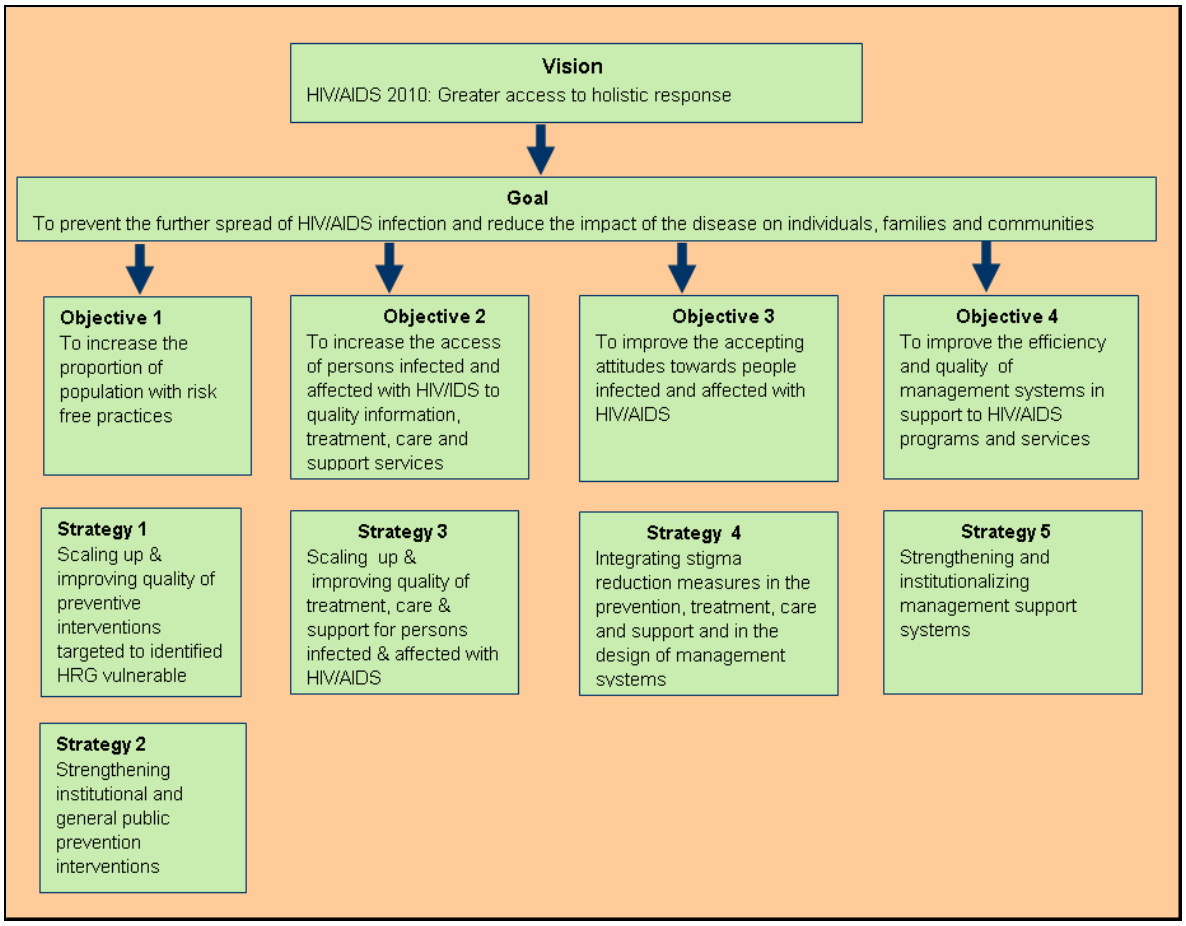
1. To increase the proportion of population using risk free practices

2. To increase the access of persons, infected and affected with HIV/IDS, to quality information, treatment, care and support services

3. To improve the attitude of society towards people infected and affected with HIV and AIDS

4. To improve the efficiency and quality of management systems in support of HIV and AIDS programs and services

Strategic Framework



3.2.2 About the Plan

The plan is comprehensive and appropriate: i.e. inclusive of relevant stakeholders, and addresses the drivers of the epidemic and target groups. It has a two-year detailed operational plan that largely guides the implementers regarding what activities each type of stakeholders should undertake. The operational plan lays out which government agency would take the lead on certain activities, thus providing clarity in the roles of implementing agencies. However, the finalization and dissemination of the costed plan was severely delayed, thus being of limited use to the stakeholders.

In planning there was a consultative process with all key stakeholders including civil society, academia and positive networks. There seems to be strong political will through the structure of Philippines National AIDS Council backed by legislation i.e. RA 8504. The approach for HIV programming is a multi-sectoral, plural approach which was much needed and provided the platform for a coordinated and effective response. The strong focus on capacity building has

yielded fruit already. Strengthening of information management and monitoring and evaluation systems has been recognized as a core strategic area, and activities have been planned around this. The plan certainly addresses some of the gaps of AMTP III.

However, a significant number of recommendations of the AMTP III have not been addressed. (See Annex C for details).

The plan itself is very broad at some levels and very specific in others, and is a mix of strategic and operational language and direction. Scope of the plan is not defined or detailed enough for implementation on the field particularly for the LGUs.

The targets are based on a baseline- some baselines have not been determined, or those which were determined have not been finalized, finalized but not shared broadly, making the program difficult to plan, cost and monitor. The budgeted plan is a rough estimate of how much an activity would possibly cost, but is stand-alone with no guidelines or resource mobilization plan. Prioritization of the strategies or the program components are missing.

Although the local response is a key element of the country's program and the Local Government Units are the mainstay of the program, they have barely been mentioned in the plan. Although the plan addresses all the relevant Most at risk populations and vulnerable groups, the definition of migrant workers has not been nuanced. This has led to confusion in the field, since migrant worker populations can be very varied, and strategies would be widely different.

3.3 Program progress

This section discusses how the national program has responded to the epidemic as well as the plan. The causative factors of achievement and non-achievements will also be highlighted in this chapter and some specific achievements and failures will be detailed as examples.

Sub chapters are arranged as follows:

1. Program Progress: Achievements and Non- achievements
    a. Policy
    b. Program and program management
2. Causative Factors for Non- achievement
    a. Governance, partnership and leadership
    b. Systems and Resources
        i. Financial
        ii. Human
    c. Environment

3.3.1 Policy

The Philippines National AIDS Council has had several achievements during the AMTP IV. The Council adopted the Three Ones' Principles of the UNAIDS on behalf of the country. In 2005, the Council also spearheaded the development of the National AIDS monitoring and evaluation system. In addition, it submitted the UNGASS report for 2006 and 2008. The Council renewed its efforts toward local response and gave fresh impetus to the creation of the Local AIDS Councils (LAC) and the enforcement of the local AIDS legislations in some 27 cities. The PNAC also facilitated and supported the formulation of the ASEAN Commitment on HIV and AIDS in 2007. The Secretariat was instrumental in organizing the Parliamentary Meeting on HIV and AIDS. The Council was instrumental in drafting the advocacy communication Plan for PNAC in 2007, although this is yet to be rolled out. In 2007, the Council carried out a review of the AIDS law and came up with specific recommendations to address challenges to the response. The contention of Philippines is that all HIV responses need to be mandated to ensure implementation. The PNAC acted as co-supervisor and member of the organizing committee in the preparation of the 2nd Regional Consultative Meeting on Universal Access to Prevention, Treatment, Care and Support in Low Prevalence Countries this year.

From 2005 till date, there have been few major policies or decisions made with respect to the program. The following are some of the resolutions that have been passed

- **Resolution No. 1, S 06:** Defined Roles and Functions of the PNAC Secretariat
- **Resolution No. 2, S. 07:** The budget of the Operational 4th AMTP Plan for 2007 to 2008
- **Resolution No. 3, S. 07**: Resolution to Create the Regional AIDS Assistance Team (RAAT) to facilitate local response to HIV and AIDS in the Philippines
- **Resolution No. 4, S 07:** Resolution to develop Guidelines on the Prevention, Treatment, Care and Support of HIV among Injecting Drug Users in the Philippines

In 2005, a sustainability mechanism for HIV and AIDS Programme Funding and Systems for Ensuring/Sustaining Access to ARVs was proposed. However, not much action has taken place in this direction.

The presence of IDUs has been reported in a number of areas in the country and cases of HIV amongst IDU have been noted in the recent years. The policy support for the IDU is a critical element to the program. Advocating and forging partnerships with the Dangerous Drugs Board was also planned, but is yet to move forward. The Philippine National AIDS Council (PNAC), with support from UNAIDS, has recently approved a resolution to develop guidelines on the prevention, treatment, care and support of HIV among Injecting Drug Users[8]. A proposal to establish a Technical Working Group within PNAC in collaboration

[8] The Philippine National AIDS Council Resolution No 2 27th April 2007

with the National Epidemiology Centre on IDU has been in discussion for so long, but no significant progress has been made till date. WHO and UNAIDS are supporting the development of a national strategic plan for harm reduction now that the resolution from PNAC has been approved.

3.3.2 Program and program management

At the National Level

With respect to AMTP IV, thematically almost all areas mentioned as objectives and strategies have been implemented in some form or the other. The assessment team made an attempt to map the responses in the country through workshops, face to face consultations as well as email consultations. However, it was difficult to determine the extent of implementation as there were no specific baselines or effective M&E in place. Targets were set for the country, however, the review can only report on those respondents or agencies who have reported their activities during the period of 2005 to 2007. There were two workshops and data gathering initiatives through email and phone to map the response in the country in order to assess the progress against plan. Although obtaining the complete picture is difficult an indicative picture of the progress shows that there has not been marked progress in implementing the plan. (Table showing program progress is in Annex D) The progress and achievements have been mapped according to the data provided by all key stakeholders who were reached through email and by invitation to two workshops. Analysis is therefore limited to data provided by the key stakeholders.

Thematic areas where some progress has been made:

- Prevention among children in risky situation
- Prevention among children and young people
- Prevention interventions for Migrant workers, PIPs, clients of PIPs, MSM and IDUs
- IEC activities through events and media
- Scaling up quality treatment , care and support

It has been difficult to rate the scale of progress, but there has been some progress in the areas mentioned above. For children in risky situations, there has been significant progress in all the activity areas as in the plan. The key players here are DoH, Department of Education, DSWD, KGPP, Lunduyan (NGO), PIA, UNICEF and ISSA. There has been some progress in activities as well as significant movement in policy and system strengthening.

There also has been some progress with the preventive interventions among children and youth in the form of capacity building initiatives, not just for the children and youth but also for teachers and guidance counselors. Progress in program relating to out of school youth has been slow, although there have certainly been some activity in the area. The number of planned activities has not really been estimated, therefore the scope of achievements in this area has been difficult to gauge. In the workplace intervention, there has been some limited progress, mainly focusing on capacity building and sensitization to employees of DSWD. A key policy activity, of enforcing the inclusion of HIV programs in government agencies' mandate, has not moved. This is a critical movement

towards mainstreaming HIV into the mandates of several agencies that are key partners to the effort against HIV.

On scaling up care and support programs, there has been some progress, with PLHAs taking a larger role in planning and designing of programs. There have been support groups and some home based care programs. Most of the activities here have been funded by Global Fund.

The effort to reduce stigma and discrimination has largely been limited to mass media campaigns, and educating policy makers.

Thematic areas where negligible progress has been made:

- IEC and other prevention interventions for employees
- Expansion of network HIV/STI practitioners
- Private sector involvement
- Prevention among Children and young people
- Follow up on organizational development actions for the improved functioning of the PNAC

The AMTP IV focuses a significant portion on children in risky situations and youth, particularly for prevention activities. Given that there are very limited resources, and insufficient evidence to link HIV to children in risky situations, there could be perhaps some basic programs addressing youth and children. During the time of the review, some studies were commissioned to link HIV vulnerability among children in risky situations and youth, however the information was not made available to validate the link.

PNAC is the premier policy making and coordinating body for HIV responses in the country. There have been at least two capacity assessments over the past four years which have listed similar weaknesses and areas of improvement. None of the key recommendations have been worked on and therefore the PNAC has remained where it was. This has hampered the progress of policy and program management within the country.

Prevention among migrants is institutionalized through the Department of Foreign Affairs by training Foreign Service Officers prior to repatriation to their duty posts. Along with the training, a guidebook on handling migration issues was developed. Research has been conducted to further understand the dynamics of the migrant sectors, particularly the seafarers.

The DOH procured anti-retroviral (ARV) drugs in 2005, that were given free of charge to patients who needed them. The Philippine Health Insurance Corporation (PhilHealth) has approved an outpatient benefit package in 2006. However, policy guidelines are yet to be developed. Philhealth is a government owned and controlled corporation which was created by the Republic Act 7875[9], also known as the "National Health Insurance Act of 1995", is mandated to provide social health insurance coverage to all Filipinos.[10] It is responsible for administering the medical care program for government and private sector

[9] http://www.philhealth.gov.ph/about_us/others/ra7875.pdf

[10] http://www.philhealth.gov.ph/about_us/history.htm

employees. Treatment hubs were expanded to include three large medical hospitals outside of Manila, totalling to eleven hospitals.

