PHILIPPINES

2010

2011

PHILIPPINE NATIONAL AIDS COUNCIL • 1992 •

2012 GLOBAL AIDS RESPONSE PROGRESS REPORT

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS Registry	Philippine HIV and AIDS Registry
AMTP	AIDS Medium-Term Plan
ARV	Antiretrovirals
CRIS	Country Response Information System
DepEd	Department of Education
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EPP/Spectrum	Estimation and Projection Package and Spectrum (Software)
FFSW	Freelance female sex workers
HIV and AIDS	Human immunodeficiency virus and Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
IHBSS	Integrated HIV Behavioral and Serological Surveillance
LGU	Local government units
M&E	Monitoring and evaluation
MARP	Most-at-risk populations
MESS	Monitoring and Evaluation System Strengthening
MEWG	M&E Working Group
MSM	Males who have sex with males
NASA	National AIDS Spending Assessment
NASPCP	National AIDS/STI Prevention and Control Program
NCPI	National Commitments and Policy Instrument
NEDA	National Economic and Development Authority
NDHS	National Demographic and Health Survey
NEC	National Epidemiology Center
NGO	Non-governmental organizations
NSO	National Statistics Office
OFW	Overseas Filipino worker
PLHIV	Persons (or People) living with HIV

PMTCT	Prevention of mother-to-child transmission
PNAC	Philippine National AIDS Council
PWID	Persons who inject drugs
SHC	Social Hygiene Clinics
R.A. 8504	Republic Act 8504, or the Philippine AIDS Prevention and Control Act of 1998
R.A. 9165	Republic Act 9165, or the Comprehensive Dangerous Drugs Act of 2002
RFSW	Registered female sex workers
STI	Sexually transmitted infections
TB	Tuberculosis
TGF	The Global Fund
UA	Universal access to HIV prevention, treatment, care and support
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary HIV Counselling and Testing
WHO	World Health Organization

SECTION 1.0

STATUS AT A GLANCE

TABLE 1.1
Philippine Progress Summary by Targets and Indicators, 2010-2011

TARGET 1. Reduce sexual transmission of HIV by 50 per cent by 2015			
Indicators for the general population			
INDICATORS	MAIN DATA SOURCE	2010-11 STATUS	REMARKS
1.1 Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	2008 NDHS Tables 12.1 and 12.2	75% (3667/4896)	2008 NDHS surveyed women only, and did not survey men. 4,896 women aged 15-24 were interviewed. 1,013 women 15-24 correctly identified HIV prevention methods and rejected major misconceptions.
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	2008 NDHS Table 12.6	2.00% (206/9792) *Age Breakdown* Age 15-19: 2.10% (58/2,749) Age 20-24: 2.10% (45/2,147)	2008 NDHS surveyed women only, and did not survey men. 15 women reported their first sexual intercourse was before age 15. 4,896 women were aged 15-24.
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	2008 NDHS Table 12.3	3.20% (276/8415) *Age Breakdown* Age 15-19: 16.00% (54/347) Age 20-24: 9.00% (99/1,101) Age 25-49: 2.00% (123/6967)	2008 NDHS collected information among women only, and did not survey men. 276 women aged 15-49 have had sexual intercourse with more than 1 partner in the last 12 months. 8,415 women were aged 15-49.
1.4 Percentage of adults aged 15-49	2008 NDHS Table 12.3	11.00% (30/276)	The 2008 NDHS surveyed women

who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse*		*Age Breakdown* Age 15-19: 9.00% (5/54) Age 20-24: 15.00% (15/99) Age 25-49: 8.00% (10/123)	only, and did not survey men. 30 women aged 15-49 years old reported had more than one sexual partner in the last 12 months, and used condoms the last time they had sex. 276 women aged 15-49 reported having had more than one sexual partner in the last 12 months.
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	2008 NDHS Table 12.4	0.70% (95/13,594)	The 2008 NDHS surveyed women only, and did not survey men. 95 respondents aged 15-49 years old tested for HIV in the last 12 months, and knew their results. 13,594 respondents were aged 15-49.
1.6 Percentage of young people aged 15-24 who are living with HIV*	2010 and 2011 AIDS Registry	*Year 2010* Males: 0.005% Females: 0.0003% *Year 2011* Males: 0.007% Females: 0.0004%	9,331,699 males and 9,195,574 females were estimated aged 15-24 in 2010. The Registry reported confirmed HIV-positive test results among 456 males and 33 females in this age group. 9,440,362 males and 9,302,039 females were estimated aged 15-24 in 2011. The Registry reported confirmed HIV-positive test results among 665 males and 39 females in this age group.

Indicators for sex workers

INDICATORS	MAIN DATA SOURCE	STATUS 2010-11	REMARKS

1.7 Percentage of sex-workers reached with HIV prevention programmes	DOH-NEC 2011 IHBSS	63.00% (4,987/7,902)	Not all of the 9834 respondents answered the survey questions used for this indicator. This explains the discrepancy between the sample size and the denominator.
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	DOH-NEC 2011 IHBSS	65.00% (6,331/9,750)	Not all of the 9834 respondents answered the survey questions used for this indicator. This explains the discrepancy between the sample size and the denominator.
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	DOH-NEC 2011 IHBSS	42.00% (1,617/3,874)	Not all of the 9834 respondents answered the survey questions used for this indicator. This explains the discrepancy between the sample size and the denominator.
1.10 Percentage of sex workers who are living with HIV	DOH-NEC 2011 IHBSS	0.27% (26/9,797)	

Indicators for men who have sex with men

INDICATORS	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	DOH-NEC 2011 IHBSS	23.00% (1,209/5,319)	Not all of the 5353 respondents answered the survey questions used for this indicator. This explains the discrepancy between the sample size and the denominator.
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	DOH-NEC 2011 IHBSS	36.29% (1,102/3,037)	Not all of the 5353 respondents answered the survey questions used for this indicator. This explains the

			discrepancy between the sample size and the denominator.
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their result	DOH-NEC 2011 IHBSS	5.00% (274/5,297)	Not all of the 5353 respondents answered the survey questions used for this indicator. This explains the discrepancy between the sample size and the denominator.
1.14 Percentage of men who have sex with men who are living with HIV	DOH-NEC 2011 IHBSS	1.68% (90/5,353)	

TARGET 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

INDICATORS	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No data source	No data available	Not applicable
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	DOH-NEC 2011 IHBSS	Data not yet submitted	
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	DOH-NEC 2011 IHBSS	25.00% (162/655)	Not all the 1283 respondents injected drugs in the past month. This is why the sample size and the denominator for this indicator do not match.
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12	DOH-NEC 2011 IHBSS	5.00% (61/1,278)	Not all of the 1283 respondents answered the survey questions used for this indicator. This

months and know their results			explains the discrepancy between the sample size and the denominator.
2.5 Percentage of people who inject drugs who are living with HIV	DOH-NEC 2011 IHBSS	13.56% (174/1,283)	

TARGET 3. Eliminate mother-to-child transmission of HIV by 2015, and substantially reduce AIDS-related maternal deaths

INDICATORS	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	DOH-NASPCP	5.00% (18/277)	In the last 12 months, 13 HIV-positive pregnant women received ART. Around 277 HIV-positive women are estimated pregnant in the last 12 months.
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	DOH-NASPCP	6.00% (13/235)	13 infants received an HIV test within two months from birth. With regard to mothers needing PMTCT, Spectrum estimated 235 HIV-infected pregnant women would have given birth in the last 12 months.
3.3 Mother-to-child transmission of HIV (modelled)	DOH-NASPCP	32.00%	Due to mother-to-child HIV transmission among those born in the previous 12 months to HIV-infected women, an estimated 76 children will be newly infected. 235 HIV-positive women were estimated to have delivered in the previous 12 months.

TARGET 4. Have 15 million people living with HIV on antiretroviral treatment by 2015

INDICATORS	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	DOH-NASPCP	82.00% (1,992/2,420)	At the end of the reporting period, 1,992 adults and children with advanced infection were currently receiving ART in accordance to nationally approved treatment protocol (or standards set by WHO and UNAIDS). 2,420 adults and children are estimated with advanced stages of HIV infection.
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	DOH-NASPCP	---	(Data withheld for further verification from source.)

TARGET 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

INDICATOR	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	DOH-NASPCP	14.00% (139/1,000)	Within the reporting year, 139 adults with advanced HIV infection received ART in accordance with nationally approved treatment protocol (or standards set by WHO and UNAIDS), and who started on TB treatment in accordance with national TB programme guidelines. 1,000 incident TB cases are estimated

			among people living with HIV.

TARGET 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low-and middle- income countries

INDICATOR	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
6.1 Domestic and international AIDS spending by categories and financing sources	NEDA 2012 NASA	2009: Php 573 million ($12.0 million) 2010: Php 576 million ($12.8 million) 2011: Php 531 million ($12.3 million)	On average, 560 million pesos ($12.4 million) were spent annually from 2009 to 2011 across AIDS spending categories, domestic and international financing sources combined.

TARGET 7. Critical enablers and synergies with development sectors

INDICATORS	MAIN DATA SOURCE	STATUS 2010-11	REMARKS
7.1 National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	PNAC NCPI Parts A & B	Data enclosed	Results of NCPI workshops are found in Annexes 8.2 and 8.3 of this Report.
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	DSWD	Data not available	Available data include cases of women, who were abused sexually, physically, and emotionally. However, data cannot ascertain whether cases involved male intimate partners.
7.3 Current school attendance	DepEd	Data not available	Data are not available from source per

among orphans and non-orphans aged 10-14*			Indicator definition.
7.4 Proportion of the poorest households who received external economic support in the past 3 months	DSWD	Data not available	Available data include individuals in crisis situations, who were given assistance. Per definition, this Indicator has recently been included in data source's new database, and will be available for the next progress reporting.

*Millennium Development Goals indicator

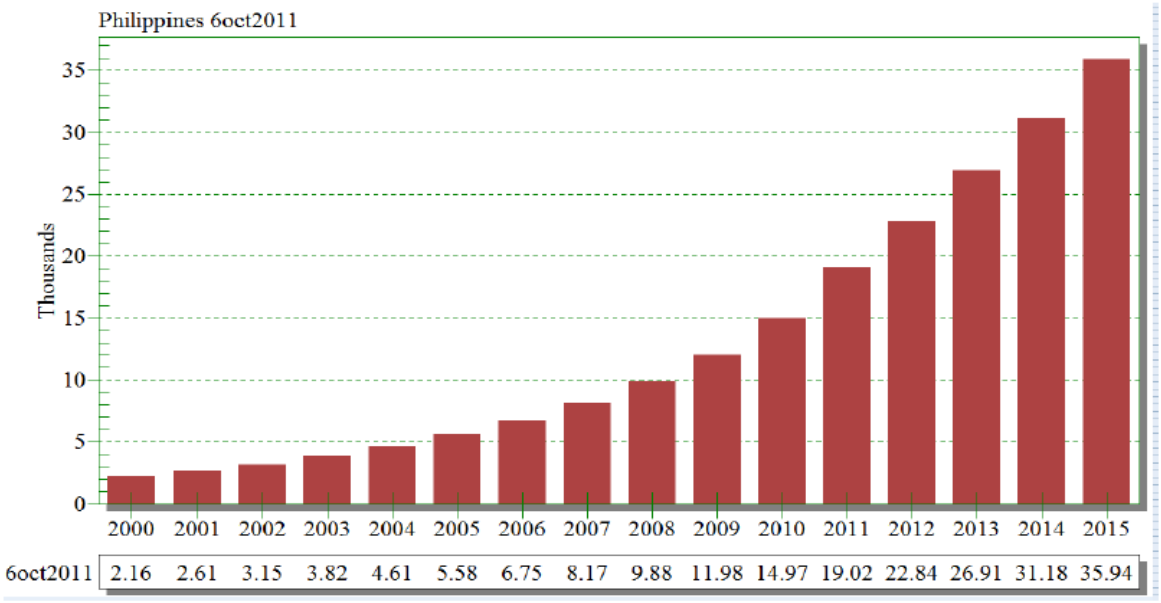
SECTION 2.0

OVERVIEW OF THE AIDS EPIDEMIC

Estimated HIV Prevalence and Reported Number of Cases

Based on the latest HIV estimates and projections released by the Philippine National AIDS Council (PNAC), the number of Filipinos living with HIV was estimated at 19,000 in 2011 (see Figure 2.1). Of this number, 82 percent are males. The number of new cases per year increased significantly from an estimated 600 cases in 2001 to more than 4,000 in 2011 (with 83 percent males). This trend, as reported in the 2010 Global Report on the AIDS Epidemic, placed the Philippines as one of seven countries that recorded more than 25 percent increase in new cases in the last decade. At least 56 countries that contributed to the Global Report have either stabilized or achieved significant declines in rates of new HIV infections during same period (UNAIDS, 2010).