In 2006, Philippines initiated the Country Response Information System (CRIS) as part of strengthening its monitoring and evaluation system. There were a number of donor- funded programs initiated during this time including the UNFPA supported 6th Country program assistance, GTZ assisted reproductive health project, World Bank's Second Women's Health and Safe Motherhood project and the USAID program on Health and Population. The Joint UN program on HIV and Migration and Round 5 Global Fund project was also initiated during this time. Also ongoing are programs of UNICEF and the Contraceptive Social Marketing Program of DKT supported by the DOH and the German Development Bank.

PNAC has worked on organizational development through a series of meetings and workshops. Health service providers, both at the local primary health facilities and at hospitals, have been trained in the management of sexually transmitted infections, HIV and AIDS (laboratory proficiency, diagnosis and treatment), voluntary counselling and testing, and surveillance. Policy guidelines were developed such as the Anti-Retroviral Therapy (ART) Guidelines, Voluntary Counselling and Treatment (VCT) Protocol, Post-Exposure Prophylaxis (PEP) Guidelines and the 100% Condom Use Program (CUP). However, some of these guidelines are still in the draft stages.

Philippines is moving towards strengthening systems by instituting mechanisms to sustain initiatives both at the national and local levels. The decentralisation of the health delivery system called for strengthening local government units through the establishment of the Regional AIDS Assistance Teams (RAATS) with collaborative efforts from PNAC and the NGOs. Local AIDS ordinances were enacted in 39 LGUs to establish Local AIDS Councils (LACs). The Monitoring and Evaluation System Unit at PNAC was established and a series of trainings among LACs was conducted with the participation of NGOs. And in early 2007, the M&E System was assessed to determine the factors that affected the functionality of the unit. Although there have been major initiatives to strengthen the PNAC and the M and E system within it, much more remains to be done towards building a robust system.

At the local level

There has been decentralization of efforts putting the onus of the HIV response on the LGUs and the LACs. It has been an uphill struggle getting the HIV legislation passed in several cities and towns due to the influence of the Catholic Church. Several LGUs and social hygiene clinic teams have laboured and advocated for the legislation in their own localities to pass the legislation. Such champions of change seem to be the leading factor for the success of the local response, as gathered from the site visits and field interviews.

In terms of prevention activities, access to condoms outside of hygiene clinics remains very low. There are no national social marketing programs and contraceptive prevalence is actually decreasing. The largest donor for family planning, USAID, has withdrawn its funding for contraceptive supply. However,

condoms are certainly available commercially even in the smallest convenience stores. Currently, most condoms are distributed through NGOs.

Prevention activities for the last three years were focused on sex workers, MSM, IDUs and OFWs. Local responses have expanded to 29 LGUs, 100% CUP has been implemented in 15 sites, public VCT centers have expanded to 43, and a pilot project on PMTCT was implemented in Davao City and reviewed for policy recommendations.

Capacity building, both at national levels and at local levels, was described as the need of the hour during the AIDS Medium Term Plan III review. During AMTP IV, the country program through its own initiatives and those of the Global Fund program carried out several training programs including:

- Sentinel STI Etiologic Surveillance System
- Behaviour Change Communication
- Voluntary Counselling and Testing
- Electronic Medical Records
- HIV and Blood Borne diseases
- Clinical Management of HIV
- Project Management
- Monitoring and Evaluation

3.4 Inhibitory Factors

3.4.1 Governance, partnership and leadership

Key to the achievement of a program is effective governance, partnerships and leadership especially in the Philippines context, particularly when the program hinges on the policy and directions of the multi-sectoral Philippines National AIDS Council, with the local response led by the multi-sectoral Local AIDS Councils.

Some of the causative factors for the success and failure of the various parts of the program are *governance, partnership and leadership.*

Governance:

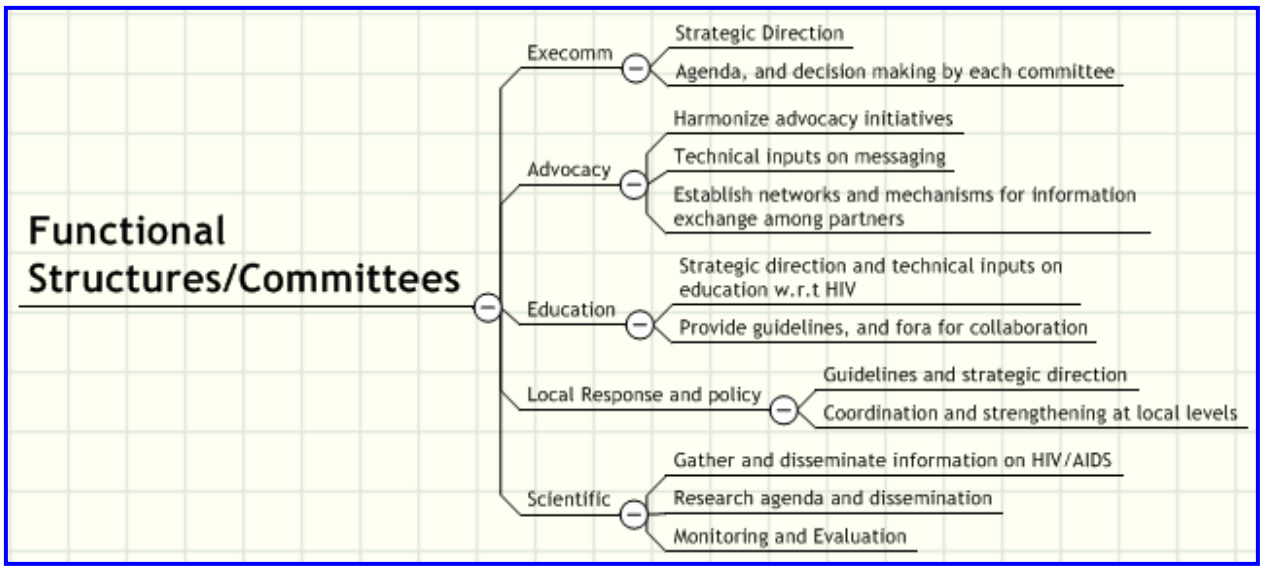
Issues surrounding the PNAC structure and functioning have been attributed as the leading cause of none, or less than optimal performance, in certain areas of the plan. The Council has 26 members, which in itself is rather large and unwieldy. Several interview respondents claim that the size of the membership is the main reason for the lack of optimal functioning. Governance is also hampered by absenteeism of key members of the council at the meetings, transient representation and membership to the council, lack of communication and feedback to inform decisions to council members.

Even some of the LAC members have shown, and stated, a lack of awareness and clarity on their own roles within the council. This has apparently harmed the program, since LAC members were unable to contribute in a meaningful manner. Although this scenario is not generalized, it does seem to be commonplace.

The structures of the council consist of:

- Secretariat: Administrative, coordination, steering decision making processes, and translating policies to action, M and E
- Executive Committee: Consists of smaller group of members who synthesize data and speed up the decision-making processes. Composed of the Chairs of the committees

There are also various technical committees whose roles and charter are described in the table below[11]:



There are clear roles and responsibilities defined on paper i.e. in the law, but when members were interviewed there seemed to be a lack of awareness of the roles and responsibilities among at least half of the sample respondents met. There also seemed to be difficulties in implementation since there is no authority figure in the council. The Committees need to be reviewed with respect to the present picture of the epidemic. Some committees may not be necessary e.g. 'policy' lodged within one committee rather than being a cross cutting issue.

One good practice is that the committees are evolved according to the need and not dependent on formal mandates. However, no decision or action is taken without formal mandate. The decision making processes and follow up action has been seen to be slow. This was elicited both from the respondents as well as the decision-making timeline analysis. There were two capacity assessments of the PNAC in three years and both reports refer to the fact that decision-making has been slow. As a result of this, there has not been sufficient movement on the harm reduction policy or on mobilization of funds. The PNAC is also plagued by the transient representation of each agency. This means, every time there is a plenary meeting, the likelihood of a different representative from each agency attending the meeting is high. This leads to loss of information and loss in follow-up. The representation itself has issues, since, many times, the representative does not carry sufficient authority or powers to aid in decision-making processes and action.

The absence of straight lines of accountability has led to endless discussions and non closure of several critical actions that were needed to be taken by the PNAC, e.g. the follow up of the organizational development of the PNAC, NGO representation in the PNAC, Harm Reduction Policy guidelines, etc.

[11] Written Mandate as of the RA 8504

Partnership:

HIV programming is unique compared to other health programs due to the need for a multi sectoral multi-pronged approach, which the PNAC membership boasts of. This is critical for multi-sectoral decision-making and coordination. We have seen that even on the field, successful partnerships lead to successful programs. However, here, coordination is limited and the government agencies of the PNAC largely work in isolation and do not have strong inter-departmental linkages. This shows that partnerships toward implementing HIV initiatives and for leveraging resources are not optimal.

At the national level, the Council is multi-sectoral and multi-pronged with civil society and networks as part of the council which is mandated through legislation. At the local level, the multi-sectoral approach seems to be effective, and the partnerships between the agencies seem very strong in the successful programs. Resources and efforts seem to be leveraged much better at the local level, where there are successful programs. Civil society has been involved not only in implementation but also in designing and policy making and there have been robust partnerships and communication between the government agencies and non-government agencies that have resulted in broad based ownership towards the program which will impact sustainability of efforts.

Apart from partnerships within the PNAC, partnership with the private sector has been minimal, and there is no identified agency to spearhead partnerships to garner involvement. The priority on HIV has been low, and therefore private sector itself has not seemed to be keen for involvement. The PNAC members were guided as part of the AMTP IV to involve and include the private sector. Unfortunately, though the intention is good, progress has been minimal.

Another key partner is faith-based organizations. Especially in the Philippine context, it is especially critical to forge strong partnerships with faith based organizations. Although there have been some efforts, they have not been optimized. Faith -based organizations are not engaged with PNAC currently, so looking at institutional linkages and advocacy with faith-based groups can be pursued more strongly for the remaining period of the term. There has been some initiative to engage FBOs e.g. PNAC and UNAIDS collaboration to engage FBOs led to the development of Training and Resource Handbook on HIV for Catholic Pastoral Workers (with strong endorsement from the Catholic Bishops Conference of the Philippines or CBCP). Now CBCP, through Catholic Relief Service – will roll out the implementation of the trainings using the materials to pilot dioceses. FBO may not be in the PNAC but their presence in most HIV forums and their celebrations of the candlelight and WAD are very notable, and will go a long way to influence communities through FBOs.

Leadership:

Strong political leadership is critical to the success of the program and through this review; its impact at the national and local levels has been evident. Where resources have been low, with lack of clarity of roles, such leadership has pushed for action and urgency. It has been observed that behind all the successful HIV programs there is a change agent. These change agents are highly motivated individuals that recognize the issues and seem to have a passion for reducing the impact of HIV. They have typically been anyone from the Social Hygiene

Clinic- nurse, physician, city health officer, representative of an NGO or CBO, city health officer, or even the local chief executive. It was obvious that that those cities with functioning LACs have successful programs.

Some of the reasons why programs or part of programs have not really taken off include:

1. Transient leadership

There seems to be, as in most government departments, rampant transfer of leaders and heads of agencies. Since the PNAC is represented by heads of key agencies, transient leadership, not just in the council but also at the PNAC Secretariat, has considerably slowed down, if not halted, the processes. Institutional memory is less than optimal, and information flow is faltering due to the transience of leadership. This also leads to disjointed deliberations and translation of policies into action. Committee leadership is also seen to be transient thus affecting its function.

2. Less than optimal political will and interest of certain agencies

The ownership of the program was raised as a query among several agencies. It is seen to be variable between the different agencies and frustrates the agencies that have higher vested interests. Added to this, there has been rampant absenteeism especially with a few agencies being defaulters. This has been attributed as a factor for demotivation of other agencies that are proactive within the PNAC. There were recommendations among many of the members of the PNAC to remove such agencies from the PNAC or have rigorous advocacy on the importance of the HIV program and PNAC.

3.4.2 Systems and Resources

Human Resources

During the interviews, it was apparent that many government agencies reported the need for at least twice the number of current staff. PNAC Secretariat and NASPCP have reported lack of appropriately trained staff, e.g. having doctors instead of managers. None of the agencies have a capacity development plan in place. Both PNAC and NASPCP are under DOH and therefore critical positions are transient and affected by departmental movements.

Finances and Financial Management Systems

The law allocates 20 million PHP a year to DoH, but due to past performance and budget utilization, only about 9 million PHP has been made available. This has apparently hampered the functioning of the PNAC Secretariat and the PNAC itself. The absence of unit costing has made it difficult to estimate the gaps in funding. This assessment will guide the making of the operational plan, which should include standardized unit costs. The different agencies would need to put forth their budgetary commitments, and this will help estimate the needs or funding gaps of the national HIV plan. Since HIV is not top priority, and the different agencies have their own mandate, it is usual for the Department of Budget and Management will allocate budget to a particular government agency

based on their Mandate. In this regard, when HIV is not in their mandate, it does not get funding. It is recommended that the agencies mainstream HIV into their activities.

The PNAC follows the financial management systems of the government. This sometimes leads to delays of processing monies required for quick and scaled up responses. Having multiple government agencies to coordinate efforts has slowed down the process further, since every agency has its own systems and cycles.

There was an attempt to have an investment plan for PNAC. The national program has been reported to be under resourced, which has apparently affected its performance significantly. At the time of the strategic plan development, there was a requirement of PHP 849 million (UNGASS 2006). There seems to be a funding gap of PHP 227 million, about 27%, with dependence on external donors particularly the Global Fund for AIDS, TB and Malaria.

Monitoring and Evaluation System

Philippines has gone through a rigorous process of strengthening the monitoring and evaluation system in the last two years. The Country Response Information System was pilot tested towards fulfilling the UNGASS goals. Among the M&E components installed or enhanced in the last three years are: 1) surveillance, 2) evaluation and research, 3) data dissemination and use, 4) M&E partnerships [linkage with UN, Global Fund, and technical advisory groups], and the installation of a National M&E officer at the PNAC Secretariat.

Surveillance in Philippines is of two kinds, passive and active. The epidemiological information system seems to be working quite well. The information is collected by the National Epidemiology Center and shared across the DOH and PNAC and UNAIDS. The National Epidemiology Center (NEC) collects and validates STI and HIV reports from social hygiene clinics and hospitals; conducts passive HIV and AIDS surveillance and furnishes the same to PNAC.

The program data however, is not being collected systematically. Global Fund supported programs have their own formats and reporting system, but these are not shared with the PNAC. Other implementers also do not have a system of sharing information. At the time of this review, formats were sent out to all major implementers and workshops were held to gather this information. However, very limited information was gathered, making it difficult to monitor the progress of the program. PNAC includes several implementers and there should be a system to monitor the progress of the national program. Although M and E is housed within the PNAC Secretariat's office, the flow of reports has been challenging. The different government agencies, the NGOs and positive networks through NGO focal points are supposed to send program reports to the PNAC Secretariat. However, this seems to be ad hoc i.e. when requested rather than systematic. There are various mechanisms of coordination between the agencies like the 100% Condom Use Program by WHO, the Regional AIDS Action Team by the PNAC, and the HIV AIDS Coordinating Team of the DOH, that run parallel and do not coordinate with each other effectively. The reporting is hampered by the absence of a clear mandate or department orders, and is largely left to the vagaries of interest and persons. All the agencies of the PNAC

that are mandated to contribute to the national plan do not have clear work plans and allocated funds. The challenges faced by the M&E system are the following: 1) Limited functionality of M&E structure (there is no M&E unit supporting the PNAC officer; ad-hoc or project-based M&E working group); 2) no routine programme monitoring (because either programme plans are unclear or unavailable), 3) no HIV database or databank, 4) no capacity building plan for M&E .

3.4.3 Environment

Contradictory policies have been seen to hamper the progress of critical activities like harm reduction programs. The Dangerous Drugs Board does not promote harm reduction; instead it criminalizes injecting drug users. This hinders the implementation of a comprehensive harm reduction program, including needles and syringe program (NSP), as punitive sanctions are provided in the RA 9165 (Dangerous Drug Act of 2002) among public health workers and even criminalizes injecting drug users (IDUS).

In addition, some local governments have encountered resistance from the Catholic Church in promoting HIV related prevention programs. Apparently the influence of the church has hindered the establishment and or functioning of the Local AIDS Councils. Several LGUs are unable to sign ordinances and set up LACs, thus hindering the progress of HIV interventions locally. Due to this, promoting the use of condoms has been hampered severely.

4 Recommendations and Ways Forward

The following recommendations flow from the analyses of the findings highlighted in the preceding sections. These recommendations address program design and strategies as well as systems and policies.

These recommendations have been discussed with key stakeholders including the members of the Philippines National AIDS Council.

4.1 Program Design and Strategy

a. Building an evidence base for responses

The targets have been fixed in percentages and the denominators based on estimates done recently, which are reportedly very different from field reality. It is necessary to undergo a country wide estimation exercise particularly for the MARPs and for selected vulnerable groups. This has been planned as part of the research agenda and it is important to note that this activity should be top priority. Without estimates, in a low prevalent country, vulnerability cannot be established. Without this information, the program gaps, the need and the funding cannot be ascertained.

b. Prioritizing interventions to maximize impact with low resources

The AIDS Commission report recommends focus on MARPs, particularly in low prevalent countries with low resources. In Philippines with the increasing trend among MARPs, the PNAC may want to consider focusing and further accelerating their interventions targeting the MARPs given the limited resources.

c. Nuance definitions of migrant workers and responses through action research

Migrant Workers are a population group identified as vulnerable groups within the AMTP IV; however the operational definition seems to vary across the project sites. This creates confusion of priority, strategy and approaches. It is therefore imperative that the PNAC develop operational definitions of migrant workers in consultation with the various program implementers and disseminate guidelines for migrant worker interventions. Based on the operational definitions, it is necessary to specify some broad guidelines of approach, and methods of monitoring and costing.

d. Address the weaker thematic areas

Some critical areas where there has been minimal or negligible progress need to be focused on, for the second half of the plan. Specifically, policy support for harm reduction, where there is a draft policy, but no active engagement with the Dangerous Drug Board, as well as action towards implementation of harm reduction strategy is urgent. In case, Harm reduction seems to be too radical to

move in the Philippine context, there must be efforts towards most appropriate in-country IDU-HIV intervention.

Another area that was neglected is the expansion of networking of HIV/STI practitioners. This is indeed critical for a well-aligned, coordinated and optimum human resource strategy to address the STI and HIV care needs of the people. Franchising and accreditation may be some models that could be piloted.

The advocacy and communication plan is still on paper and has not been endorsed by the PNAC. It is imperative that this has to be reviewed and endorsement happens quickly and the plan is piloted within the next two years.

The AIDS Commission report recommends scaling up and saturation of interventions for High Risk groups such as FSWs, MSMs and IDUs. In the case of Philippines, were resources are limited, and the epidemic drivers are indeed the High risk groups, it is recommended to prioritize targeted interventions over general population interventions.

e. Facilitation of decentralized implementation, including guidelines and processes

The response at the local level is critical for the success of the national program. There is a need for funds, clarity of role and monitoring. Local responses need more support from the national level on how to access funds and plan programs. Some amount of money must be kept aside for capacity building of LACs, especially on fund raising, planning, and program management. Some LACs are very effective and the PNAC Secretariat should provide the platform for sharing and cross learning. The Regional AIDS Action Teams can also provide a platform for sharing and cross-learning. RAATs are ideally placed to address concerns of the LACs, at the regional levels.

f. Package of services approach

A package of services approach may help in streamlining and harmonizing the program in the different project sites. Some of the steps to developing a package of services approach are as follows:

1. Map geographies which have similar settings
2. Develop a package of services for each setting;
3. Develop minimum standards and implementation modalities
4. Package strategies for each of the MARPS
5. Manual of operations to be developed for each package
6. Costing guidelines to be developed
7. Costing per package to be developed

The above steps will promote nuanced implementation and serve as a basis for monitoring.

4.2 Systems Strengthening

a. Enhance M&E systems

The pilot monitoring and evaluation system has thrown up several lessons and good practices. It is recommended that these lessons be used to develop a stronger, workable and simple M and E system. It is imperative to identify focal points from each player. The baselines, targets and performance indicators need to be clearly defined and there needs to be rigorous capacity building on operating and using M&E systems. Partnership and agreement with development partners is necessary and should be geared towards sharing information with PNAC.

The PNAC Secretariat is the nodal agency and its capacity needs to be developed so that it can perform its role. The PNAC Secretariat must also be positioned to serve as a repository for all program related information of the country. This can be done online, so that LGUs and other partners can access critical information, either related to the epidemic or to programmatic response. All the guidelines and studies (those without confidential information) should also be readily available on this online platform. Once a year the PNAC Secretariat should host learning seminars, where the LGUs, government and non government agencies can share their experiences and learn from each other.

It is important to identify M and E focal points within each major agency, who will then liaise with the M and E Unit within the PNAC Secretariat. M and E system protocol should be developed and followed, with systems for regular updates. Clear Terms of Reference, should be given to each M and E focal point as well as regular capacity development initiatives. A costed M&E Plan and routine program monitoring should also be part of the system e.g, blood safety, education, workplace etc.

b. Increase and improve human resources

In response to the shortage of manpower and capacities, a thorough work load assessment for typical kinds of interventions needs to be carried out. The human resource requirements need to be revisited and revised. Resources for capacity development need to be identified and a HR policy needs to be put in place in response to the needs of the program.

c. Increase the effectiveness of existing structures (Secretariat, Council)

The Philippines National AIDS Council needs to identify one clear leader / driver mandated to drive accountability. Sub-structures like Committees need to work on schedule and towards fixed objectives in order to be effective. Agendas should be fixed beforehand, schedules shared and one person in each committee should drive the process of the meetings of the committees. Each action plan for the committee could have a set timeline within which the action/decision has to be taken.

There needs to be a Capacity Development Plan for PNAC and PNAC Secretariat. One of the areas of urgency is addressing transient leadership – and move towards semi-permanence and systems for continuity. Human resource policies of the DOH may need to be looked at and reforms advocated. The

Secretariat should have a clear work plan for each year, which is specific and time bound.

It is recommended that there be a planned and interactive organization development process as a follow-up to the PNAC capacity assessments.

d. Improve the partnership with private sector and FBOs

Partnerships are critical to the success of the program. Some types of partnerships have either not taken off or not blossomed in the last few years- particularly, partnerships with the private sector, faith-based organizations and within different government agencies. Partnerships with donor communities also have not been fostered very strongly. Partnerships need not be in the form of PNAC membership; however, the Committees and the Secretariat can take the lead in fostering these partnerships.

e. Resource mobilization and investment plan

A new costed operational plan covering the next two years needs to be developed. There is also a need to mainstream the collection of expenditure data in the M&E system. The experiences of the implementers and the recommendations need to be taken into consideration during the costing. Costing guidelines and standards need to be developed and shared. A plan to raise additional resources should be developed. Systems for managing and co-coordinating with NEDA for proper documentation need to be streamlined.

5 Moving Forward

This report is to serve as a guide to the operational plan of the second half the strategic plan i.e. Operational plans of 2009, and 2010. The development of the operational plan will also serve as a guide to understand the resource gaps.

As part of developing the operational plan, following needs to be done:

Step 1: Broad framework of plan to be disseminated by PNAC to all the key member agencies

Step 2: Work plans integrating HIV into agencies' activities to be finalized and submitted to PNAC

Step 3: This is not linear but package of services needs to be created, and costing per area and per HRG person to be developed.

Step 4: Specific numbers based targets to be set, based on historical experience, as well as a percentage of the most recent estimates.

Step 5: A costing model can be used, to determine the resources needed from the above mentioned steps.

Step 6: Resource estimation, based on historical allocation (if agencies have not budgeted their plans)

Step 7: Resource Mobilization plan, based on the funding gap thus calculated.

6 Annexures

6.1 Annex A: Terms of Reference

In consultation with the team, the initial Terms of Reference was revised for clarity. Below is the revised Terms of Reference for this Assessment:

HIV/AIDS Technical Support Facility
Southeast Asia & the Pacific

TERMS OF REFERENCE

Title: Midterm Assessment of Fourth AIDS Medium Term Plan 2005-2010
Ref. No.: TAF/PH/11/2008
Duration: 28th August 2008 to 15th December 2008
Period: 39 days
Location: Manila, Philippines

Background

The Philippine National AIDS Council (PNAC) was created in 1992 by Executive Order No. 39 as an advisory body to the Office of the President on all matters related to AIDS. It was reconstituted by virtue of Republic Act 8504 as the central advisory, planning and policy making body on the prevention and control of HIV and AIDS in the country. Made up of 26 members from the government, civil society and organization of people living with HIV, the council envisions a fully empowered national coordinating body where different individuals and sectors work in partnership to prevent the transmission of the virus and lessen its impact on the affected persons in particular and society in general.

Technical assistance was requested from TSF, by the PNAC, to undertake a mid-term assessment of the 4th AIDS Medium Term Plan (AMTP4) due by 2007 as endorsed by the PNAC during its plenary last April 2007. The PNAC budget for mid-term assessment is not adequate. The 2008 approved budget (P7million) for PNAC secretariat operation, which includes AMTP4 mid-term assessment, was significantly lower than the requested budget (P20million).
The results of the mid-term assessment will help gauge the performance of PNAC and will also identify areas for improvement for adoption by the Council in the 2009-2010 implementation of the AMTP-IV. The midterm assessment results will inform the strategic direction of both AMTP4 (2009-2010).

Global Fund proposals are developed based on the country's medium term plans. The implementation of these grants is assessed and based on, among others, their contribution to the achievement of the national plans' goals and objectives. Thus, the Global Fund-supported HIV initiatives (Rounds 3, 5, and 6) to the AMTP-IV will be included in this mid-term assessment.