FIGURE 2.1
Projections of the Total Number of People Living with HIV in the Philippines by Year, 2000-2015



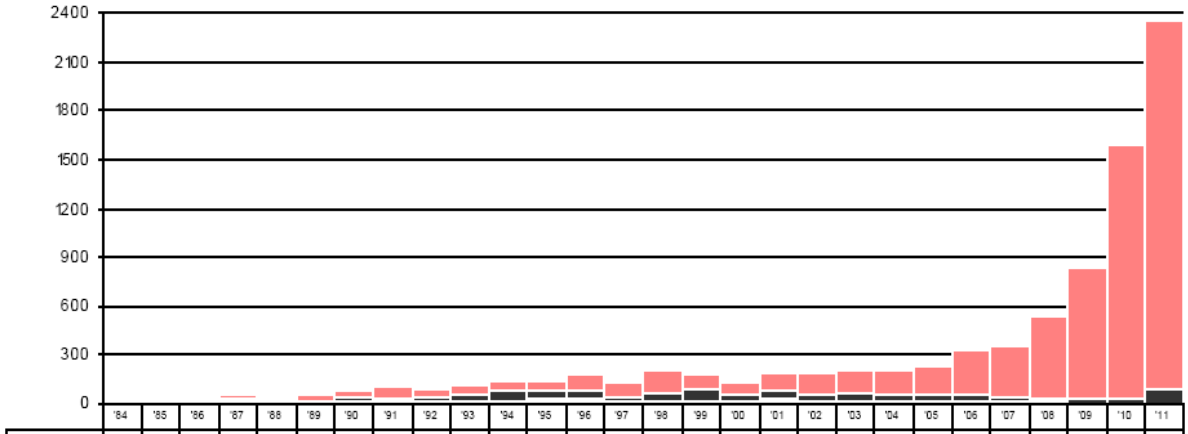
SOURCE: 2011 Philippine Estimates of Most At-Risk Population and People Living with HIV, PNAC

From 1984 to end of 2011, the Philippine HIV and AIDS Registry recorded a cumulative total of 8,364 cases, 82 percent of which 82% were males. In 2011 alone, 93 percent of the 2,349 reported cases were males. Based on Figure 2.1's estimates, HIV cases recorded in the Registry appear under-reported by 50 percent.

In general, the Philippines has a low HIV prevalence, estimated at 0.036 percent in 2011 or 36 cases per 100,000 adult Filipinos. Based on current trend, HIV prevalence will likely double but remain below one percent by 2015, or 0.062 percent, or 62 per 100,000 (PNAC, "Estimates," 2011). The vast majority of people living with HIV are reported from three highly urbanized areas: Metro Manila, Metro Cebu, and Davao City. But 72 of 80 provinces in the country, encompassing all 17 ethno-linguistic regions, already have HIV cases recorded in the AIDS Registry (DOH-NEC, "WAD," 2011).

Total estimated number of AIDS-related deaths from 1984 to 2011 was 3,700 (PNAC, "Estimates," 2011) with around 500 deaths in 2011 alone. But AIDS-related deaths reported in the Registry were very few – in 2011, only 94 AIDS-related deaths were report (see Figure 2.2).

FIGURE 2.2
Number of HIV and AIDS Cases and Deaths Reported in the Philippines by Year, January 1984 to December 2011 (N=8,364)



	'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	'09	'10	'11
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	528	835	1591	2,349
* Asymptomatic	0	6	18	25	21	29	48	68	51	64	61	65	104	94	144	80	83	118	140	139	161	171	273	312	506	806	1571	2,255
* AIDS	2	4	11	13	11	10	18	17	21	38	57	51	50	23	45	78	40	56	44	54	38	39	36	30	22	29	20	94
Death	2	4	10	12	9	8	15	13	13	11	19	24	27	10	16	17	9	20	11	11	8	16	18	10	7	1	2	*17

**Nine initially asymptomatic cases reported in 2011, died due to AIDS that same year.*

Source: Philippine HIV and AIDS Registry, December 2011, DOH-NEC

Modes of HIV Transmission

From 1984 to 2011, sexual contact was the primary mode of HIV transmission in the country, which accounted for more than 90 percent of reported cases. In smaller proportion, HIV was also transmitted through sharing of contaminated needles among persons who injected drugs (PWID). Fewer still were reported cases of transmission from mother to child, and through transfusion of contaminated blood.

From within the same period, 41 percent of sexual modes of HIV transmission was through unprotected heterosexual contact, 36 percent "homosexual" and 23 percent "bisexual." A close examination of the distribution of sexual transmission in the last five years (from 2007 to 2011) showed that unprotected heterosexual contact declined to below 25 percent while unprotected homosexual and bisexual contacts (or male-to-male sexual contact) have become predominant modes (DOH-NEC, "Registry, Dec 2011").

HIV cases among overseas Filipino workers (OFW) continue to rise despite decrease in proportion to total reported cases, from 42 percent in 2006 to 20 percent in 2009, and just 14 percent in 2011 (Ibid.). Local transmission has started to outpace infections contracted overseas. It should be noted, however, that HIV infections among OFW was reportedly mostly due to unprotected male-to-male sex or unprotected sex with sex workers.

Table 2.1 shows increasing number of reported cases among males who have sex with males (MSM) in the AIDS Registry, which was also detected in the bi-annual HIV surveillance of DOH-NEC, the Integrated HIV Behavioral and Serologic Surveillance (IHBSS). HIV prevalence among MSM **quadrupled** from 0.28 percent in 2007 to 1.05 percent in 2009. By 2011, it rose to 2.12 percent with at least three sites reaching up to six percent (PNAC, "2010 UNGASS" and DOH-NEC, "2011 IHBSS"). Among female sex workers (FSWs), HIV prevalence **doubled** from 0.16

percent in 2007 to 0.24 percent in 2009. By 2011, prevalence was 0.68 percent among freelance female sex workers (FFSW). The most rapid increase was detected among PWID whose prevalence **doubled** from 0.13 percent in 2007 to 0.21 percent in 2009. By 2011, HIV prevalence ballooned to 13 percent with one site reaching 53 percent.

TABLE 2.1
HIV Prevalence Among Female Sex Workers and MSM in 10 Sentinel Sites, and PWID in 3 Sentinel Sites, 2009 and 2011

Populations Included in the IHBSS	2009	2011
Registered Female Sex Workers (RFSW)*	0.23%	0.13%
Freelance Female Sex Workers (FFSW)**	0.54%	0.68%
Men who have sex with Men (MSM)	1.05%	2.12%
People who Inject Drugs (PWID)***	0.21%	13.00%

*Note: *RFSW are females working in registered night entertainment establishments; **FFSW are female sex workers who are "street-based;" *** PWID in three surveillance sites*

Adapted from 2011 IHBSS, DOH-NEC

Knowledge and Behavior

Results from IHBSS 2007, 2009, and 2011 rounds consistently showed low HIV knowledge among populations surveyed (representing FFSW, RFSW, PWID and MSM). Proportions of these populations, who correctly identified ways of preventing sexual transmission, and rejected major myths and misconceptions remained below 45 percent.

In an age-specific analysis of the 2009 IHBSS data, those under the age of 18 fared the weakest across knowledge scores. Only 29 percent of MSM younger than 18 correctly answered HIV-related knowledge questions compared to 41 percent of those aged 25 and older. Similarly, correct knowledge among PWID aged under 18 was 20 percent as opposed to 43 percent among those aged 25 and older.

Use of condoms during last sex among populations surveyed was very low, especially among MSM and PWID (below 30 percent). The percentage was even lower among MSM under the age of 18 (below 20 percent). Younger MSM cited unavailability of condoms as reason for their infrequent and/or non-use. Similarly, younger FFSW and PWID were less likely to receive a free condom. Younger FFSW and PWID were less likely to access Social Hygiene Clinic services. More than half of PWID younger than 18 reportedly accepted money or drugs in exchange for sex.

SECTION 3.0

NATIONAL RESPONSE TO THE EPIDEMIC

One National Coordinating Body

The PNAC was created on 3 December 1992 through Executive Order No. 39, and was reconstituted by virtue of Republic Act 8504, or the AIDS Prevention and Control Act of 1998, to "enable the Council to oversee an integrated and comprehensive approach to HIV/AIDS prevention and control in the Philippines." The PNAC is composed of 26 representatives from 17 government agencies, two organizations of medical/health professionals, six non-government organizations involved in HIV prevention, treatment, care and support, and one organization of persons dealing with HIV and AIDS.

As the central advisory, planning and policy-making body on HIV and AIDS in the Philippines, PNAC's core functions include among others, the development of a comprehensive national AIDS strategic plan with "indicators and benchmarks against which PNAC shall monitor its implementation." In addition, PNAC is mandated to "evaluate the adequacy of and make recommendations regarding the utilization of national resources for the prevention and control of HIV/AIDS."

One National Strategic Plan

The AIDS Medium-Term Plan (AMTP) serves as the country's common action framework and accountability tool on AIDS. The Plan intends to guide policy decisions and programme priorities (including resource allocation) of stakeholders at national and local levels – government, civil society and development partners.

The Fifth AMTP for 2011-2016 was developed by the PNAC through a broad-based and participatory process. The Plan is the country's roadmap towards "Getting to Zero." The Philippine Government is signatory to the "Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS" (United Nations General Assembly High Level Meeting on AIDS, 10 June 2011), and the "ASEAN Declaration of Commitment: Getting to Zero New HIV Infection, Zero Discrimination, Zero AIDS-Related Deaths" (19th ASEAN Summit, 17 November 2011).

The Fifth AMTP aims to achieve, by 2016, "fewer HIV infections" and "improved quality life for PLHIV" through three key results at the outcome level, and 12 key results at the output level, which are laid out on Table 3.1.

TABLE 3.1
The Fifth AMTP Matrix of Results at Impact, Outcome, Output and Input Levels

Input	Output	Outcome	Impact
Funds ALLOCATED Policy IN PLACE	1.1. Coverage and quality of prevention programs for persons at-most-risk, vulnerable, and living with HIV IMPROVED 2.1. Coverage and quality of treatment, care, and support programs for people living with HIV and their families IMPROVED	1. Persons at-risk, vulnerable and living with HIV avoid risky behaviors to prevent HIV infection.	**Fewer** HIV infections **Quality life** for PLHIV

Input	Output	Outcome	Impact
	(including those who remain at risk and vulnerable) 3.1. Policies for scaling up implementation, effective management and coordination of HIV program at all levels STRENGTHENED 3.2. Capacity of PNAC member agencies, LGU, private sector, civil society (including communities at-risk, vulnerable and living with HIV) to manage the AMTP5 STRENGTHENED	2. People living with HIV live longer and more productive. 3. Country AIDS Response is well governed and accountable.	