Project Objective

General Objective
Mid Term Assessment of AMTP IV in order to review achievements and lessons for the first half of the plan, so as to inform the second half of the program.

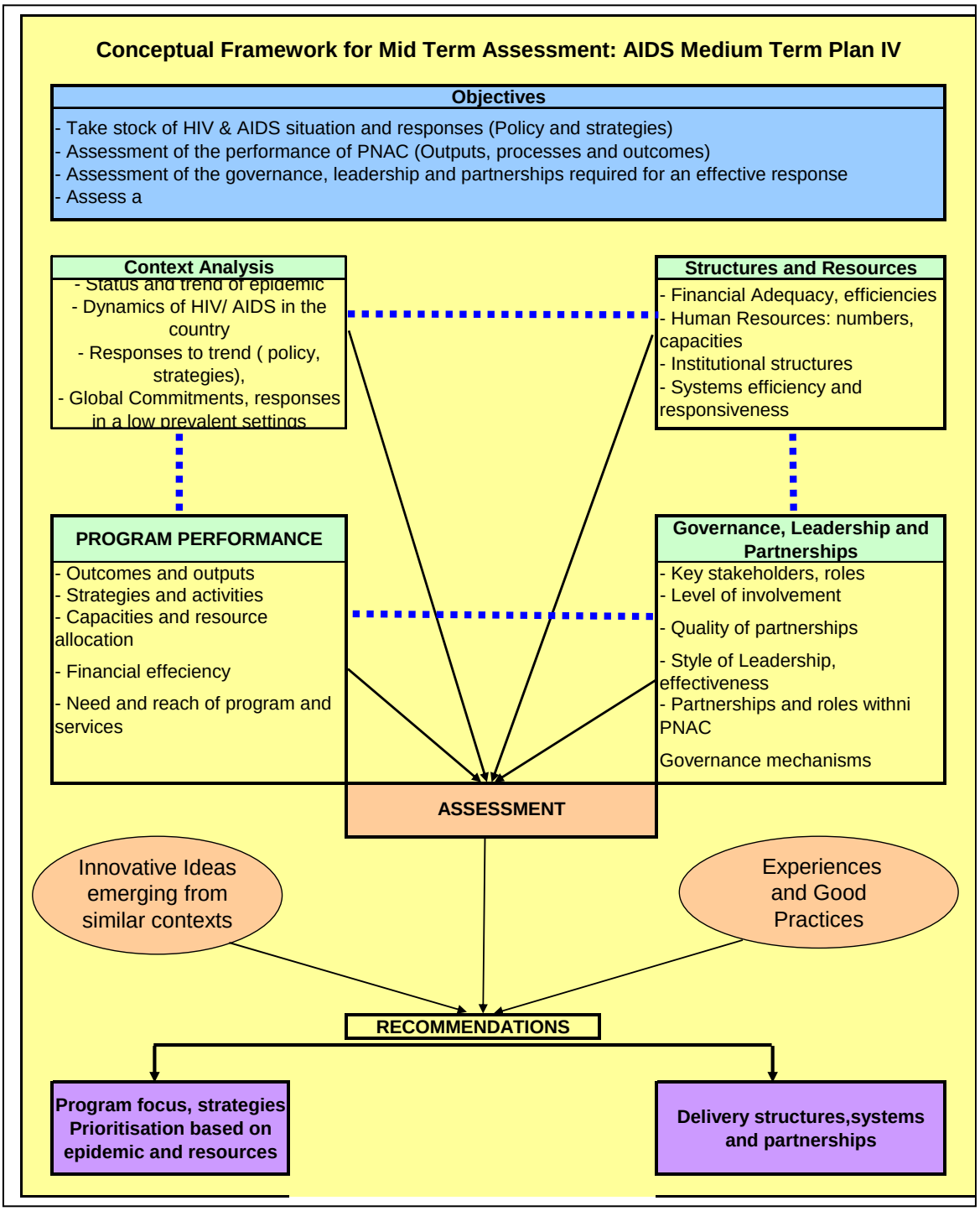
Specific Objectives

Take stock of HIV & AIDS situation and country responses (Policy and strategies)
- Assessment of the performance of PNAC (Outputs, processes and outcomes)
- Assessment of the governance, leadership and partnerships required for an effective response
- Assess adequacy of financial, human resources, systems and structures
- Suggest strategies and recommendation for 2009-2010 of AMTP IV

Purpose of the Consultancy

The primary purpose of this assessment is to determine the AMTP4 accomplishments to date, the status of achieving its targets, the relevance and adequacy of current strategies, and the process of developing budgeted plans in view of new issues- like recent HIV data and strategic information particularly the 2007 UNGASS report- and to develop recommendations to address identified data and response gaps. In the same manner, good practices and successful strategies shall be highlighted in this assessment. Further, the mid-term assessment will determine how the AMTP4 responds to international and regional commitments like Global Campaign *Unite for Children, Unite against AIDS, MDG and ASEAN Declaration* and principles and framework like the “Three Ones” and “Universal Access” and other new international guidance and how to incorporate these. Finally the findings of this assessment will provide or guide PNAC in the conduct of the end-term assessment of AMTP IV in 2010.

The following framework will be utilised as a lens to assess the first half of the AMTP IV:



Deliverables/Outputs

- Framework for evaluation
- Guidelines and Evaluation tools
- Field evaluation of AMTP-IV
- Midterm Assessment Technical Report (containing key findings, gaps, and recommended strategies for future programming)

Inputs

- PNAC Secretariat
- PNAC Exec. Comm. & Partners
- UN agencies
- Relevant key stakeholders

Reporting Practice
End of assignment

i. Consultant to produce timesheet with **clients' signature** upon completion of the assignment (*before leaving the assignment site*)

ii. Consultant would provide final output of deliverables and submit to TSF-SEAP (***TSF-SEAP would forward the final outputs by assuring QA to the client***)

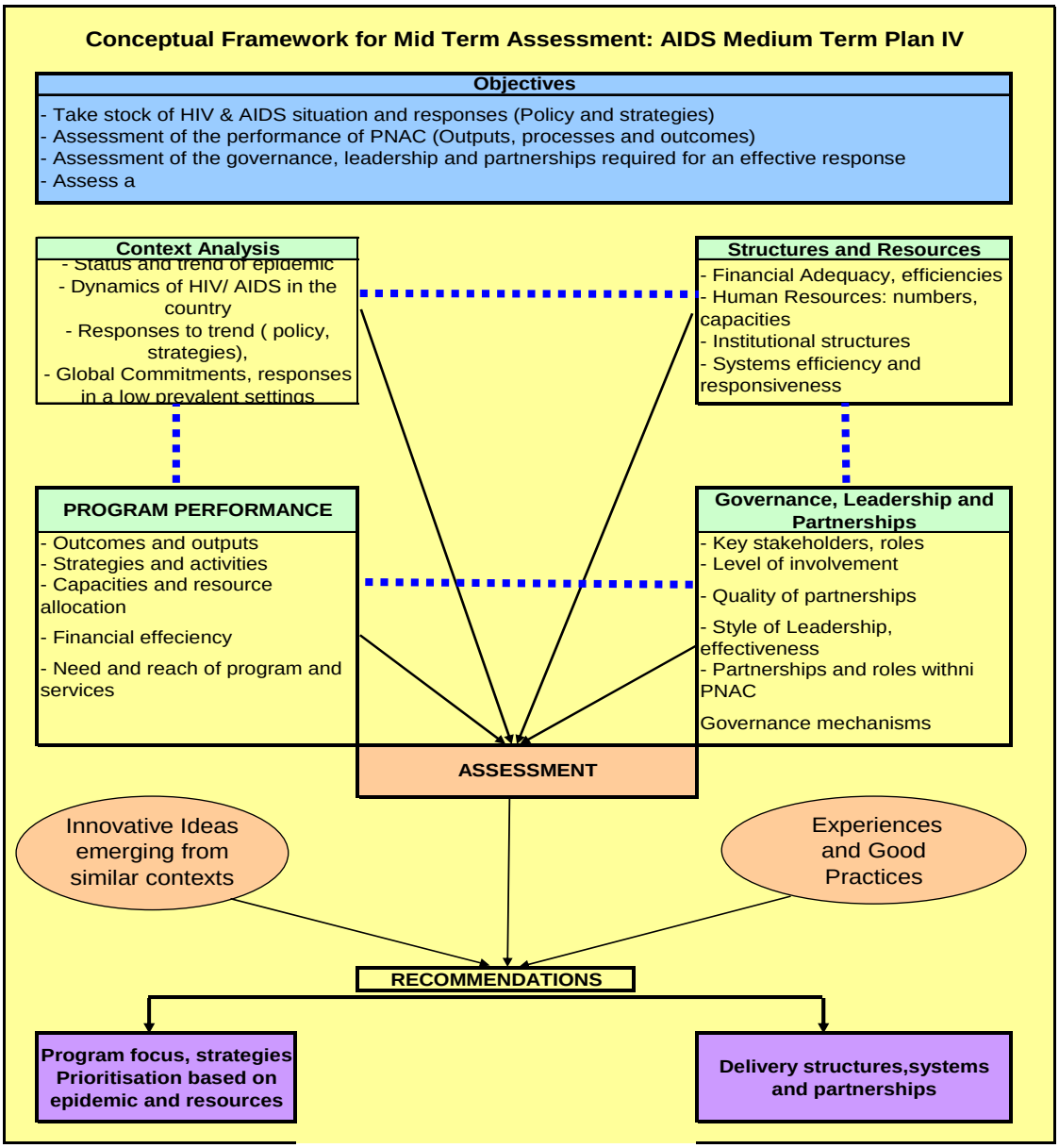
iii. Consultant to complete Consultancy Report & Feedback Form within 5 working days upon completion of the assignment and return to TSF-SEAP

iv. Any amendments to the current assignment and deliverables in regards to the TOR must be acknowledged by the client and TSF-SEAP

6.2 Annex B: List of Review Team Members

Name	Designation/Organization	Role	Email/Phone Number
Dr. Angela Chaudhuri	Consultant, Swasti Health Resource Centre/TSF-SEAF	Team Leader	angela@swasti.org 0929-7539992
Dr. Ferchito Avelino	Director III, PNAC Secretariat	Team Member	fl_avelinoyahoo.co.uk 743-0512/0917-5585139
Dr. Jessie Fantone	M&E Officer, PNAC Secretariat	Team Member	fantonej@ymail.com 743-0512/0919-5799990
Dr. Gerard Belimac	Program Manager, IDO-NASPCP	Team Member	Naspcp@doh.gov.ph naspcp@yahoo.com 7116808/0915-9402115
Dr. Ethel Dano	Program Officer IDO-NASPCP	Team Member	ethel_dan@yahoo.com 7116808/0915-8757509
Dr. Susan Gregorio	Medical Specialist II PNAC Secretariat	Team Member	docsanpnac@yahoo.com 7430512/0922-8885770
Dr. Madeline Salva	HIV/AIDS Officer, WHO	Team Member	salvam@wpro.int.org 731-3914 /0917-8062118
Mr. Joselito De Mesa	Consultant, TSF	Team Member	Joeldemesa@yahoo.com 0927-9164549
Mr. Noel Palaypayon	Surveillance Officer/NEC-DOH	Team Member	Noel_1226@yahoo.com 7431937/0919-4913583
Ms. Cristina Ignacio	Program Manager – HIV/AIDS Component,TDF	Team Member	cignacio@tdf.org 8402178/0917-8920217
Mr. Zimmbodilion Mosende	M & E Adviser, UNAIDS	Team Member	mosendez@unaids.org 901-413/0917-8626675
Ms. Noemi B. Leis	Consultant, TSF	Team Member	noemi.leis@gmail.com 09209382023
Ms. Virginia Evangelista	Administrative Officer, PNAC Secretariat	Team Member	virginialily2004@yahoo.com 743-0512/0921-5596068
Mr. Rench Chanliongco	Administrative Asst. IV/(FSW), PNAC Secretariat	Team Member	rench-chanliongco@yahoo.com 743-0512/0905-5133311

6.3 Annex C: Evaluation Framework and Tools



Stakeholders and Information Required

	Stakeholders	Role in the Program	Information from the SH for the evaluation	Person to meet	Where	No.
1	World Health Organization	Health sector responses	Process of AMTP IV planning, type of partnership , inputs taken, perception of progress	HIV/STI Coordinator, WPRO	Manila	2
2	UNAIDS	Coordination and mult- sectoral responses	Process of AMTP IV planning, type of partnership , inputs taken, perception of progress. Coordination of AMTP 4 with Universal access goals. About surveillance system and HIV governance	UCC M and E	Manila	2
3	Philippine National AIDS Council	Apex body- coordination	Governance, planning, surveillance, partnerships with NASPCP, DoH, UNAIDS etc, policy making and decision making processes	1. Director 2. M and E, 3. Vice-Chair of PNAC	Manila	3
4	National AIDS/STI Prevention and Control Program, DOH	Implementation programs	Surveillance, relevance of policies, achievements, lessons learnt, challenges and achievements of implementation, partnerships, relationships with PNAC	1. Director III 2. PO - TO (Dr. Gerard Belimac) 3. Division Chief	Manila	3
5	National Epidemiology Center	Surveillance	Surveillance, plans in strengthening M and E, and movement thereof	Director IV	Manila	1
7	Treatment Hubs (1 Government Referral Hospitals)- San Lazaro	TCS for PLHIV	Awareness of AMTP IV, program adequacy. Funding adequacy, capacities, HR, challenges and recommendations	Physician	Manila	1