The high estimation for target investments in HIV prevention is consistent with the priority direction of targeting 80 percent of all MARP by 2016. However, should resources be constrained, it was recommended that coverage for HIV prevention services focus on cities and municipalities considered as Category A and B, where most infections come from. Pouring investments in these areas are expected to create more impact in terms of averting new infections, especially among MSM and PWID. With this scenario, the total investment target could be reduced to 6.8 billion pesos (see Table 3.2).

TABLE 3.2
Costing Scenarios of Implementing the Fifth AMTP, 2011-2016

Coverage	2011	2012	2013	2014	2015	2016	Total
Nationwide	1.778	2.601	3.070	3.530	3.827	4.142	18.950
Category A, B, C	0.707	1.175	1.321	1.417	1.539	1.681	7.839
Category A, B	0.618	1.049	1.169	1.250	1.346	1.462	6.895
Category A	0.504	0.898	0.975	1.043	1.126	1.229	5.775

Note: Annual investment targets by coverage in billions of Philippine Pesos

Given the limited information on available resources, the funding gap was calculated based on estimated available resources. For 2011, the estimated available resources amount to about 347 million pesos from selected National Government Agencies, Donor Agencies and LGU. Resources from LGU were based on estimated average spending at the Social Hygiene Clinics (SHC), pegged at one million pesos per SHC. There are about 119 SHC but only 86 are fully functioning. However, there are LGU that spend more than one million pesos annually.

One National Monitoring and Evaluation System

The Philippines had gone through a rigorous process of establishing and strengthening the monitoring and evaluation system, which commenced at the onset of the Fourth AMTP (2005-2010). Through collaboration between PNAC and the UN, a number of components of the National M&E System was installed and enhanced from 2006 to date. The System was assessed

towards the end of the Fourth AMTP in 2010. Upon the finalization of the Fifth AMTP in 2011, a corresponding National M&E Plan was developed, which included key activities to achieve major objectives of National M&E Plan, a list of national M&E indicators with baseline data and targets, and an annual estimated cost for implementing M&E.

National Commitments and Policy: Compared to the previous report, i.e. the NCPI of the 2010 UNGASS report, most of NCPI categories rated for 2012 improved. The Philippines has developed its Fifth AIDS Medium Term Plan (Fifth AMTP), a multi-sector plan covering the period of 2011-2016. Workshops were conducted to come up with the strategic and operational plans. The development team was composed of technical representatives from the different PNAC agencies. The Fifth AMTP continues the Fourth AMTP's commitment towards achieving Universal Access, and modified based on latest information from researches, M&E reports, and surveillance. It focused on key affected populations (MSM, SW and their clients, PWID), and considered vulnerable populations (women, children, migrant workers, people with disabilities). Cross-cutting issues like addressing stigma, discrimination, gender, poverty, human rights, and meaningful engagement of PLHIV also guided the Plan's development.

The Fifth AMTP was coupled with the development of an M&E Plan and an Investment Plan. The M&E Plan was developed by the M&E Working Group (MEWG), which is composed of M&E representatives from PNAC members' agencies and organizations. The M&E Plan included data collection, analysis, and dissemination and utilization strategies. It also contained programmatic goals and targets with corresponding indicators set by lead agencies. The Investment Plan aimed to (1) provide options for financing key interventions aside from those traditionally viewed as funding sources, (2) describe ways to increase LGU and private sector investments, (3) estimate funding gaps for the Fifth AMTP's implementation, and (4) propose different scenarios on how this gap can be filled upon prioritization of proposed activities. Different development partners have endorsed and expressed support for the Fifth AMTP through alignment of their HIV country related programs.

Political support for HIV programs in the country has been demonstrated by no less than the President Benigno Simeon C. Aquino III. The President was present during the 2011 UN General Assembly High Level Meeting in New York, and expressed his support in adopting the new Political Declaration. Even though expressions of support improved in recent years, the quality and extent of political action remains to be perceived insufficient to address the country's need.

The country has identified essential interventions for RFSW while still developing essential packages for other MARP. DOH has been conducting scaling up efforts like increasing the number of SHC and treatment hubs, ensuring availability of drugs for PLHIV, and increasing coverage targets for those needing treatment. These services should be supported by policies, and there are still policies that hinder such as Republic Act 9165, the Dangerous Drugs Law, which hamper the use of harm reduction approaches for PWID interventions. The Fifth AMTP's implementation needs more enabling policies enacted.

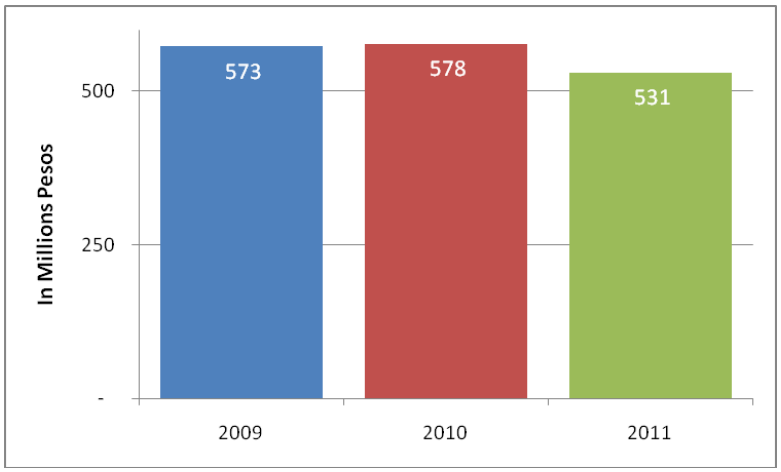
National AIDS Spending: The UNAIDS-developed NASA tool was used in determining the country's AIDS spending from 2009 to 2011. Data collection was done by the National Economic and Development Authority (NEDA), with assistance from the PNAC Secretariat. Primary data collection was undertaken by requesting PNAC members to fill up the NASA funding matrices, which served as data collection tool. Development partners, other NGOs, and selected LGU were also requested to provide spending data.

A number of data limitations were encountered including the following: absence of disaggregated/detailed spending data, availability of budget/allocation only rather than actual expenditures, very few submissions from local government units (LGUs), limited non-government organization (NGO) spending data (only known NGOs and Manila-based),

unaccounted spending items (from LGUs, social hygiene clinics, treatment hubs), estimated spending of other LGUs, among others. Based on historical spending assessments since 2000, the final result, however, pretty much covers the bulk of AIDS spending in the country.

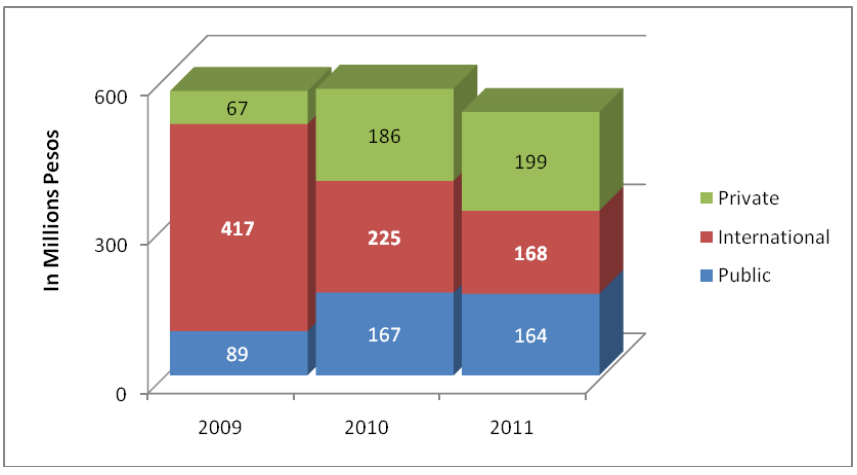
***AIDS Spending by Source*:** A total of 1.7 billion pesos ($37 million) was spent on AIDS from 2009 to 2011, or an annual average of 560 million pesos ($12.4 million). Of the country's expenditure, 48 percent was contributed by development partners (international or external support), or around 810 million pesos ($17.9 million). A recorded 27 percent has been spent through the private sector, or 451 million pesos ($10 million) mainly from DKT International and Levi Strauss Foundation. The Government shared 25 percent of AIDS expenditures, or 420 million pesos ($9.3 million), as on Figure 3.1.

FIGURE 3.1
Total AIDS Spending by Year, 2009-2011, Philippines (1.7 Billion Pesos)



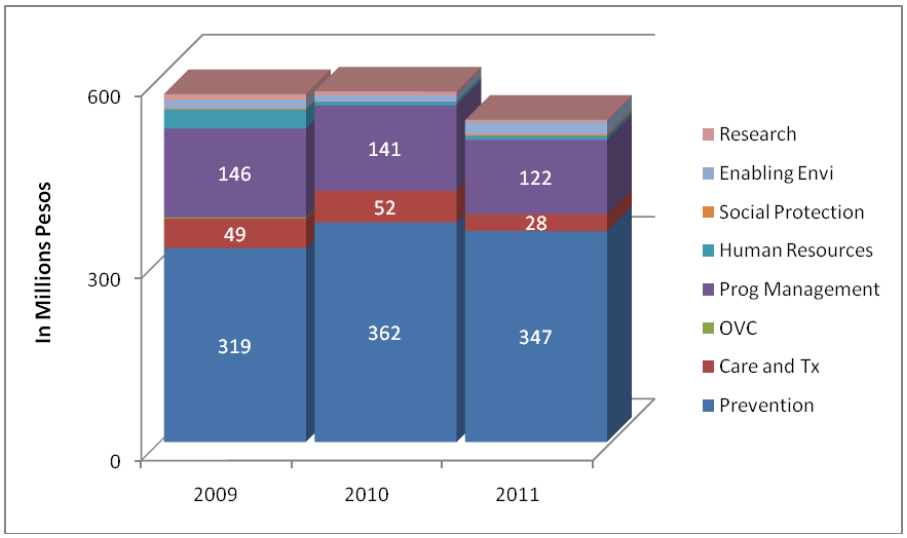
On Figure 3.2, AIDS expenditures appear to have stabilized at a rate of 560 million pesos per year, and reported highest at 578 million pesos in 2011. A significant decrease in spending was observed among international sources primarily because of the closure of two grants of the Global Fund (i.e. Rounds 3 and 5) in 2010. However, three-fold increase in HIV expenditure of both the private and the public (Government) sector were recorded from 2009 to 2011, which kept the total annual expenditure above 500 million pesos.

FIGURE 3.2
AIDS Spending by Source, 2009-2011, Philippines



***AIDS Spending by Function*:** On Figure 3.3, with regard to individual components of AIDS expenditures, no significant changes were observed in spending by function. There were some decreases in spending for care and treatment, incentives for human resources, and research, but also worth noting, there were also increases in social protection and enabling environment expenditure, mainly due to increased UN support and funding allocation from the DSWD.

FIGURE 3.3
AIDS Spending by Function, 2009-2011, Philippines



There was an observed general increase in Government expenditure in all functions except for human resources, and care and treatment. Increase was also observed in allocations and/or expenditures of DOH-NASPCP budget from 50 million pesos in 2009 to 65 million pesos in 2010, and DOH-NEC budget from 15 million pesos in 2010 to 20 million pesos. Expenditures for orphans and vulnerable children may have been integrated in care and treatment, or social protection hence not reflected markedly in the assessment.