8	Tropical Disease Foundation (Principal Recipient)	One implementer for GF grants	Role of PNAC, relevance and importance of AMTP IV, policies etc. Resources, achievements and successes in relation to AMTP IV	Tina Ignacio	Manila	1
9	PNGOC	One implementer for GF grants	Role of PNAC, relevance and importance of AMTP IV, policies , as implementer of GF grants, etc. Resources, achievements and successes in relation to AMTP IV	Program Manager (Ruthy Libatique)	Manila	1
10	Department of Social Welfare and Development	Community advocacy and Family Suport- TCS	Role of PNAC, relevance and importance of AMTP IV, policies etc. Resources, achievements and successes in relation to AMTP IV, Qs on mandate and plans, achievements thus far, challenges in implementing plans	1. Under Secretary (Alice Bala) 2. Implementer	Manila	2
11	DILG	LGU, implementers	Role of PNAC, relevance and importance of AMTP IV, policies etc. Resources, achievements and successes in relation to AMTP IV, Qs on mandate and plans, achievements thus far, challenges in implementing plans	1. Under Secretary 2. Division Chief	Manila	2
12	Girls, Women's Health AIDS Network	Consortium of NGOs, promoting gender equality, gender issues and HIV, health promotions	Country responses in relation to gender, need of the country, access to health care (HIV), stigma and discrimination, perceived role in PNAC, and how is PNAC doing its job as a response to HIV	Coordinator	Manila	1

Guide Questions						
Questions	**Interview Qs.**	**Methodology**	**Source**	**Documents additional**	**Facts (Y/N)**	**Percep-tions (Y/N)**
What is the trend of MARPs in Philippines, trend of routes of transmission, has this changed, is AMTP IV reflective of this	a. Who are the populations most at risk (MARP) to HIV infection? Who else are at-risk or vulnerable?	IDI	PNAC members, PNAC Secretariat; Regional Officers (DOH, DILG, DSWD); LGU stakeholders (STI clinic staff, LAC Officials; NGOs)		N	Y
	b. What are the trends in the mode of transmission among MARPs? Among others who are at risk or vulnerable?	IDI	DOH-NEC; DOH-NASPCP; LGU stakeholders (STI clinic staff, NGOs, Private Sector)		N	Y
	c. Are you familiar of the national strategic/local plans on HIV? What are these? Do you know of the national operation plan? Were you involved in the consultations for making the plan? Do you think that the national plan is relevant and appropriate?	IDI	PNAC Members LAC		N	y

	d. Were the UA targets appropriate/adequate, given the trends in the HIV epidemic (populations at risk, mode of transmission, etc)?	IDI	PNAC M and E; National M&E Team , NEC, PNAC M&E Officer, UNAIDS M and E)		N	Y
	e. Are you aware of the existing costed operational plan of AMTP IV?	IDI	- PNAC Execomm and Development Partner		N	Y
	f. Are all the activities costed? Are these sufficient ? Is money actually available?	IDI	- PNAC members - Local Chief Executives (LAC)	Costed plan, progress report, annual workplan	Y	N
	g. Who is responsible for your costed work plan? During implementation, did u find the costing sufficient for the activities?	IDI	- PNAC members - Local Chief Executives (LAC)	Costed plan, progress report, annual workplan	Y	N
Are there sufficient and appropriate Human resources (capacities vs numbers)	a. Do you think there are suffient and appropriate Human resources in your agency for HIV? Pls explain	IDI	- PNAC Members - LAC members and Sec- NASPCP- Regional Health Office- NEC- Treatment Hubs			

	b. Do you think that the staff hired for vairous positions have appropriate capacities? Why/why not, describe	IDI	- PNAC Chair, - DILG - DSWD - LAC members - NASPCP - Regional Health Office - NEC - Treatment Hubs			
	c. Do you have a capacity development plan for your staff and how far has this been implemented? What r the factors that facilitate successful implementation of the plan? What r the factos that hinder the implementation of the plan	IDI	- PNAC Chair, '- DILG - DSWD - LAC members - NASPCP - Regional Health Office - NEC - Treatment Hubs -DOLE		N	Y
Who are the different players in this program, and what is their relationship	a. Who are the major players in your AIDS program?what is their relationship to the program?	IDI	Assessment team			

What are the systems within the program that facilitate or hinder decision making and processes	a. How does your agency make policy decisions? What is the process?	IDI	- PNAC Members- LGU-LAC	TB/HIV policy (minutes of meetings - DoH)Minutes of meetings of last policy decision (Ordinances etc) from initiation to policy	N	Y
	b. What information aids evidence-based programming	IDI	- PNAC Members - LGU -LAC		N	y
	c. Who sets the direction of the program within the agency's mandate?	IDI	- PNAC Members - LGU -LAC		N	y
	d. How aligned is the operational plan to the AMTP IV (Review national operational and site work plans)	IDI	- LAC members - SHC - City Health Officer			
	e. Do you have a plan? How much of the plan have you achieved? What are the factors that hindered the achievement of the plans?	IDI	- LAC members - SHC - City Health Officer			

Are the program outputs and subsequent outcomes different from what was planned	a. Do you have any key accomplishments which were developed as a result of emerging scenario, maybe not a part of the plan?	IDI	- LAC members- SHC- City Health Officer			
	b. Do you have any activity that is different from what is in the operational plan? Why?	IDI	- LAC members - SHC - City Health Officer - PNAC members: -NASPCP -DOLE			
Who are the Key stakeholders in governance and policy making and what are their roles? What is their level of involvement during decision making and implementation?	a. Do you have a policy/ies on HIV/STI prevention in your LGU? If no why?	IDI	Social Hygiene clinic/MHO/CHO/LAC member	Policy Documents/ordinances/minutes	Y	
	b. If you do not have an LAC , does anyone else provide a forum for discussion and policy and planning for HIV programs?	IDI	Social Hygiene clinic/MHO/CHO/LAC member		Y	

	c. Who are the main agencies/persons involved in decision-making pertaining to policy, programming and implementation?	IDI	Social Hygiene clinic/MHO/CHO/LAC member		Y	
	d. What are the roles of these agencies as individual organization and as member of the coordinating/decision-making body?	IDI	Social Hygiene clinic/MHO/CHO/LAC member	Matrix of agency, mandated roles, and actual roles	Y	
	e. Are there other groups engaged in HIV related activities outside the decision-making/coordinating body in the community? Level of involvement.	IDI	Social Hygiene clinic/MHO/CHO/LAC member	matrix, agency, type of agency, kind of involvement		Y
	f. Is the policy making body currently active? If no why and any recommendations/suggestions.	IDI	Social Hygiene clinic/MHO/CHO/LAC member			Y
What determines the quality of partnerships?	a. Is there an existing partnership in your LGU? If no, do you think there is a need to establish one? Why?	IDI	- LGU- LAC members			Y
	b. If there is, is partnership official? (MoU, Office Orders, etc.)	IDI	- LAC - LGU -Chief Executives	copy of MOU etc		Y
	c. Do you think they are the "right" partners? Why or why not?	IDI	- LAC - LGU -Chief Executives			Y

	d. Do you think the partners contributed positively to the program. Why and why not?	IDI	- LAC - LGU -Chief Executives			Y
What are the leadership styles that work?	a. Who is the acknowledged leader of the HIV/STI initiative in your LGU?	IDI	- LAC - LGU -Chief Executives - PNAC			Y
	b. What type of leadership style does he practice? (Hands-on, delegation, democratic, directing, dictatorial, or others)	IDI	- LAC - LGU -Chief Executives - PNAC			Y
	c. Do you think the leader is effective?	IDI	- LAC - LGU -Chief Executives - PNAC			Y
	d. Does he inspire each member to actively contribute?	IDI	- LAC - LGU -Chief Executives - PNAC			Y
Has the program reached its target groups, in numbers and type? Quality and ease of access	a. What are the target groups in your LGU? (PIP, MSM, IDU, OFW)	IDI	LGU, SHC staff, NGO		Y	

	b. Do you think there are other target groups that should be reached? Why? Why was this not included in your plan? Are these new groups you have identified?	IDI	LGU, SHC staff, NGO			Y
	c. Do you think that your program has reached its intended target groups? Why/why not?	IDI	SHC staff and client			Y

6.4 Annex D: Inception Report

Mid Term Assessment of AIDS Medium Term Plan IV- Philippines

Inception Report

Submitted by

Dr Angela Chaudhuri, Swasti-Health Resource Center
(Technical Support Facility- South East Asia Pacific)

20th September 2008

TABLE of CONTENTS

Abbreviations and acronyms

AMTP	**AIDS Medium Term Plan**
ARV	**Anti-retroviral drugs**
ASEP	**AIDS Surveillance and Education Project**
BSS	**Behavioral Sentinel Surveillance**
BFAD	**Bureau of Food and Drugs**
CRIS	**Country Response Information System**
CHD	**Center for Health Development (DOH Regional Office)**
CHED	**Commission of Higher Education**
DepEd	**Department of Education**
DOH	**Department of Health**
DOLE	**Department of Labor and Employment**
GIPA	**Greater involvement of persons with HIV and AIDS**
HACT	**HIV AIDS Core Teams**
HRG	**High Risk Group**
HSS	**HIV Serologic Surveillance**
IDU/s	**Injecting drug users**
IHBSS	**Integrated HIV Behavioral Serologic Surveillance**
LAC	**Local AIDS Council**
LGU	**Local Government Unit**
MARP/s	**Most-at-Risk Population/s**
MDG/s	**Millennium Development Goals**
MEWG	**Monitoring and Evaluation Working Group**
MSM/s	**Males having sex with Males**
MTCT	**Mother-to-Child Transmission**
MTPDP	**Medium Term Philippine Development Plan**
NASPCP	**National AIDS STI Prevention and Control Program**
NEC	**National Epidemiology Center**
NEDA	**National Economic and Development Authority**
NGOs	**Non-government Organizations**
NHSSS	**National HIV and AIDS Sentinel Surveillance System**
NSO	**National Statistics Office**
OFW	**Overseas Filipino Worker**
OI	**Opportunistic Infections**
OSY	**Out-of-School Youth**
PIP/s	**People in prostitution**
PLHIV/s	**People Living with HIV**

PNAC	**Philippine National AIDS Council**
RA 8504	**Republic Act 8504, The Philippine AIDS Prevention and Control Act of 1998**
RESU	**Regional Epidemiology and Surveillance Unit**
RHU	**Rural Health Unit**
RITM	**Research Institute for Tropical Medicine**
SACCL	**STI/AIDS Central Cooperative Laboratory**
SHC	**Social Hygiene Clinic**
SSESS	**Sentinel STI Etiologic Surveillance System**
STI	**Sexually Transmitted Infections**
UNGASS	**UN General Assembly Special Session on HIV and AIDS**
VCT	**Voluntary Counseling and Testing**

1. Introduction

This report sets out the objectives and design of the mid term assessment of the AIDS Medium Term Plan IV of the Philippines, based on the terms of reference and the approach discussed and finalized by the assesment team (AT). Following a brief overview of the context within which Philippines National AIDS Council (PNAC) is operating, the report summarises the purpose and scope of the assessment, describes the assessment design and provides details about the proposed plan of work.The report has benefited from a process of consultation with stakeholders. A first draft was circulated to members of the PNAC and is discussed at a workshop held on 29th September 2008. Additional comments were also received in writing. Errors of fact have been corrected and improvements made to the evaluation design as far as practicable within the scope of the assessment and budgeted resources.

2. Background:

The Philippine National AIDS Council (PNAC) was created in 1992 by Executive Order No. 39 as an advisory body to the Office of the President on all matters related to AIDS. It was reconstituted by virtue of Republic Act 8504 as the central advisory, planning and policy making body on the prevention and control of HIV and AIDS in the country. Made up of 26 members from the government, civil society and organization of people living with HIV, the council envisions a fully empowered national coordinating body where different individuals and sectors work in partnership to prevent the transmission of the virus and lessen its impact on the affected persons in particular and society in general. PNAC was scheduled to undertake the mid-term assessment of the 4th AIDS Medium Term Plan (AMTP4), due by 2008, as endorsed by the PNAC during its plenary last April 2007.

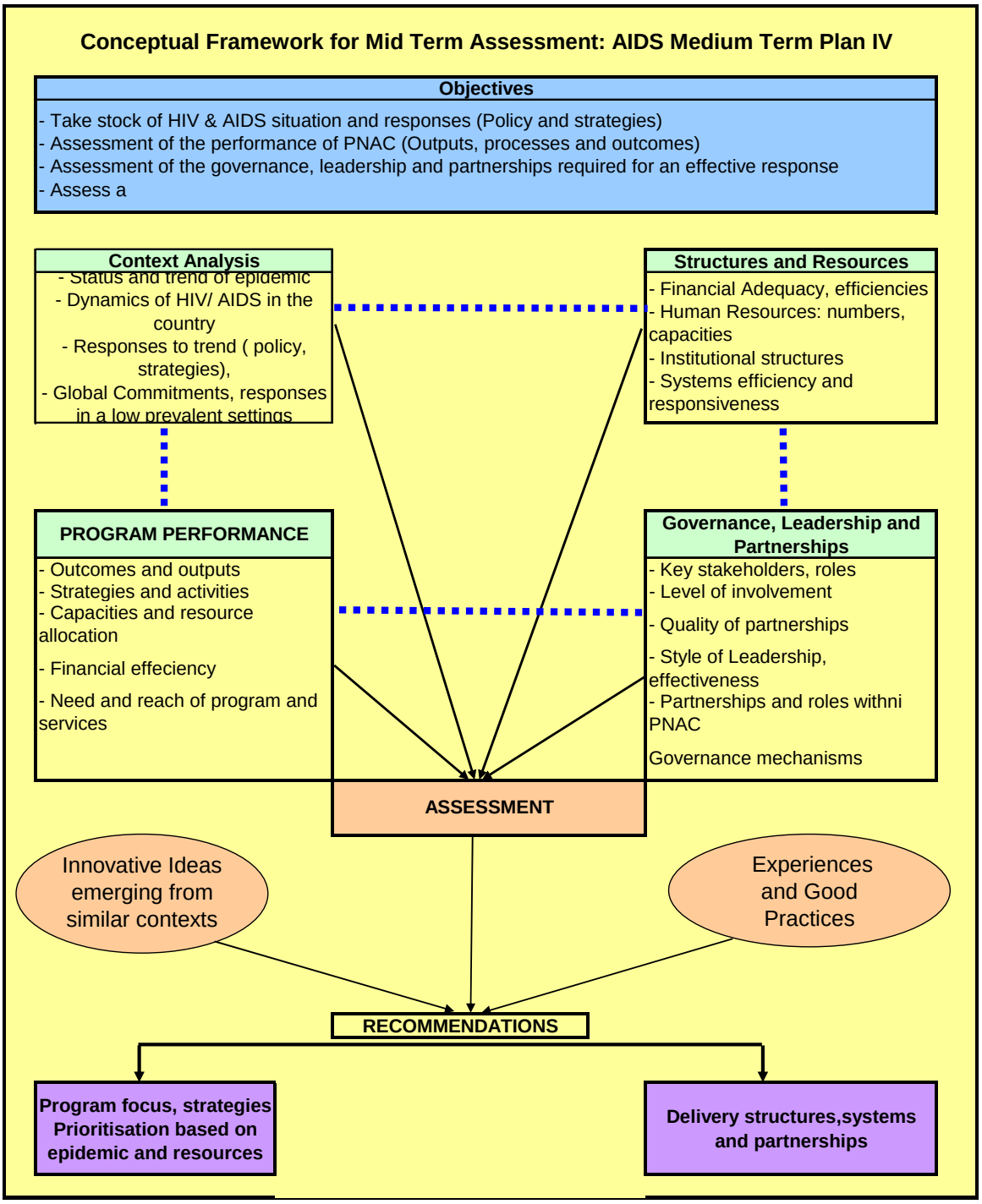
3. Purpose of assessment

Mid Term Assessment of AMTP IV is being conducted in order to review achievements and lessons for the first half of the plan, so as to inform the second half of the program and provide guidance towards the development of the subsequent medium term plan.

The primary purpose of this assessment is to determine the AMTP4 accomplishments to date, the status of achieving its targets, the relevance and adequacy of current strategies, and the modalities of developing costed plans in view of new issues like recent HIV data and strategic information particularly the 2007 UNGASS report and to develop recommendations to address identified data and response gaps. In the same manner, good practices and successful strategies shall be highlighted in this assessment. Further, the mid-term assessment will determine how the AMTP4 responds to international and regional commitments like Global Campaign *Unite for Children, Unite against AIDS, MDG and ASEAN Declaration* and principles and framework like the “Three Ones” and “Universal Access” and other new international guidance and how to incorporate these. Finally the findings of this assessment will provide or guide PNAC in the conduct of the end-term assessment of AMTP IV in 2010. The assessment will also cover the performance of PNAC, and the levels of governance, leadership and partnerships required for an effective response. The period assessed includes 2005 to 2008 (June).

4. Assessment Framework

According to the Terms of Reference, the review looks at the AMPT IV for relevance, appropriateness, responsiveness, extent of coverage and quality w.r.t implmentation of the country program. The review also assesses PNAC's performance and effectiveness of governance, partnerships and leadership.



Factors of Assessment
Relevance: The extent, to which AMTP IV reflects stakeholder priorities and policy objectives, is consistent with beneficiaries' requirements, country needs, global priorities, partners and donors, policies.
Effectiveness: The extent to which the programme has achieved its objectives or are expected to be achieved, taking into their account their relative importance.
Efficiency: Given the low availability of resources, has the program allocated funds appropriately, for maximum impact
Outcomes: The positive and negative changes produced by the programme, directly or indirectly intended or unintended.
Partnerships: The extent of commitment of partners and sustainability of efforts will lead to country wide multi sectoral effort against HIV, as stated in AMTP IV.
Governance: The effectiveness of leadership and decision making processes within the PNACE secretariat sets the ground for successful implementation of the program

4.1 Guiding Principles

Guiding Principles used in the assessment include:

1. Driven on Country's needs
2. Participatory in nature, including field level implementers
3. Appreciative Enquiry
4. Collective Learning approach
5. Data Collection based on standardized methodologies
6. Tools were made participatively in consultation with assessment team which included key staff at the PNAC, NEC, UNAIDS and DOH.
7. Set criteria for site selection have been developed and nine sites, proposed
8. Differentiation of information between Fact and Perception, and reported in the assessment as either Fact or perception.
9. Recommendations by stakeholders differentiated between recommendation of the assessment team.

The conceptual framework provides the lens for assessment, a structure for analysis and reporting, with a perspective for future action.

The assessment framework structures the issues and questions as indicators that can gauged during the assessment. The Assessment Framework also identifies the range of documents to be reviewed and key informants to be interviewed for each question. This framework is an important part of the assessment process and not an end-product. The framework has been finalized together with the assessment team and presented to the various key stakeholders.

4.2 Methodology

The Evaluation Framework tables provide a basis from which interview questions will be developed. By matching questions to sources of data from the framework tables, respondents

or documents, the evaluation team will prepare interview guides for specific individuals such as Focal Point for surveillance (National Epidemiology Center), program director (NASCP), local chief executives etc and documents, which bring together topics from across.

The evaluation methodology comprises a mix of site visits and observation, telephone and face-to-face interviews, discussion groups, desk-based research and review of existing reports and secondary data. A list of key documents to be reviewed follows.

4.2.1 Methods

- **Document review against structured checklist** – These will be used to help analyse the content of key documents such as policies, strategies, annual work plans, surveillance reports, progress reports and evaluation reports. Checklists help to ensure comprehensive coverage against the evaluation questions and a consistent approach to document review.

No	Name of the document	Information Required
1	4th AIDS Medium Term Plan and costed operation al plan	Strategic plan for the program in the country
2	UNAIDS Strategies for low prevalence countries	Strategies are matching with country plan
3	Previous evaluations of PNAC	recommendations, have they acted on it or not, why and why not
4	Minutes of the meeting of the PNAC (5)	Partnership and collaborative work – quality
5	TWG	Minutes of meeting, how decisions are made, how discussions are taken to action, involvement of MARPs,
6	CCM meeting	Minutes,how integrated with health sector plan, decision making process w.r.t GF, harmonization and alignment,
7	Current M&E system (National- PNAC)	National M and E indicators visavis other donor funded indicators, issues
8	UNGASS2004- 2008 Country Report	trend and context analysis, National M and E
9	Estimation Report (2005 and 2007)	MARP mapping estimates trend
10	NCPI report	Policy Index, perceptions of SH towards country response
11	Laws pertaining to HIV and AIDS	Enabling Environment, Decision making analysis

- **Policy/Decision making timeline –** This is a visual means of recording and presenting key events in the evolution and implementation of a decision or policy. PNAC being such a large committee with a multitude of stakeholders, it becomes particularly important to assess the quality of PNAC meeting particularly in decision making and policy development and implementation. Last five 'minutes' of meetings have been taken for analysis, where two decision making topics will be taken and followed for action and implementation.
- **Semi-structured interview interview guides –** Interview guides will be developed prior to discussions to help ensure systematic coverage of questions and issues by smaller teams/team members working individually. The topics have been developed around the assesment questions, but grouped and focussed according to the organisation or individual being interviewed. Semi-structured nature of the interviews and discussions allow assessment team to probe further and explore deeper avenues of enquiry as the issues arise through the discussions.

A sample of checklist as below:

Question	Interview Qs.	Methodology	Source	Documents additional	Facts (Y/N)	Perceptions (Y/N)
1. What was the trend of the epidemic in 2003 till now, is this reflected in AMTP4?	What is the HIV prevalence from 2003 to 2007?	Desk review	UNGASS Report, HIV Estimation Reports		y	n
	What are the trends in the mode of transmission from 2003 to 2007?	Desk review	AIDS Registry		y	n
	What population (economic and demographic profile) are mostly infected with HIV from 2003 - 2007?	Desk review	HIV Estimation Reports, AIDS registry		y	n
	Are the above reflected in the national strategic plan (AMTP4) particularly in the annual operational plan?	Desk review	AMTP4; AMTP4 Operational Plan 2007-2008		y	n
2. What is the trend of MARPs in Philippines, trend of routes of transmission, has this changed, is AMTP IV relfective of this	Who are the populations most at risk (MARP) to HIV infection? Who else are at-risk or vulnerable?	IDI	PNAC members,PNAC Secretariat; Regional Officers (DOH, DILG, DSWD); LGU stakeholders (STI clinic staff, LAC Officials; NGOs)		N	Y
	What are the trends in the mode of transmission among MARPs? Among others who are at risk or vulnerable?	IDI	DOH-NEC; DOH-NASPCP; LGU stakeholders (STI clinic staff, NGOs, Private Sector)		N	Y
	What are the trends in the mode of transmission among MARPs? Among others who are at risk or vulnerable? Transmission Dynamics (HIV prev with high STIs?.)	Desk Review	AIDS Registry, UNGASS 2006, 2008		y	y
	Are you familiar of the national strategic/local plans on HIV? What are these? Do you know of the national operation plan? Were you involved in the consultations for making the plan? Do you think that the national plan is relevant and appropriate?	IDI	PNAC Members LAC		N	y
3. Does AMTP 4 reflect Global Commitments: UA indicators, and strategies for MDGs and approaches for low prevalence countries etc	Are UA targets set in the AMTP4?Dissemination of UA targets to SH	Desk Review	AMTP4; AMTP4 Operational Plan 2007-2008; UA Report 2006; UA Targets 2007		y	n

- **Appreciative enquiry –** An approach that seeks to explore successes and positive experiences in dialogue with individuals and groups of individuals or organizations in order to record and deepend the understanding of why something worked well, and how the good practice may be adapted and applied elsewhere.
- **Workshops-** This is an approach we are using where stakeholders will gain from cross discussions particularly when assessing their own capacities (PNAC), progress against plans,

partnerships and collaborative efforts. Three such workshops are planned: first one to disseminate the inception report, evaluation framework and assess PNAC's capacities as well as make a data prourement plan. The second workshop will involve collation all the data, present the findings and share experiences. The third one will involve feedback on the draft report, and inputs to the report.

4.3 Site Visits: Selection and Preparation

The selection of sites was based on specific criteria:

1. **Presence of Local AIDS Council:** Present and Active, Present and non functional, and absence of LAC
2. **Distance from Capital:** Distant (More than 6 hours by road or one hour by flight), and near (less than 6 hours by road and one hour by flight).
3. **Socio economic status:** Urban and Rural
4. **All sites selected covered all the identified MARPs and vulnerable groups**
5. **All sites totally covered prevention and care and support programs**

SITE	STI	EE (Presence of LAC)	Target Population	Urban/Rural	Distance from Capital
Cebu	19.5	Old	IDUs	U	Far
Laoag	9.6	Old	PIP	U	Far
Legaspi	23.94	No	MSM, PIP, MW	Mixed	Medium
Cagayan De Oro	8.76	New	MSM, PIP, MW	U	Far
Dumaguete	0	No	MSM, PIP, MW	U	Close
Malay Aklan	0	No	MSM, PIP, MW	R	Close
Daraga	27.83	New	MSM, PIP, MW	R	Far
Bocaue		No	TCS	R	Medium

There were considerations of ease of travel, costs, time and also the weather, this being a season for typhoons.

4.4 Assessment Schedule

The schedule given below is for the first half of the assessment. There will be a break of 10 working days from October 2nd to enable feedback from stakeholders to the draft report. There will be site visits, additional interviews and analysis after this. Assessment will be completed by October 28th 2008 and the report is to be finalized by December 10th 2008.