Coverage of National Programs and Other AMTP Outputs

Prevention Programs for Key Populations at Risk: The Global Fund supported the bulk of HIV prevention programs. Programs have been implemented by building the foundation for a strong multi-sector response: it was critical to involve the LGU in a decentralized health care delivery system such as in the Philippines. Clearly, local governments' increased awareness of HIV paved for setting of priorities – existence of 119 SHC, where HIV prevention services are lodged, the creation of Local AIDS Councils (18 in TGF Round 5 sites and 14 in TGF Round 6 sites), and appropriation of local funds to support local responses (estimated at $2.7 million annually) are testimonies (PNAC, "Investment Plan," 2011).

Prevention interventions in the country primarily focus on targeted education and risk-reduction counselling delivered through trained peers in high-risk cities. The target populations include FSW, MSM, SHC STI clients, and PWID. TGF Rounds 3 and 5 grants have particularly boosted peer education programs such as those in Quezon and Mandaue cities, which took the initiative of hiring peer educators after TGF funding concluded. Recognizing their important role in reaching MARP, LGU continue partnering with NGO for service delivery at the community levels. To maximize NGO participation in programming, further capacity-building and partnerships will be supported by the TGF Round 10 multi-country grant for MSM and

transgender communities. Other, supportive interventions included private sector implementation of education programs in the workplace.

Other development partners, particularly the UN agencies and USAID supported prevention activities in the epidemiological hotspots of Metro Manila, Cebu and Davao cities. There is a need to better coordination among different agencies to maximize efficiency and effectiveness of various interventions.

LGU support focus on the provision of STI diagnosis, risk reduction counselling and HIV testing, facility-based interventions augmented by outreach programs and awareness campaigns. The DOH continuously supports LGU in terms of trainings, technical guidance on service provision, strategic planning and direction-setting, surveillance and monitoring, and improvement of logistics for STI drugs.

Scale up of voluntary counselling and testing began in 2007, during the start of TGF Round 6. By institutionalizing VCT in LGU and training private clinics and NGO on counselling, the project was able to accomplish more than its target for HIV counselling and testing by March 2011. The DOH all through these years has been responsible for centralized confirmatory testing of HIV in the country. The Japanese government provided technical support in ensuring quality laboratory systems for HIV testing.

National and local governments rely on NGO for their expertise on advocacy communication, social mobilization, and partnership building. As PNAC members, NGO representatives are proactive partners for the entire program cycle, including direction-setting and policy-making. To cascade further the multi-sector approach in HIV programming, PNAC set up 16 Regional AIDS Assistance Teams to advocate, assist and mentor LGU via the Local AIDS Councils. TGF Round 6 gave special attention in reducing stigma in the health care and community settings, including PLHIV-led community forums and PNAC-supported awareness campaigns.

As of December 2011, prevention activities under TGF Round 6 HIV grant in 16 project sites reached a cumulative total of 77,992 FSW, 26,493 MSM, and 1,162 PWID. While significant gains were achieved in the past 3 years in terms of expanding prevention coverage of key populations at risk, these remain below AMTP targets for Universal Access, which is 80 percent.

Prevention Programs for the General Population: The main HIV data source about the general population is the NDHS. The most recent available data were results of the 2008 NDHS, and was already reported in the 2010 UNGASS. It was observed that HIV testing in the general population was below one percent.

Until now HIV education among young people remains to lack reliable coverage data, particularly on school-based education activities. Based on DepEd's 2010-2011 enrolment records, there were 14 million elementary and 7 million High School students in the country (DepEd website, updated 2011). HIV education activities among employees are conducted in workplaces as part of compliance to R.A. 8504, which requiring companies to have HIV programs in the workplace. Monitoring of these activities has recently started.

Treatment and Care Programs for People Living with HIV: TGF support has been instrumental in the institutionalization of ARV programs in the country. From 2004 (TGF Round 3) until January 2012, the cumulative number of PLHIV enrolled to treatment is 1,992, representing approximately 82 percent of those who are in need of treatment. From six treatment hubs in 2004, DOH-NASPCP expanded ARV services to 16 treatment hubs with the assistance of TGF Round 6 grant.

SECTION 4.0

GOOD PRACTICES

In the coordination of the development of this Progress Report, the members of the M&E Working Group were encouraged to invite partner-organizations to submit good practice documentation in the areas of political leadership, supportive policy environment, scale-up of effective prevention and treatment, care and support programs, and capacity building. The intention was for the Working Group to adopt the process undertaken from the 2008 and 2010 UNGASS reporting. But no good practice documentation was submitted within the very limited time of this Report's preparation. However, other "good practice" documentation eventually emerged, and considered for citation in this Report. One documentation source came from the 2011 Innovative Approaches series of the UNDP Asia-Pacific Regional Centre, the other was realized from actual submissions for the 2009-2011 Report of the Philippine National AIDS Council, whose preparation coincided with this Report.

As noted from the country's 2010 UNGASS report, some good practices submissions were actually "still in the early stage(s) of implementation, but considered because (of reported) good results and… potentials for sustainability and replicability" (PNAC, "2010 UNGASS"). The National M&E System, recognizing these good practices were documented "too early to look at impact" is committed to continuously monitor progress of reported good practices (Ibid.). In the 2008 UNGASS report, a social mobilization approach espoused by TLF Sexuality, Health and Rights Educators Collective (TLF-SHARE) was documented in a submission entitled "Integrating Community Organizing with Scaling Up of Prevention and Care of STI and HIV among MSM" (PNAC, "2008 UNGASS"). Progress of TLF-SHARE's program was part of UNDP's 2011 Innovative Approaches publications, from one entitled "Strengthening Community Leadership among Men who have Sex with Men and Transgender Persons," (UNDP, "Strengthening," 2012) described below:

> *This document showcases the work and lessons learned of a programme UNDP developed in partnership with Health Action Information Network and TLF-SHARE that produced and disseminated strategic information on MSM and transgender people in order to build greater understanding of the behaviors, motivations, needs and background of these key populations, and critically assess current interventions… (This) research fed into national and local policy-making, programmatic planning and strengthened advocacy and local programming capacity of community-based organizations.* (Settle, 2012)

In the 2010 UNGASS report good practices, capacity building and networking of the HIV/AIDS Ministry of the Order of the Ministers of the Infirm (or Camillians) was documented in "Partnerships with Catholic Institutions for Enhanced HIV Treatment, Care and Support Services" (PNAC, "2010 UNGASS"). Encouraged to submit for the PNAC Report preparation, and subsequently included in the National AIDS Spending Assessment of this Report, the Camillians' 2009-2011 accomplishments included the following:

- Establishment of the Woodwater Center for Healing, a center for services catering to PLHIV, their affected families and caregivers
- Leadership and participation of the Camillians in the founding of the Philippine Catholic HIV/AIDS Network
- Pastoral capacity-building activities for the prevention of further HIV transmission, including basic awareness and voluntary, confidential counselling and testing for HIV for an even more expanded network of parish workers, personnel of Catholic hospitals, officials of member-institutions of the Catholic Educational Association of the Philippines, and bishops of the Roman Catholic Church
- Expansion of partners and collaborated responses including formation of the HIV/AIDS Ministry of the Camillians' Philippine Province, and participation in Catholic Asia Pacific HIV/AIDS (Thailand)
- Continuing assistance to PLHIV and their affected families, which included treatment for tuberculosis and other opportunistic infections, vaccination, shelter and nutritional support, referral to treatment hubs, and assistance in laboratory work for health monitoring.

In addition to the earlier mentioned Innovative Approach, UNDP Asia-Pacific Regional Center included "Decentralizing AIDS Responses – Local Government," (UNDP, "Decentralizing," 2012) which documented a component of the country's UNDP project in partnership with the Department of the Interior and Local Government's Local Government Academy, as described below:

This document reveals the successes of the 'Leadership for Effective and Sustained Responses to HIV and AIDS' in the Philippines. The programme worked closely with the Philippines National AIDS Council and the UN Joint Team on AIDS to increase leadership and improve local commitment to HIV and AIDS, with a goal of bridging the gap between national and local institutions, as well as Local Government Units, to implement effective responses at the local level and ensure there was adequate technical support. (Settle, 2012)

Initially informed through the Pinoy-UNGASS electronic mailing list, the PNAC Secretariat during the conduct of the NCPI Workshop encouraged Action for Health Initiatives (ACHIEVE) to submit a good practice documentation on the formation of the Aid4AIDS Network,

a network for the benefit of PLHIV and affected families, who are seeking legal redress. ACHIEVE was not able to make the submission, but the M&E Working Group strongly felt Aid4AIDS is worth noting in this Report – text of the electronic communication quoted below:

> *People living with HIV continue to experience stigma and discrimination in their everyday lives because of their status. Despite this, only 1 out of 4 PLHIVs thought of seeking legal redress. [Citation included: "Based on a research conducted by ACHIEVE in 2010 titled 'Positive Justice: Utilization of People Living with HIV of the Philippine AIDS Prevention and Control Act of 1998'."] Reasons include fear of disclosure, fear of discrimination, and no idea where to get help.*
>
> *Now, PLHIVs can seek legal and alternative legal redress through the Aid4AIDS Network.*
>
> *The Aid4AIDS Network is a loose network of law organizations and institutions, law schools, alternative law groups, and private lawyers who can provide legal services – from legal advice, consultation, and representation.*
>
> *Some of the member organizations include:*
>
> 1. *Initiatives for Dialogue and Empowerment through Alternative Legal Services (IDEALS, Inc.)*
> 2. *Office of Alternative Dispute Resolution - Department of Justice (OADR-DOJ)*
> 3. *Integrated Bar of the Philippines – Quezon City Chapter*
> 4. *Public Attorney's Office*
> 5. *Ateneo Human Rights Center*
> 6. *Ateneo Public Interest and Legal Advocacy (APILA) Center, Ateneo De Davao University*
>
> *ACHIEVE currently functions as secretariat and main referral point of the Aid4AIDS network* (Acaba, 2011).

SECTION 4.0

MAJOR CHALLENGES AND REMEDIAL ACTIONS

At the end of the Fourth AMTP implementation, most resounding of challenges was the dwindling financial resources for HIV and AIDS. The 2008 Commission on AIDS Report recommended $1 per capita per year expenditure for HIV prevention and control; with a population of 94 million Filipinos (2000 NSO projection) this translates to $94 million, far from the country's $9.2 million average spend. Problems with manpower and systems strengthening follow in effect of financial constraints, and eventually explain the low intervention coverage. Further on, sustainability issues emerge as in low priority in effecting HIV/AIDS activities among government agencies, and disinterest of local chief executives to fully adopt interventions in their localities. In a special UA report developed in 2010, these and other (related) issues were explored, and ways forward identified, summarized on Table 4.1.

TABLE 4.1
Obstacles to Achieving Universal Access, Status in 2010, and Recommended Ways Forward

UA Obstacle 1: Inadequate financing for scaled-up AIDS responses	
CURRENT STATUS (2010)	WAYS FORWARD TO ACHIEVE UA
▪ Resources for the program have been poorly invested ▪ The funding gap has become bigger with total funding requirement; in 2010 only $11.9 million was spent on HIV and AIDS ▪ There is lack of political support for the response at national and local levels ▪ Due to inadequate resources, coverage is very low ▪ Essential outreach and education activities by CSO could not be sustained	▪ **Fifth AMTP operational plan should serve basis for financial projections, and be submitted to Congress** ▪ **Advocate to highest political leaders and government officials for articulation of support** ▪ Increase domestic budget and spending with support from the Executive Branch and the President ▪ Institutionalize National Response, including budget for non-health sectors ▪ **Promote the Fifth AMTP investment plan for programming and funding assistance from development partners** ▪ Localize or popularize the Fifth AMTP
UA Obstacle 2: Human resource capacity, health, social, education systems constraints	
CURRENT STATUS (2010)	WAYS FORWARD TO ACHIEVE UA
▪ Trained health personnel are limited to treatment hubs and project sites ▪ Sustaining LGU human resources remains a problem ▪ Strengthening capacities of stakeholders at all levels needed for management and supervision, service delivery, M&E ▪ Clearly defined comprehensive prevention strategies for each MARP are needed to guide human resource needs	▪ Develop competency-based training programs to build capacity essential and specific for prevention among key affected populations, treatment, care and support ▪ Implement HRH Plan, including mechanisms to manage migration and retention ▪ **Build capacities to identify and locate sources of new infections** ▪ Evaluate prevention coverage and impact ▪ **Strengthen PNAC and Secretariat, establish focal units within members'**

	agencies that will mainstream PNAC programs and activities ▪ **Restructure PNAC and Secretariat through a programmatic approach, using a Capacity Development Plan (2008 PNAC Report)** ▪ Strengthen public-private partnership to recruit essential skills needs such as psychiatrists, psychologists, among others

UA Obstacle 3: Access to affordable commodities and low-cost technologies

CURRENT STATUS (2010)	WAYS FORWARD TO ACHIEVE UA
▪ Access to and availability of condoms, OI and STI drugs and reagents, needles and syringes, and IEC materials are limited ▪ No access to (water-based) lubricants ▪ Support for laboratory work-ups for PLHIV is inadequate ▪ Referral mechanism between LGU and NGO, treatment hubs and NGOs, facility-based care and home-based care are functional in some sites; ▪ Sustaining LGU logistics is a problem	▪ **Strengthen MARP outreach and education by geographic priorities, and increase coverage in relation to total estimates** ▪ **Implement effective comprehensive package of interventions for MARP** ▪ **Strengthen health systems and community systems** ▪ Address sustainability in the Fifth AMTP ▪ Promote public-private partnerships to all facilities

UA Obstacle 4: Human rights, stigma, discrimination, and gender equity

CURRENT STATUS (2010)	WAYS FORWARD TO ACHIEVE UA
▪ No monitoring of discrimination incidence is in place ▪ Human rights commission is neither pro-active nor reactive on HIV and AIDS-related cases ▪ Stigma Index Report revealed PLHIV lost jobs, denied promotion, forced to change residence or denied renting, in addition to physical, social abuse and isolation ▪ PLHIV who suffered abuse did not try to seek legal redress out of fear, lack of financial resources, little confidence on outcomes, perception of legal processes as too bureaucratic ▪ No pro-active enforcement mechanisms for human rights, access to legal assistance and justice mechanisms ▪ Ambivalence or conflicting views on condoms, needles and syringes ▪ Inconsistency between R.A. 8504 and 9165 is a major concern	▪ Sensitize health, education, labor personnel and the general public on HIV and AIDS towards minimizing stigma ▪ **Implement guidelines on treatment, care and support such as ARV treatment, pediatric treatment, hospital-based care** ▪ Develop mechanisms and guidelines for addressing HIV related rights violations ▪ Amend punitive laws that block effective responses such as laws against vagrancy, drug abuse and human trafficking), and/or harmonize rules and regulations ▪ **Establish enforcement mechanisms to promote and protect rights, legal assistance providers, and access to justice mechanisms** ▪ **Implement operations research in aid of developing harm reduction policy**

NOTE: Recommended Ways Forward that have been initiated in 2011-11 are emphasized; activities and/or results may be reflected in other sections of this Progress Report

SECTION 6.0

SUPPORT FROM DEVELOPMENT PARTNERS

Figure 6.1 shows expenditure from development partners (international sources) totalled 810 million pesos ($17.9 million), an average 270 million pesos ($6 million) annually. It comprised 48 percent of total AIDS expenditure. The biggest contribution was from The Global Fund, more than 50 percent of expenditures. Other international sources included UN agencies, USAID, and other international NGO (e.g. Bread for the World and German Doctors). Due to the closure of TGF Rounds 3 and 5 in 2010, spending decreased from 417 million pesos ($8.8 million) in 2009 (73 percent of total spending that year) to 168 million pesos ($3.9 million) in 2011.

FIGURE 6.1
Total International AIDS Spending by Year, 2009-2011, Philippines ($17.9 Million)

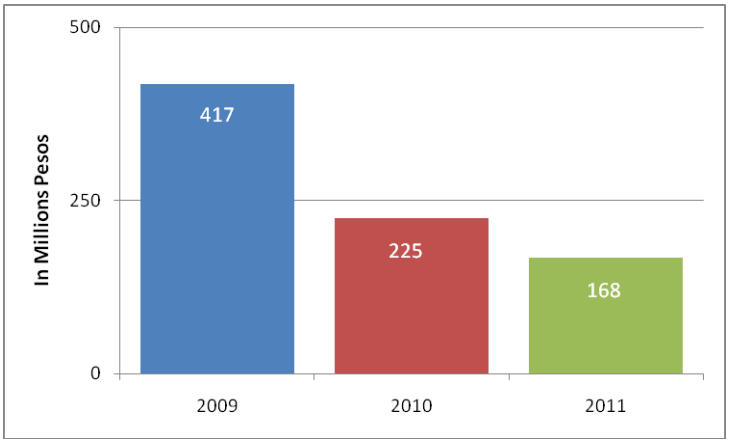
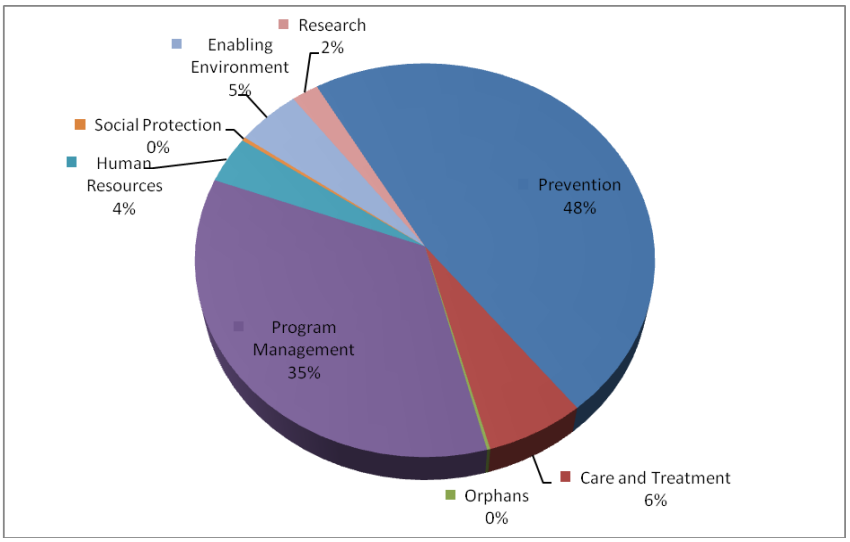


Figure 6.2 shows development partners supported mainly prevention (46 percent) and program management (34 percent). Much of the support on prevention covered risk reduction for vulnerable and accessible populations, prevention programs for sex workers and their clients, MSM, communications for social and behavioural change, community mobilization, blood safety, PMTCT, and PWID. Program management included support for strategic planning, coordination, program management, M&E, and administration strengthening.

FIGURE 6.2
Distribution of Support from Development Partners, 2009-2011 ($17.9 Million)



SECTION 7.0

MONITORING & EVALUATION ENVIRONMENT

The Philippines had gone through a rigorous process of establishing and strengthening the M&E System, which commenced at the onset of the Fourth AMTP (2005-2010). The initiative was mainly triggered by the submission of the first country report to UNGASS in 2003, which showed how badly a system of monitoring and reporting is needed in the country. Through collaboration between PNAC and UN, a number of components of the National M&E System was installed or enhanced from 2006 to date. The system was assessed towards the end of the Fourth AMTP in 2010, utilizing the MESS Tool (UNAIDS 2010) that looked into 12 components of the M&E system (UNAIDS 2008). An assessment workshop was organized by the PNAC M&E Unit, and was participated in by M&E practitioners in the country (around 40 attendees from 23 agencies), including program managers and government and civil society organizations from national and local levels involved in the establishment and implementation of the Philippine M&E System on HIV.

Areas of Accomplishments in M&E

The 2010 assessment found the following to be key accomplishments in M&E:

- Creation of an M&E Unit in the PNAC Secretariat (although limited in number of staff)
- Convening of M&E Technical Working Groups (although mostly ad hoc e.g. UNGASS Core Group, AMTP4 Core Group)
- Enhancement of M&E partnerships, particularly linkages with UN agencies, The Global Fund, and technical advisory groups
- Strengthening of HIV surveillance systems (IHBSS and AIDS Registry)
- Development or enhancement of national databases such as AIDS Registry, IHBSS, STI surveillance, national surveys in the general population with behavioural component in (NDHS), and pilot testing of the Country Response information System (CRIS) in 2006-2007 to ensure progress towards achieving UNGASS commitments were captured by a national database
- Regular dissemination of M&E products and selected strategic information during national forums and online (e.g. M&E Blog, Research Blog, PNAC and UNAIDS websites)

Areas in M&E that Need Attention

The culture for M&E in HIV is relatively young in the Philippines. The M&E System is still in development, pilot-testing and institutionalization stages. The national M&E structure is still not fully built (or not formalized) because of limited number of designated M&E officers from key government agencies and other PNAC members. Most M&E working groups were formed on an as-need basis (e.g. UNGASS Core Team, surveillance technical advisory group, etc). In terms of M&E capacity, the M&E functions of the M&E officers (among the agencies with M&E staff) were not clearly defined or indicated in their terms of reference. The M&E capacities of agencies were never assessed hence, capacity building activities were mostly project-based and not on a capacity building plan. Most agencies had no clear sector-based HIV strategic plans (or annual HIV work plan with clear funding allocation), and consequently, no routine program monitoring.

While data from surveillance, researches, surveys and other studies were available and analyzed, there was no systematic dissemination of strategic information on HIV. Most dissemination forums were done on an ad-hoc basis, and utilization of information was not monitored. Since program data were not collected systematically, most implementers did not have a system of sharing program reports or analyses.

Although an M&E unit is housed within the PNAC Secretariat, the flow of reports had been challenging. Data reporting was hampered by the absence of clear agency mandates or department orders, and was largely left to the vagaries of interests and persons.

Recommended Actions

The key recommendation of the assessment was to prioritize national guidelines for M&E that would pave for the following:

1. Formalize the creation of the national M&E working group (MEWG), composed of officially designated M&E officers from PNAC members' agencies and organizations with clearly-defined M&E functions
2. Conduct series of M&E capacity building activities for the MEWG, including a series of M&E planning workshops to transform the Fifth AMTP into an in-line 2011-2016 National M&E Plan, and with corresponding annual M&E work plans and cost
3. Define and guide the activities, roles, networking mechanisms and resources for monitoring at the national and local levels
4. Expand and sustain partnerships on M&E through institutionalization of existing structures
5. Establish and maintain a national M&E database (or sustain CRIS-Pinoy)
6. Improve routine HIV programme monitoring
7. Establish a system of regular dissemination of strategic information on HIV to ensure utilization by policy makers and programme managers

The Fifth AMTP5 National M&E Plan (2011-2016)

Development of the Fifth AMTP National M&E Plan coincided with the finalization of the Fifth AMTP. The National M&E System on HIV and AIDS by which the plan is anchored on has four major objectives: (1) to create an enabling environment for monitoring and evaluation; 2) to generate accurate, timely, and relevant HIV data; (3) to intensify HIV research and evaluation; and (4) to increase HIV response data demand and information use. The M&E Plan will measure results of the Fifth AMTP through 81 national indicators namely results and targets at levels of input (8), output (41), outcome (24), and impact (8).