Activity	Who	Where	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2
			T	W	TH	F	S	S	M	T	W	T	F	S	S	M	T	W	Th
Site Visits	Team A/Gerard	Manila																	
Analysis and Writing	Team A	Manila																	
Site Visits	Team A	Legaspi																	
Site Visits	Team A	Gumaca																	
Collation and analysis	Team A	Manila																	
SH Workshop	**Workshop**	Manila											X						
Writing Workshops	**Team A**	Manila																	
	Team B																		
Site Visits	Team B	Dumagete																	
Analysis and Writing	Team B	Manila																	
Site Visits	Team B	Cebu City																	
Site Visits	Team B	Malay Aklan																	
Collation and analysis	Team B	Manila																	
SH Workshop	Team B	Manila																	
Writing Workshop	Team B	Manila																	
Site Visits	Team C	CDO																	
Analysis and Writing	Team C	Manila																	
Site Visits	Team C	Bocaue																	
Site Visits	Team C	Laoago																	
Collation and analysis	Team C	Manila																	
Workshop	Team C	Manila																	
Writing workshop	Team C	Manila																	

6.5 4.5 Team

The assessment team has a strong national and local expertise and perspective, good gender balance and sound technical expertise in planning, evaluation, HIV and AIDS and health systems.
The team consists of members of PNAC secretariat, National Epidemiology Center, NASPCP, UNAIDS, Tropical Disease Foundation (one of the largest HIV program implementers), independent local consultant, and the team leader, an international consultant, identified by Technical Support Facility South East Asia Pacific, from Swasti-Health Resource Center (based in India) which is a leading international agency on programme evaluations particularly in HIV and Health systems.

Team A
Angela
Rench
Tina
Team B
Joel
Peter
Susan
Team C
Jessie
Noel
Gerard/Ethel

4.6 Factors Affecting Assessment

Some of the key factors affecting the assessment are listed as follows:

1. Participation of key stakeholders at consultations and workshops
2. Availability of key information needed for analysis
3. Weather, this being typhoon season in Philippines, site visits are affected by this, as well as availability of people to be interviewed.

5. Outputs of the Assessment

The outputs of the Assessment include:

1. **Evaluation Framework and Tools**
2. **Inception Report** (Although this was not included in the Terms of Reference, this has been considered to be vital in an assessment of this criticality, size and scope)
3. **Assessment Report,** with key recommendations for the second phase of AMTP IV

6. Key Contacts

For further details, please contact:

Dr. Ferchito L. Avelino
Executive Director
Philippine National AIDS Council
3rd floor, Building 15, Department of Health,
San Lazaro Compound, Sta Cruz,
Manila, Philippines
Telephone numbers : 63 (02) 743-8301 local 2552
Fax : 63 (02) 743-8301 local 2551
fl_avelino@yahoo.co.uk
pnac_sec@yahoo.com

NAME	DESIGNATION/ORGANIZATION	ROLE	EMAIL/PHONE NUMBER
Dr. Angela Chaudhuri	Consultant/Swasti Health Resource Center/TSF-SEAF	Team Leader	angela@swasti.org 0929-7539992
Dr. Ferchito Avelino	Director III PNAC Secretariat	Team Member	fl_avelino@yahoo.co.uk 743-0512/0917-5585139
Dr. Jessie Fantone	M & E Officer PNAC Secretariat	Team Member	jessiefantone@yahoo.com 743-0512/0919-5799999
Dr. Gerald Belimac	Program Manager IDO-NASPCP	Team Member	naspcp@co.doh.gov.ph 711-6808/0915-9402115
Dr. Ethel Dano	Program Officer IDO-NASPCP	Team Member	ethel_dan@yahoo.com 711-6808/0915-8757509
Dr. Susan Gregorio	Medical Specialist II PNAC Secretariat	Team Member	docsanpnac@yahoo.com 743-0512/0922-8885770
Dr. Madeline Salva	HIV/AIDS Officer WHO	Team Member	salvam@wpro.int.org 731-3914/0917-8062118
Mr. Joselito De Mesa	Consultant/TSF	Team Member	joeldemesa@yahoo.com 0927-9164549
Mr. Noel Palaypayon	Surveillance Officer NEC-DOH	Team Member	noel_1226@yahoo.com 743-1937/09194913583
Ms. Tina Ignacio	Program Manager HIV/AIDS Component - TDF	Team Member	cignacio@tdf.org 840-2178/0917-8920217
Mr. Zimbodillion Mosende	M & E Adviser UNAIDS	Team Member	mosendez@unaids.org 901-0414/0917-8626675
Ms. Virginia Evangelista	Administrative Officer PNAC Secretariat	Team Member	virginialily2004@yahoo.com 743-0512/0921-5596068
Mr. Rench Chanliongco	Administrative Asst. IV/(FSW) PNAC Secretariat	Team Member	rench_chanliongco@yahoo.com 743-0512/0921-6187557

7. Terms Of Reference

In consultation with the team, the initial Terms of Reference was revised for clarity. Following is the Terms of Reference for this Assessment:

HIV/AIDS Technical Support Facility
Southeast Asia & the Pacific

TERMS OF REFERENCE

Title: Midterm Assessment of Fourth AIDS Medium Term Plan 2005-2010
Ref. No.: TAF/PH/11/2008
Duration: 28th August 2008 to 15th October 2008
Period: 39days
Location: Manila, Philippines

Background

The Philippine National AIDS Council (PNAC) was created in 1992 by Executive Order No. 39 as an advisory body to the Office of the President on all matters related to AIDS. It was reconstituted by virtue of Republic Act 8504 as the central advisory, planning and policy making body on the prevention and control of HIV and AIDS in the country. Made up of 26 members from the government, civil society and organization of people living with HIV, the council envisions a fully empowered national coordinating body where different individuals and sectors

work in partnership to prevent the transmission of the virus and lessen its impact on the affected persons in particular and society in general.

Technical assistance is requested from TSF by the PNAC to undertake the mid-term assessment of the 4th AIDS Medium Term Plan (AMTP4), due by 2007 as endorsed by the PNAC during its plenary last April 2007.
The PNAC budget for midterm assessment is not adequate. The 2008 approved budget (P7million) for PNAC secretariat operation, which includes AMTP4 mid-term assessment, was significantly lower than the requested budget (P20million).
The results of the mid-term assessment will help gauge the performance of PNAC and will also identify areas for improvement for adoption by the Council in the 2009-2010 implementation of the AMTP-IV. The midterm assessment results will inform the strategic direction of both AMTP4 (2009-2010).
Global Fund proposals are developed based on the country's medium term plans. The implementation of these grants is assessed based on, among others, their contribution to the achievement of the national plans' goals and objectives. Thus, the Global Fund-supported HIV initiatives (Rounds 3, 5, and 6) to the AMTP-IV will be included in this mid-term assessment.

Project Objective

General Objective

Mid Term Assessment of AMTP IV in order to review achievements and lessons for the first half of the plan, so as to inform the second half of the program.

Specific Objectives:

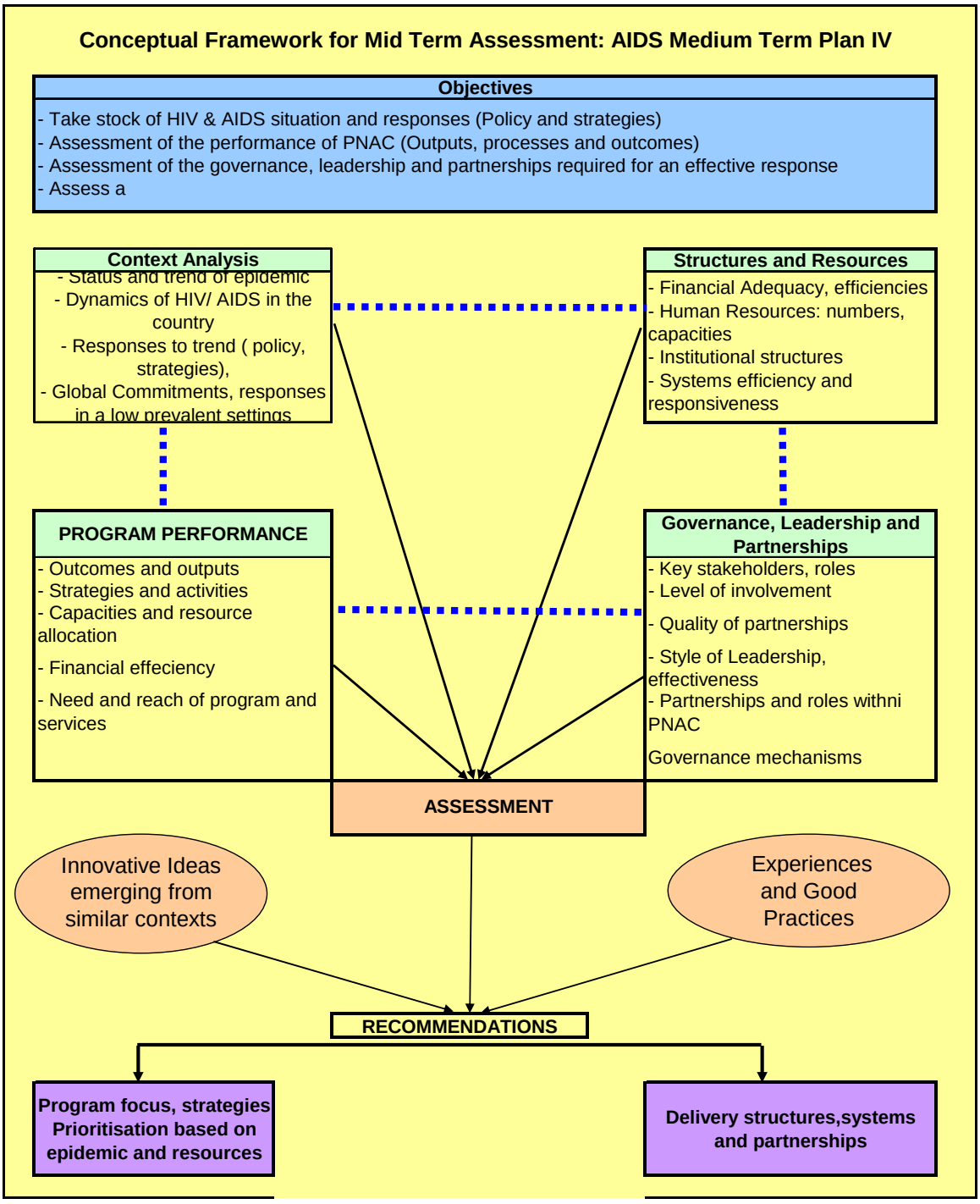
Take stock of HIV & AIDS situation and country responses (Policy and strategies)

- Assessment of the performance of PNAC (Outputs, processes and outcomes)
- - Assessment of the governance, leadership and partnerships required for an effective response
- Assess adequacy of financial, human resources, systems and structures
- Suggest strategies and recommendation for 2009-2010 of AMTP IV

Purpose of the Consultancy

The primary purpose of this assessment is to determine the AMTP4 accomplishments to date, the status of achieving its targets, the relevance and adequacy of current strategies, and the process of developing costed plans in view of new issues like recent HIV data and strategic information particularly the 2007 UNGASS report and to develop recommendations to address identified data and response gaps. In the same manner, good practices and successful strategies shall be highlighted in this assessment. Further, the mid-term assessment will determine how the AMTP4 responds to international and regional commitments like Global Campaign *Unite for Children, Unite against AIDS, MDG and ASEAN Declaration* and principles and framework like the "Three Ones" and "Universal Access" and other new international guidance and how to incorporate these. Finally the findings of this assessment will provide or guide PNAC in the conduct of the end-term assessment of AMTP IV in 2010.