An estimated 279 million pesos ($6.6 million), or an annual average of around 46 million pesos ($1.1 million), will be needed to implement the entire M&E plan. This represents around 1.5 percent of the annual average resource needs of the Fifth AMTP5 (3 billion pesos or US$70 million).

ANNEX 8.1

The Global AIDS Response Progress Reporting 2012 Development Process

The Philippine National AIDS Council (PNAC) through its Secretariat facilitated the development of the "Global AIDS Response Progress Reporting (GARPR) 2012". Planning for the development of GARPR started on December 2011. The development team was composed of the Monitoring and Evaluation Working Group (MEWG), which consisted of representatives from different government agencies and civil society organizations. The team was headed by the PNAC M&E Officer with the assistance from the UNAIDS M&E advisor.

On January 09, 2012 the PNAC Secretariat started to coordinate with concerned agencies for the different GARPR indicators. A letter of request for information was sent to the corresponding heads of agencies. One-on-one meetings with technical representatives of the agencies were conducted with the objective of appreciating and fully comprehending relevant indicators.

To accomplish the National Commitment and Policy Instrument (NCPI) – Parts A and B, an additional live-in workshop was conducted in February 14, 2012. Participants from the government agencies included representatives from the Department of Health (DOH), Department of the Interior and Local Government (DILG), Department of Education (DepEd), Department of Labor and Employment (DOLE), Department of Social Welfare and Development (DSWD), Department of Justice (DOJ), Department of Tourism (DOT), National Economic and Development Authority (NEDA), League of Provinces of the Philippines (LPP), Technical Education and Skills Development Authority (TESDA), and Philippine Information Agency (PIA). Representatives from Civil Society included AIDS Society of the Philippines (ASP), TLF SHARE Collective, LUNDUYAN Foundation, Philippine NGO Council for Population, Health and Welfare (PNGOC), Pinoy Plus Association, and Action for Health Initiatives (ACHIEVE).

During the NCPI workshop, two session groups were formed: the first group, composed of the government agency representatives answered NCPI Part A, and the second group, composed of Civil Society representatives answered NCPI Part B. Each group's processes were conducted independently, and had their own facilitators and documenters. Participants all had equal opportunity to share and explain answers to the NCPI questionnaires, listen from others, dialogue on diverging views, and finally, arrive at group consensus. A validation forum for the final outputs of NCPI A and B was held on March 8, 2012.

The development of the National AIDS Spending Assessment was headed by the National Economic Development Authority (NEDA) with assistance from the PNAC Secretariat. Spending data were collected from the government agencies including some local government, NGO, development partners, and private entities.

ANNEX 8.2

National Commitments and Policy Instrument – Part A (GOVERNMENT AGENCIES)

National Commitments and Policy Instrument (NCPI)

Data Gathering and validation process

Describe the process used for NCPI data gathering and validation:
The Philippine National AIDS Council (PNAC) through the M&E Unit facilitated the NCPI process. On January 09, 2012 the PNAC Secretariat started to send the 2012 NCPI questionnaires together with the copy of the NCPI 2009 to each PNAC member agency (GA, NGOs and CSO). The intention of sending the NCPI documents is to provide an ample time for each agency to review the previous NCPI consensus and to discuss each agencies' stand for the NCPI 2012. February 14-17, 2012 a live-in workshop for NCPI vetting forum was conducted at Tagaytay International Convention Center. The participants were technical representatives from the PNAC member agencies. Before the start of the vetting forum the participants were oriented of the NCPI process. Two groups were formed, the first group which was composed of the government agencies and the second group which was composed of the NGOs and CSOs. The two groups answered the NCPI Part A and NCPI Part B respectively. The process for each group was conducted independently both had their own facilitator and documenter. The outputs of each group were documented by the PNAC Secretariat, a validation forum for the final output was held after three weeks (March 8, 2012).
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
Disagreements were resolved by taking time to listen on the argument of the different parties and finally coming up with a group consensus for the matter.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

I. STRATEGIC PLAN

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

Yes	No

IF YES, what was the period covered [write in]:	AMTP5 2011-2016

IF YES, briefly describe key developments / modifications between the current national strategy and the prior one. **IF NO or NOT APPLICABLE**, briefly explain why.
The current strategy (AMTP V) is essentially a continuation of the AMTP IV. The modifications made were based from the current data that the country has. The key development for the current strategy was the development of an "AMTP V Investment Plan", the "AMTP V Monitoring & Evaluation Plan" and the development of the "Health Sector Plan"

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

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies [write in]:

PNAC with Partnered agencies, as follows: 1. DOH 2. DILG 3. Dep Ed 4. Ched 5. DOLE 6. DSWD 7. DOJ 8. DFA 9. NEDA 10. DOT 11. DBM 12. LPP 13. LCP 14. Senate of the Phils. 15. House of Representatives 16. ASP 17. WHCF, Inc 18. HAIN 19. LUNDUYAN 20. ISSA 21. TUCP 22. PNGOC 23. PINOY PLUS 24. PHA 25.TESDA 26. PIA 27. ACHIEVE

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

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military / Police	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Other [write in]: Tourism	Yes	No	Yes	No
Social Services	Yes	No	Yes	No

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

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations31	Yes	No
SETTINGS		
Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the Country?

KEY POPULATIONS
Key Populations: MSM, SW and their clients, PWID Vulnerable Groups: women, children, migrant workers, people with disabilities

1.5. Does the multisectoral strategy include an operational plan?

Yes	No

1.6. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	Yes	No	N/A
b) Clear targets or milestones?	Yes	No	N/A
c) Detailed costs for each programmatic area?	Yes	No	N/A
d) An indication of funding sources to support programme implementation?	Yes	No	N/A
e) A monitoring and evaluation framework?	Yes	No	N/A

1.7. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?

Active Involvement	Moderate Involvement	No Involvement

IF YES or MODERATE INVOLVEMENT, briefly explain why this was the case:
Philippine National AIDS Council which is composed of 26 member agencies (17 from the GAs , 2 from organizations of medical/health professionals, 6 representatives from NGOs involved in HIV/AIDS prevention and control efforts or activities and A representative of an organization of persons dealing with HIV/AIDS. All members were invited to participate during the process.

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

Yes	No	N/A

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

Yes, all partners	Yes, some Partners	No	N/A

IF SOME PARTNERS or NO, briefly explain for which areas there in no alignment/harmonization and why:
In general some partners are aligned with the AMTP but DOH clears that other International NGO's have others strategies that were not aligned.

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

Yes	No	N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS	Yes	No	N/A
Common Country Assessment/UN Development	Yes	No	N/A

Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
Sector-wide approach	Yes	No	N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S)			
HIV impact alleviation	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support (including social security or other schemes).	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training	Yes	No	N/A
Other[write in below]:	Yes	No	N/A

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

Yes	No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "low" and 5 is "high"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

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

Yes	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?

Yes	No

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes	No

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

Estimates of Current and Future Needs	Estimates of Current Needs Only	No

5.3. Is HIV programme coverage being monitored?

Yes	No

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

Yes	No

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

Yes	No

IF YES, for which population groups?

- MSM
- FSW
- RFSW
- PWID
- OFW

Briefly explain how this information is used:

- For program planning
- Advocacy
- For resource mobilization
- For improvement of program implementation
- Policy Development

(c) Is coverage monitored by geographical area?

Yes	No

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

- Municipalities, Cities, Province and Regions

Briefly explain how this information is used:

- Advocacy
- Resource mobilization
- Planning
- Policy development
- Program improvement

5.4. Has the country developed a plan to strengthen health systems?

Yes	No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

- Improvement of Social Hygiene Clinics
- Strengthening and expansion of DOH-designated treatment hubs
- Integration of HIV with other programs (MCHN, TB)
- Strengthening of laboratory systems
- Improvement of procurement and supply management (PSM) through better reporting And Surveillance
- Blood Safety from DOH
- Referral System initiated by DSWD

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you Rate strategy planning efforts in your country's HIV programmes in 2011?

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

Since 2009, what have been key achievements in this area:

Development of an AMTP 5 which is a continuation of the AMTP 4, AMTP 5 Investment Plan, Health Sector Plan

What challenges remain in this area:

Fund releases, political support, limitations of mandates of different government agencies.

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV Programmes.

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

A. Government ministers

Yes	No

B. Other high officials at sub-national level

Yes	No

1.1. In the last 12 months, have the head of government or other high officials taken action that Demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
• President Aquino committed to the achievement of the Millennium Development Goals which includes HIV during the U.N. high level meeting on December 2011. • The Secretary of Health Enrique T. Ona ensured the continuity of services for PLHIV. • Several congressmen are advocates of HIV.

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

Yes	No

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

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, what is his/her name and position title? Sec. ENRIQUE T. ONA,MD , Secretary of Health		
Have a defined membership?	Yes	No
IF YES, how many members? 26		
Include civil society representatives?	Yes	No

IF YES, how many?	8	
Include people living with HIV?	Yes	No
IF YES, how many?	1	
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and Duplication of effort in programming and reporting?	Yes	No

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

Yes	No	N/A

IF YES, briefly describe the main achievements:
• HIV policy in the workplace • Public-private partnership strengthened
What challenges remain in this area?
• Sustainability of partnership • Change in leadership

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

60 %

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

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]:	Yes	No

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

Yes	No

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

Yes	No

IF YES, name and describe how the policies / laws were amended
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
1. Republic Act 9165 or "Dangerous Drugs act of 2002 – hinders the implementation of "Harm Reduction Program" since it uses the possession of paraphernalia like needles and syringes as an evidence to persecute) 2. Republic Act 8504 – prohibits some HIV/AIDS services like HIV testing to younger age group 3. Republic Act 9208 – "Anti Trafficking in Persons Act of 2003" – this law does not state that the use of condom is illegal but, the law enforcers implementing this law use the condoms that they recover during raids as an evidence for persecution. 4. Department of Health – Administrative Order No. 1 S.2003 "Operational Guidelines In the Conduct of Pre-employment Medical Examination of Overseas Workers and Seafarers" (allows HIV testing if required by the employer)

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?

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

Since 2009, what have been key achievements in this area:
Prevention, Financial Management, Treatment, and Diagnosis
What challenges remain in this area:
• Sustainability of programs due to change in leadership • Extent of political support and availability of resources.

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations [write in]:	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
• Magna Carta for Persons with Disabilities • Magna Carta for Women • RA 8504 • Family Code

Briefly explain what mechanisms are in place to ensure these laws are implemented:
Women's desk, Women and Child Protection Units, Task Force Women

Briefly comment on the degree to which they are currently implemented:
These mechanisms are being fully implemented.

2. Does the country have laws, regulations or policies that present obstacles[34] to effective HIV Prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/ mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who injects drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/ young men	Yes	No
Other specific vulnerable populations. [write in below]: children <18	Yes	No

Briefly describe the content of these laws, regulations or policies:
1. Republic Act 9165 or "Dangerous Drugs act of 2002 2. Republic Act 9208 - Anti Trafficking in Persons Act of 2003 3. Republic Act 8504
Briefly comment on how they pose barriers:
1. RA 9165 - hinders the implementation of the Harm Reduction Program for PWID. It uses the possession of paraphernalia like needles and syringes as an evidence to persecute) 2. Republic Act 9208 – hamper some HIV/AIDS activities (condom use) for sex workers and MSM since condoms are being used as evidence for persecution.

3. Republic Act 8504 – hinders some HIV/AIDS activities (HIV testing for the **children** / young population)

IV. PREVENTION

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

Yes	No

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	**Yes**	**No**
Avoid commercial sex	**Yes**	**No**
Avoid inter-generational sex	**Yes**	**No**
Be faithful	**Yes**	**No**
Be sexually abstinent	**Yes**	**No**
Delay sexual debut	**Yes**	**No**
Engage in safe(r) sex	**Yes**	**No**
Fight against violence against women	**Yes**	**No**
Greater acceptance and involvement of people living with HIV	**Yes**	**No**
Greater involvement of men in reproductive health programmes	**Yes**	**No**
Know your HIV status	**Yes**	**No**
Males to get circumcised under medical supervision	**Yes**	**No**
Prevent mother-to-child transmission of HIV	**Yes**	**No**
Promote greater equality between men and women	**Yes**	**No**
Reduce the number of sexual partners	**Yes**	**No**
Use clean needles and syringes	**Yes**	**No**
Use condoms consistently	**Yes**	**No**
Other [write in below]:	**Yes**	**No**

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

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes	No

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes	No

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

Yes	No

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

YES	NO

Briefly describe the content of this policy or strategy:

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

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

	IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
Condom promotion	☑	☑	☑	☑	☑	
Drug substitution therapy	☐	☐	☐	☐	☐	
HIV testing and counselling	☑	☑	☑	☑	☑	
Needle & syringe exchange	☐	☐	☐	☐	☐	
Reproductive health, including sexually transmitted infections prevention and treatment	☑	☑	☑	☑	☑	
Stigma and discrimination reduction	☑	☑	☑	☑	☑	

Targeted information on risk reduction and HIV education	☑	☑	☑	☑	☑	
Vulnerability reduction (e.g. income generation)	☐	☐	☑	☐	☐	

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

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

Since 2009, what have been key achievements in this area:

1. Guidelines in the implementation of workplace Policy and Education Program on HIV and AIDS.
2. Department orders on HIV/AIDS prevention and control program in the workplace (DOLE)
3. Department orders on HIV/AIDS prevention and control program in the workplace (DOT)
4. Department orders on HIV/AIDS prevention and control program in the workplace (DILG)

What challenges remain in this area:

- Behavior change
- Funds

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

YES	NO

IF YES, how were these specific needs determined?

Identification of the specific needs for HIV prevention programmes were identified through the current available data from researches on HIV conducted, M&E products and through a consultation with the involved target populations.

IF NO how is HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

The majority of people in have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A

Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counselling	1	2	3	4	N/A
IEC on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction of intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Others [write in]:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

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

V. TREATMENT, CARE AND SUPPORT

1. **has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?**

YES	NO

If YES, Briefly identify the elements and what has been prioritized:
• Provision of peer counselling, psychosocial support, referral for access of ART and Treatment for OI's • Education of R.A 8504 emphasizing their rights and services available for PLHIV • Referral for livelihood program • Capacity building for peer counselling including ARTM peer counselling • Nutritional Support • Prophylaxis

Briefly identify how HIV treatment, care and support services are being scaled-up?
• Increase number of treatment hubs • Ensuring the availability of drugs for PLHIV and increasing the target of coverage for those needing the treatment. • Access of PLHIV and their families in the psychosocial care and support services of the DSWD-Crisis Intervention Units (CIU) particularly in the Assistance to Individuals in Crisis Situations (AICS) which may be in the form of transportation, food, educational, medical, and burial assistance.

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

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	5
ART for TB patients	1	2	3	4	5
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	5
Early infant diagnosis	1	2	3	4	5
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	5
HIV testing and counseling for people with TB	1	2	3	4	5
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	5
Nutritional care	1	2	3	4	5
Paediatric AIDS treatment	1	2	3	4	5
Post-delivery ART provision to women	1	2	3	4	5

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	5
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	5
Psychosocial support for people living with HIV and their families	1	2	3	4	5
Sexually transmitted infection management	1	2	3	4	5
TB infection control in HIV treatment and care facilities	1	2	3	4	5
TB preventive therapy for people living with HIV	1	2	3	4	5
TB screening for people living with HIV	1	2	3	4	5
Treatment of common HIV-related infections	1	2	3	4	5
Other[write in]:	1	2	3	4	5

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	No

Please clarify which social and economic support is provided:

- Transportation
- Medical
- Livelihood,
- Food pack,
- Burial support,
- Cash for work
- Therapy services

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

YES	NO	N/A

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

YES	NO	N/A

IF YES, for which commodities?

- ARVs,
- HIV test kits, and
- Reagents

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?

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

Since 2009, what have been key achievements in this area:

- Improved facilities (VCT, treatment hubs)
- Referral system in place
- Availability of logistic support

What challenges remain in this area:

- Funds
- Sustainability

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

YES	**NO**	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

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

Yes	No

6.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

6.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

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

Since 2009, what have been key achievements in this area:
Orphaned children of parents with HIV were given ART and being managed / taken care of by a non government organization
Since 2009, what have been key achievements in this area:
Policy / strategy and data for orphan and vulnerable children

VI. MONITORING AND EVALUATION

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

Yes	In Progress	No

Briefly describe any challenges in development or implementation:
The culture for M&E in HIV is relatively young in the Philippines. M&E system is still in the development and institutionalization stages. Most M&E working groups were formed on a need basis (e.g. UNGASS Core Team, surveillance technical advisory group, etc). In terms of M&E Capacity, the M&E functions of the M&E officers (among the agencies with M&E staff) were not clearly defined in their terms of reference (TOR).

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

2011-2016

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

Yes, all partners	Yes, some partners	No	N/A

Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No

IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardized set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

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

Yes	In Progress	No

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

2 %

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

Yes	In Progress	No

Briefly describe any obstacles:
Resources in terms of budget and manpower are the major issue in the M&E system. In the existing structure, the National M&E Unit which is lodge within the PNAC Secretariat a budget of approximately $30,000-40,000/year. The M&E Unit has 3 staff, the National M&E Officer, the Program evaluation Officer and an IT expert. Among the staff only 2 has a permanent position.

4.1. Where is the national M&E Unit based?

In the Ministry of Health? PNAC Secretariat is at DOH	Yes	No
In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere [write in]?	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in space below]	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]			
Medical Officer	1		2006
Program Evaluation Officer	1		2006
Database Officer		1	2010
	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]			

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

YES	NO

Briefly describe the data-sharing mechanisms:
Data sharing mechanism has been practiced through the conduct of dissemination forum, on-line posting (e.g. PNAC Web site, Philippine M&E blog site etc.) and through publications (e.g. AIDS Registry, HIV/AIDS Journal, UA Report etc.)
What are the major challenges in this area:
Timely dissemination of data among all the stakeholders

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

Yes	No

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

YES	NO

IF YES, briefly describe the national database and who manages it.
CRIS Pinoy is the Philippine Country Response Information System (CRIS) - the country's national M&E database.

6.1. IF YES, does it include information about the content, key populations and geographical Coverage of HIV services, as well as their implementing organizations?

Yes, all of the above	Yes, but only some of the above	No, none of the above

IF YES, but only some of the above, which aspects does it include?
It does not include the local stakeholders

6.2. Is there a functional Health Information System?

At national level	Yes	No
At sub national level	Yes	No
IF YES, at what level(s)? [write in] All information related to HIV is maintained at the national level.	National Level	

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

Yes	No

8. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other [write in]: Policy Development	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
Existing M&E data were used during the development of the AIDS Medium Term Plan V, Investment Plan and Health Sector Plan.

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

At national level?	Yes	No
IF YES, what was the number trained: 29		
At sub national level?	Yes	No
IF YES, what was the number trained: 6		
At service delivery level including civil society?	Yes	No
IF YES, how many? 18		

9.1. Were other M&E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities

- Needs Assessment
- Report writing
- Standard M&E tools development
- Technical Assistance among PNAC agencies and task forces

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

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

Since 2009, what have been key achievements in this area:

1. Assessment of the Philippine HIV/AIDS Monitoring & Evaluation System
2. Creation of the Monitoring and Evaluation Working Group (MEWG) in which each PNAC member agency has a permanent representative and an alternate (PNAC Resolution 5).
3. Development of the AMTP V M&E Plan
4. Development of the Philippine HIV/AIDS Research and Evaluation Agenda (PHREA)
5. Monitoring and evaluation of the Integrated HIV/AIDS Behavior and Serologic Surveillance (IHBSS).
6. Updating of CRIS PINOY

What challenges remain in this area:

1. Budget
2. Manpower

ANNEX 8.3

National Commitment and Policy Instrument – Part B (NON-GOVERNMENT ORGANIZATIONS)

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					HIGH
0	1	2	3	4	5

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

LOW					HIGH
0	1	2	3	4	5

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

LOW					HIGH
0	1	2	3	**4**	5

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

LOW					HIGH
0	1	2	**3**	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	**3**	4	5

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, and faith-based organizations)?

LOW					HIGH
0	1	2	**3**	4	5

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	**2**	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	**3**	4	5

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

Prevention for key-populations				
People living with HIV	<25%	25-50%	51–75%	**>75%**
Men who have sex with men	<25%	25-50%	**51–75%**	>75%
People who inject drugs	<25%	25-50%	**51–75%**	>75%
Sex workers	<25%	25-50%	**51–75%**	>75%

Transgendered people	<25%	25-50%	51–75%	>75%

Testing and Counseling	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	<25%	25-50%	51–75%	>75%

*ART = Antiretroviral Therapy; OI=Opportunistic infections
**OVC = Orphans and other vulnerable children

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?

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

Since 2009, what have been key achievements in this area:

- Some CSO are getting involved in TCS; more PLHIV network are getting involved
- Partnership with FBO
- MSM TG Network, MSM/TG national response discussion
- Phil health package
- Establishment of 14 condom shop social marketing
- HIV/AIDS issue has been mainstreamed with workers at the workplace
- Trade union policy has been formulated on prevention and control of HIV and AIDS
- Support for passage of legislative measures relative to AIDS prevention

What challenges remain in this area:

- Inclusion of new organizations; sustaining engagement with other organizations
- Actual representation of the sectors; currently, some sectors are only represented by NGOs
- Budgetary allocation and commitment of implementers
- Integration of MSM and TG response from the local level to the national level
- Sustainability of CSO initiatives, including government funding support
- Strengthening of LAC; closer coordination with PNAC
- Commitment of organizations
- Commitment of employers to provide support and resources for plant-level implementation of HIV/AIDS and STI prevention and program
- Male involvement in the HIV/AIDS and STI prevention program at the workplace

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No

IF YES, describe some examples of when and how this has happened:

- AMTP consultation workshop
- Inclusion of TG in the IHBSS questionnaire
- Some LGUs support HIV programs
- Establishment of additional treatment hubs
- Representation of Trade Union at PNAC and other local bodies that tackle the issue of HIV

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations43[write in]:	Yes	No

1.2 Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
An act prohibiting discrimination on the basis of sexual orientation and gender identity and providing penalties therefor (House Bill 515)
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
• Magna Carta on Women • Solo Parent Act • People with Disabilities have cards; there is a provision protecting them from discrimination based on how they look • Commission on Human Rights as a mechanism • Labor Code of the Philippines
Briefly comment on the degree to which they are currently implemented:
Laws are localized through ordinances • Advocacy efforts • Expansion of Phil health package for PLHIV

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS	Yes	No
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No

Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations43[write in]:	Yes	No

Briefly describe the content of these laws, regulations or policies:

- Dangerous Drugs Act of 2000 or RA 9165
- Republic Act 9208 - Anti Trafficking in Persons Act of 2003
- RA 8504 and Family Code

Briefly comment on how they pose barriers:

- Dangerous Drugs act of 2002 – conflicts with the "Harm Reduction Program" since it uses the possession of paraphernalia like needles and syringes as an evidence to persecute
- Republic Act 9208 - Anti Trafficking in Persons Act of 2003 – in its implementation, the law enforcers uses the presence of condom as an evidence for prostitution activities
- RA 8504 and Family Code: access to testing is limited to those over 18 years old; with regards to access of young people to contraceptives, it depends on the discretion of the service provider. With regards to access to commodities, there is no specific law barring minors. The challenge is more on the cultural mindset of the providers.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.