The following framework will be utilised as a lens to assess the first half of the AMTP IV



Deliverables/Outputs

- Conceptual framework for evaluation
- Guidelines and Evaluation tools
- Field evaluation of AMTP-IV
- Midterm Assessment Technical Report (containing key findings, gaps, and recommended strategies for future programming)

Inputs

- PNAC Secretariat
- PNAC Execomm & Partners
- UN agencies
- Relevant key stakeholders

Reporting Practice
End of assignment

i. Consultant to produce timesheet with **clients signature** upon completion of the assignment (*before leaving the assignment site*)
ii. Consultant would provide final output of deliverables and submit to TSF-SEAP (***TSF-SEAP would forward the final outputs by assuring QA to the client***)
iii. Consultant to complete Consultancy Report & Feedback Form within 5 working days upon completion of the assignment and return to TSF-SEAP
iv. Any amendments to the current assignment and deliverables in regards to the TOR must be acknowledged by the client and TSF-SEAP

Twining Accountability

The responsibility of the lead consultant towards twining consultant in delivering expected outputs by transfer of knowledge with mentoring and coaching. He or she will ensure the local consultant have a realistic and clear plan to participate and learn methodology of key tasks such as reviewing of key documents, meeting & consultation with key stakeholders, at national level and finally review and produce an assessment with budget.
Objective

The objective of the assignment is to strengthen the capacity of the local consultant to able to produce excellent outcomes.
Deliverables/Outputs

- Consultant would be required to submit a consultancy report by the end of the assignment, which will include the process of coaching and mentoring, technical assistance and advice provided, added values of twinning for the assignment, suggestion for the local consultant for his further professional development to be shared with the local consultant

6.5 Annex E: Actions taken against recommendations of the AMTP III review

Recommendation of the AMTP III Review towards AMTP IV			
S.No.	**Recommendations**	**Actions Taken**	**Implications**
1	Policies review, amendments and issuances	Done	Several amendments in the works and 4 small amendments to policies made
2	Guideline standardization and documentation	There had been several guidelines on standardisation and manual of procedures by different agency members to PNAC (e.g. DOH SOP of SHCs). Manual of Operation for PNAC is needed as well as national costing guidelines.	-Will ascertain the role of the PNAC in relation to its partners (e.g. CCM) - Define how the Council will mainstream itself with potential donors and how it will manage resources
3	Investment plan, donor coordination and intensive mobilization of responses	Attempted, but not completed	No resource plan in place and resource mobilization less than optimal. Donor coordination as part of HIV programming not harmonized.
4	Development and implementation of a Unified Advocacy Plan	Done on paper, but yet to be implemented	With no advocacy plan, the council will have no direction as to what messages to promote
5	Fast tracking establishment of a monitoring and evaluation system	Partly done: CRIS established, and a monitoring system planned Capacity building of LACs and NGOs was conducted in 9 areas	Evidence-based decision making leading to focussed interventions and optimal resource utilisation. However, M&E system still being finalized and institutionalized
6	PNAC strengthening and establishment of a sub-national coordination mechanism	Regional AIDS Assistance Team (RAAT) composed of regional point/technical persons from the regional offices of DOH, DILG and DSWD to coordinate responses at local level. Not taken off fully.	Regional coordination and technical support provision is key to strengthening local responses. Currently local response not receiving support from national level.
7	Revisiting the research agenda and focussing of small scale intervention measures	There is a research agenda but it is not incorporated with other research groups or initiatives. It was disseminated to funders in 2007.	Evidence-based information is critical to program design. Operational and exploratory research needed to generate evidence.

8	Scaling up Care and Support	Done through the Global Fund projects	Large number of needy PLHIV able to access care and support. There is a need to expand access to blood supply, medicines for OIs, and pain relievers.
9	Expanding collaboration with private and religious sectors	Done by engaging the religious sectors, and, to an extent, private sector with respect to work place intervention.	Larger reach of the two sectors, showing increasing awareness and improved behaviour towards less risky behaviours (IHBSS)
10	Expanding HIV/AIDS response to LGUs outside the identified high risk areas	There are identified LGUs with local response (roughly 36). These have been at the provincial level (Aklan in the Visayas and Albay in Luzon) and at the City and Municipal levels.	Areas where there are high concentration of MARPs and other vulnerable groups also need to have functional LACs in order to reduce impact.
11	Expanding HIV/AIDS program in the workplace	Done through the Department of Labour and Employment (DOLE). Department of Foreign Affairs (DFA)-- also provides HIV and AIDS training for its employees assigned abroad	Work place interventions have large captive audience for behaviour change communication and therefore, risk reduction
12	Bringing preventive services to OFWS.	Pre-departure orientation seminar or PDOS have been designed and implemented.	OFWs had been identified as a vulnerable group, -- 88% of HIV positive individuals have been identified as OFWs. There is only one common strategy for OFWs, which needs to be reviewed and evaluated.
13	Reaching the other population groups that were left out	Being done -except for focus on free lance sex workers	Free lance sex workers have been seen to be drivers of the epidemic.
14	Multi sectoral and consultative process of AMTP IV	Done	Multi sectoral and multi pronged approach – comprehensiveness of the program and leveraging of resources and capacities.

6.6 Annex F: Program Progress

**Denominator used in calculating the percentage of targets achieved is based in denominator provided in column 4.*

	UA Targets (%)	**Amtp4 Targets in percentage and actual number 2008**	**Denominator in figures** (source: 2007 Estimates of Adults Living with HIV in the Philippines, [2008])	**Targets Achieved** (quote source)
PIP/FSW	Reached by prevention programs: 2008: 30 2010: 60	Reached by prevention programs: 2008: 30% (54,000) 2010: 60% (108,000) Additional: GFr3: 14,100 GFr5: 2,500	180,001	Reached by prevention programs: 14% (25,200) - *UNGASS 08* Additional: GFr3: 8% (14,087) *Nov 2004-Feb 2008* GFr5: 3% (5,997) *Jan 2007-Feb 2008*
	Knowledge: 2008: 90 2010: 90	Knowledge: 2008: 90% (162,001) 2010: 90% (162,001)		2% (3,600) *UNGASS 08*
	Condom use: 2008: 85 2010: 90	Condom use: 2008: 75% (135,001) 2010: 90% (162,001)		Condom use: 65% (117,001) UNGASS 2008
		HIV Tested and know the results: 2008: 15% (27,000) 2010: 30% (54,000)		HIV Tested and know the results: 12% (21,600) UNGASS 2008
		STI prevalence: 2008: 5% (9,000) 2010: 2.5% (4,500)		STI prevalence 11% (19,665 occurring in 2005-07) *National Dissemination Forum 2008*

MSM	Reached by prevention program: 2008: 30 2010: 60	Reached by prevention program: 2008: 30% (200,797) 2010: 60% (401,594) Additional: GFr3: 13,150 GFr5: 4000	669,323	Reached by prevention program: 19% (127,154) *UNGASS 2008* Additional: GF3: 2% (14,530) GF5: 0.83% (5,564)
	Knowledge: 2008: 90 2010: 90	Knowledge: 2008: 90 (602,391) 2010: 90 (602,391)		Knowledge: 10% (66,932) UNGASS 2008
	Condom use: 2008: 85 2010: 95	Condom use: 2008: 85% (568,925) 2010: 95% (635,857)		Condom use: 32% (214,183) UNGASS 2008
		HIV Tested and know the results: 2008:15% (100,398) 2010: 30% (200,797)		HIV Tested and know the results 16% (107,092) UNGASS 2008
		STI prevalence: 5/2.5		
IDU	Reached by prevention program: 2008: 30 2010: 60	Reached by prevention program: 2008: 30% (6,095) 2010: 60% (12,197) Additional: GFr5: 500	20,316	14% (2,844) *UNGASS 08* Additional: GFr5: 4.4% (899)
	Knowledge: 2008: 90 2010: 90	Knowledge: 2008: 90% (18,284) 2010: 90% (18,284)		Knowledge: 26% (5,282) *UNGASS 08*
	Condom use: 2008: 50 2010: 85	Condom use: 2008: 50% (10,158) 2010: 85% (17,267)		No data
	Use of sterile eqpt: 2008: 50 2010: 50	Use of sterile eqpt: 2008: 50% (10,158) 2010: 50% (10,158)		Use of sterile eqpt: 48% (9,752) *UNGASS 07*
		HIV Tested and know the results: 2008: 15% (3,047) 2010: 30% (6,095)		HIV tested and know the results: 4% (813) *UNGASS 08*
		STI prevalence: 2008: 5% (1,016) 2010: 2.5% (508)		No data

Male Clients	Reached by prevention program: 2008: 30 2010: 60	Reached by prevention program: 2008: 30% (468,387) 2010: 60% (936,774)	1,561,290	Prevention: 6% (93,677) *UNGASS 08*
	Knowledge: 2008: 70 2010: 90	Knowledge: 2008: 90% (1,405,161) 2010: 90%		Knowledge: 19% (296,645 *UNGASS 08*

		(1,405,161)		
		HIV Tested and know the results: 2008: 15% (23,418) 2010: 30% (468387)		6% (93,677) *UNGASS 07*
		STI prevalence: 2008: 5% (78,064) 2010: 2.5% (39,032)		No data
		Condom use: 2008: 60% (936,774)		No data
Current OFWs	Prevention: 2008: 60 (530,338) 2010: 100	Prevention: No target. Additional: GFr3: 11,338 GFr5: 3,000	883,897	Prevention: No data Additional: GF3: 2% (14,250) GF5: 0.95% (8376)
	Knowledge: 2008: 60 (530,338) 2010: 90 (795,507)	No target		No data
	Condom use: 45/67.5			No data
		STI prevalence: 2008: 5% (44,195) 2010: 2.5% (22,098)		No data
OSYs	Reached by prevention program: 2008: 15 (1,740,000) 2010: 45 (5,220,000)		11.6 million *Source: UNGASS report 2007*	No data
		STI prevalence: 2008: 5% (580,000) 2010: 2.5% (290,000)		No data
Street Children	2008: 15 (33,663) 2010: 45 (100,988)		224,417 *Source: UNGASS report 2007*	No data
		STI prevalence: 2008: 5% (11,221) 2010: 2.5% (5,610)		No data

OTHER COUNTRY SPECIFIC INDICATORS (As listed in AMTP4 Operation Plan 2007-2008) *Note: the indicator numbers refer to the national indicator listing. Those that are missing are incorporated in the table above.*				
	UA Targets (%)	**Amtp4 Targets (%) 2008/2010**	**Denominator in Number**	**Targets Achieved (quote source)**
Indicator 12.1 Note: denominator should be both public and private schools	Percentage of **primary** schools where life-skills based HIV and AIDS education is taught.	2008: 60%	Public: 37,807 Private: 6,664 **Total: 44,471**	No data
Indicator 12.2 Note: denominator should be both public and private schools	Percentage of **secondary** schools where life-skills based HIV and AIDS education is taught.	2008: 60%	Public: 5,110 Private: 4,392 **Total: 9,502** http://www.deped.gov.ph/factsandfigures/default.asp	No data
Indicator 13	Percentage of functional Local AIDS Councils	No target	29	21 (GF Grant Performance Report 2008 and http://ariusproject.com/%7Ehivdb/ph_full.htm)
Indicator 14	Percentage of PNAC member agencies implementing HIV and AIDS programs.	2008: 95%	26	No data
Indicator 15.1	Percentage of PLHIV receiving Opportunistic Infection (OI) treatment.	2008: 90%	Number of reported cases: 395 (AIDS Registry Sept 08)	
Indicator 15.2	Percentage of PLHIV who adhered to ARV and OI treatment.	2008: 95%	Number of reported cases: 395 (AIDS Registry Sept 08)	
Indicator 16	Percentage of PLHIV receiving prophylaxis treatment.	2008: 50% 2010: 75%		
Indicator 17	Percentage of PLHIV eligible for treatment and receiving ARV.	2008: 50% 2010: 75% Additional: GFr5: 90%		2006: 99% 2007: 56% UNGASS 2007 GFr5: 227 (Grant Performance Report 2008)
Indicator 18.1	Percentage of babies of HIV-positive mothers receiving ARV.	2008: 100% 2010: 100%		

Indicator 18.2	Percentage of known HIV+ pregnant women receiving ARV.	2008:95% 2010: 100%		
Indicator 19	Percentage of STI cases who are appropriately diagnosed, treated and counseled.	2008: 80% (15,732) 2010: 90% (17,599) Additional: GFr3: 1,012 GFr5: 14,000	19,665 NDF Forum 2008	No data GFr3: 15% (2,943) GFr5: 122% (24,126)
Indicator 20.1	Percentage of **large-scale** enterprises/companies that have HIV and AIDS workplace policies and programmes.	2008: 50% 2010: 70%		
Indicator 20.2	Percentage of **medium-scale** enterprises/companies that have HIV and AIDS workplace policies and programmes.	2008: 25% 2010: 35%		
Indicator 20.3	Percentage of **small-scale** enterprises/companies that have HIV and AIDS workplace policies and programmes	2008: 15% 2010: 25%		
Indicator 21	Percentage of affected families receving psychosocial support.	2008: 60% 2010: 80% Additional: GF5: 360		Additional: GFr5: 564
Indicator 22	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	2008: 60% (9,900,000) 2010: 60% (9,900,000)	16.5 million YAFS	No data
Indicator 23	Percentage of health providers with accepting attitudes towards PLHIV.	2008: 30% 2010: 50%		No data
Indicator 24	Percentage of general public with accepting attitudes towards PLHIV.	2008: 50%		No data
Indicator 25	Median age at first penetrative sexual intercourse among 15-24 years old.	2008: <18		No data
Indicator 26.2	Percentage of **young people aged 15-24** who used a condom with the last sex partner.	2008: 60% (9,900,00)	16.5 million (YAFS)	No data

Indicator 27	Coordination and collaboration: Efficiency rate of operating guidelines for PNAC and its member agencies.	None		
Indicator 28	Monitoring and Evaluation: Efficiency rate of data collection, analysis and dissemination.	None		
Indicator 29	Percentage of PLHIV who are still alive after 12 months of ARV.	None		
Indicator 30	Percentage of Public Health Facilities complying with Voluntary Blood Donation program Protocols.	100%		
Indicator 32	Percentage of Workplace with accepting attitudes towards PLHIV.	2008: 50%		