- Law on sexual assault
- Anti-rape law
- Anti-Violence on Women and Children law

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

Yes	No

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

- RA 8504
- Framework of children on HIV
- AMTP 5

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	No

IF YES, briefly describe this mechanism:
• A grievance procedure • Documentation (ex: OFW deported because of their HIV status) • Educating work place arbiters • Presence of a workplace policy, although there is a need to revise the policy to plug the gaps • Establishment of Aid for AIDS, which is a network of alternative law groups providing referral mechanism for discrimination cases. The group currently handles five such cases.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or"no" as applicable).

Program	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided free-of-charge to some people in the country	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services44	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?

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

Yes	No

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

Yes	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or Other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
RA 8504 guarantees equal access. Nevertheless, there is a provision in the law that bars minors from accessing testing. The group also discussed the access of PWID to services. Although there have been efforts

in the past two years to reach this sector, particularly in Cebu where the tri-city council is set to do an operational research, there are contravening laws that make it harder to reach PWID.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes | No

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

Amendment of laws to ensure the equal access of service to all key affected population.

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

II.

Yes | No

IF YES briefly describe the content of the policy or law:

Article III of RA 8504 States that No compulsory HIV testing shall be allowed. However no specific laws for general employment purposes.

10. Does the country have the following human rights monitoring and enforcement mechanisms?
a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes | No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes | No

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?

Yes | No

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?

Yes | No

12. Are the following legal support services available in the country?
a. Legal aid systems for HIV casework

Yes | No

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

Yes	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other [write in]:	Yes	No
• General public advocacy campaigns • Community program for MARCY • Faith-based organization		

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

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

Since 2009, what have been key achievements in this area:
• Development of a redress mechanism • Implementation of OHAT • CHR is more involved • Move to amend RA 8504 • Development of a strategic framework for children • HIV workplace policy
What challenges remain in this area:

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

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

Since 2009, what have been key achievements in this area:
• Aid for AIDS handling five cases • 5% of offices comply with HIV in the workplace policy • Expanded Phil health package
What challenges remain in this area:

IV. PREVENTION

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

Yes	No

IF YES, how were these specific needs determined?
• Research • FGD • Community consultations • M&E/program reviews • ILO Code of Practice must be apply in all workplaces, formal and informal covering and protecting the rights of all workers and all people living with HIV/AIDS
IF NO, how are HIV prevention programmes being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who Inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC on risk reduction	1	2	3	4	N/A

IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other[write in]:	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

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

Since 2009, what have been key achievements in this area:

- Increasing number of LAC
- Organizations are able to conduct gender sensitivity training even if the national response has no gender
- sensitivity framework
- Some LGUs providing VCT
- Department of Education's approval to introduce Power of Youth
- MSM and TG capacity building (ex: generating and utilizing strategic information)
- Internet campaign
- Increasing access to VCT

What challenges remain in this area:

- Implementation of sex education
- Procurement of commodities in certain LGU
- Most prevention programs are not yet scaled up
- Involvement and participation of LGU and government agencies in children and youth concerns
- Rising rate of HIV among young people
- Increase of demand for contraceptives

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:

- Provision of peer counseling, psychosocial support, referral for access of ART and Treatment for OI's
- Education of R.A 8504 emphasizing their rights and services available for PLHIV
- Referral for livelihood program
- Capacity building for peer counseling including ARTM peer counseling
- Nutritional Support
- Prophylaxis

tify how HIV treatment, care and support services are being scaled-up?

- Increase number of treatment hubs
- Ensuring the availability of drugs for PLHIV and increasing the target of coverage for those needing the treatment.

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

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counseling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Pediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A

Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other[write in]:	1	2	3	4	N/A

1.2 Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

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

Since 2009, what have been key achievements in this area:

- Additional treatment hubs can dispense ARV
- Additional CD4 machines
- Development of DSWD Referral System
- OHAT package

What challenges remain in this area:

- Expiring external support
- Livelihood
- Strengthening of home-based care, particularly in Mindanao
- Stigma and discrimination (certain doctors/institutions are strongly associated with HIV; some PLHIV are hesitant to go to them because of this association)
- There are still gaps in testing (ex: minors cannot avail of VCT; there are cases of young people who are already in the late stage when diagnosed)
- Benefits from DSWD are coursed through the municipality; confidentiality is a major concern

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

Yes	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

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

Yes	No

2.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing Interventions?

Yes	No

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

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

Since 2009, what have been key achievements in this area:

- National strategic framework

What challenges remain in this area:

- Children is often categorized together with women
- Comprehensive study on children to identify diversity
- Closure of Bahay Lingap, which will be converted into an out-patient department

Annex 8.4

National AIDS Spending Assessment 2009-2011

The objective of the NASA report is to track HIV/AIDS spending from 2009 to 2011 from various sources of financing covering both public and international funds. The aim of this initiative is to inform policy-makers, program managers, and the donor community on the magnitude of HIV/AIDS expenditures in the country and guide them in their planning and decision-making activities.

Spending data were collected from National Government Agencies, Development Partners (bilateral and multilateral organizations), Non-Government Organizations (NGOs), and private sector. It should be noted, however, that there remains some data limitations. These limitations include: non-disaggregation of expenditure data; some have been budget data but no actual expenditures; data from local government units (LGUs), non-government organizations (NGOs), and private sector are limited; some spending items are unaccounted for; and some expenditure items are projected/extrapolated.

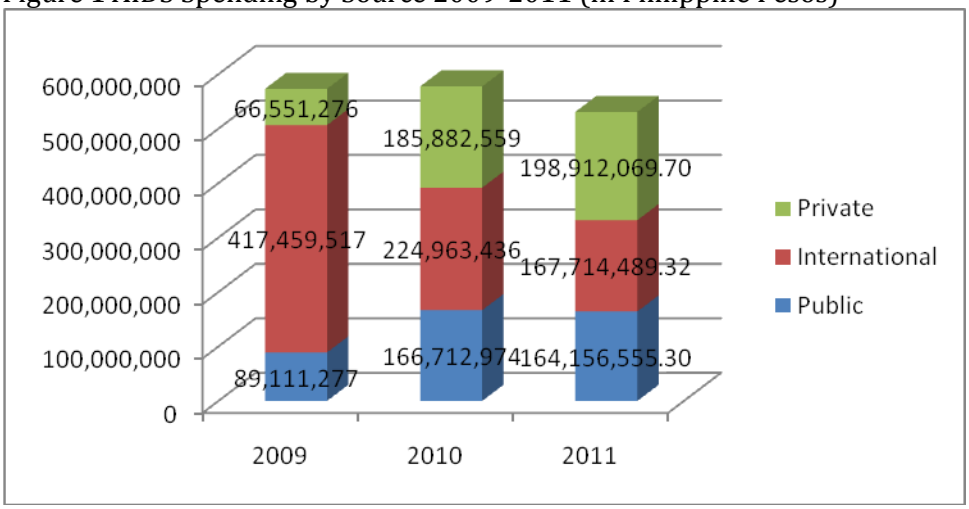
TOTAL AIDS SPENDING BY SOURCE

For the period 2009 to 2011, the country spent about Php 1.6 billion for HIV and AIDS (or an annual average of Php 560 million). Table 1 shows an erratic trend in overall spending for AIDS increasing in 2010 (from Php 573 million in 2009 to Php 577 million in 2010) and decreasing in 2011 (Php 530 million). On the average (from 2009 to 2011), about 48% of total spending was from international sources while public sources accounted for about 25% and the private sources accounted for about 27%. The biggest contribution was from *The Global Fund*. It can be observed that there is generally a dwindling amount from international sources, especially with the completion of Global Fund Rounds 3 and 5 (Round 6 is to be completed in 2012) in the country. Other international sources include: the UN agencies, United States Agency for International Aid (USAID), and other international NGOs (e.g. *Bread for the World and German Doctors*).
However, it is notable that spending from public sources increased given the higher budget allocation for the Department of Health (DOH), as well as for Department of Social Welfare and Development's (DSWD) mainstreaming of social protection-related activities. Other public sources of fund include: expenditures from the national government (Department of Labor and Employment, Department of Education, Philippine National AIDS Council Secretariat, among others), some public hospitals, and the local government units (LGUs.) Expenditures data collected from the local government units (LGUs) remain limited as well as spending data from private sources. Bulk of the expenditures from private sources reflected here came from *DKT Reproductive Health, Inc.*

Table 1: Total AIDS Spending by Source, 2009-2011

Source	2009	% share	2010	% share	2011	% share	Total
Public	89,111,277	15.55%	166,712,974	28.87%	164,156,555.30	30.93%	419,980,806
International	417,459,517	72.84%	224,963,436	38.95%	167,714,489.32	31.60%	810,137,442
Private	66,551,276	11.61%	185,882,559	32.18%	198,912,069.70	37.48%	451,345,905
Total (in Php)	**Php573,122,070**	100.00%	**Php577,558,969**	100.00%	**Php530,783,114**	100.00%	**Php1,681,464,153**
(in US$)	$12,030,977		$12,803,432		$12,254,563		37,088,972
forex	47.6372		45.1097		43.3131		

Figure 1 AIDS Spending by Source 2009-2011 (in Philippine Pesos)



The expenditures of non-government organizations (NGOs) are generally sourced from development partners and international NGOs. Notably, a lot of AIDS-related activities are being carried out by NGOs. These NGOs include: AIDS Society of the Philippines (ASP), The Library Foundation (TLF-SHARE Collective, Inc.), Positive Action Foundation Philippines, Inc. (PAFPI), Pinoy Plus, Action for Health Care Initiatives (ACHIEVE), Philippine NGO Council (PNGOC), ALAGAD-Mindanao, among others. Private spending in this report includes corporate contributions (e.g. *Levis Foundation* in 2011), other private donations, and funds from revenues (DKT Reproductive Health Inc.).

TOTAL AIDS SPENDING BY FUNCTION

For the period 2009-2011, most of the resources, on the average went to prevention interventions (61%), followed by program management and administration (24%), and care and treatment activities (8%). Although there is general decline in AIDS spending, there is an observed increase in expenditures for social protection and enabling environment expenditures. It should be noted that spending for orphans and vulnerable children (OVC) of HIV affected persons may have been integrated under social protection category. Furthermore, there are NGOs that provide services for OVC but expenditure data could not be collected.

Table 2: Total AIDS spending by function, 2009-2011

Function	2009	% share	2010	% share	2011	% share	Total
Prevention	319,132,057	55.68%	361,716,736	62.63%	347,425,850	65.46%	1,028,274,643
Care and Tx	49,412,597	8.62%	52,166,334	9.03%	27,630,338	5.21%	129,209,270
OVC	1,714,939	0.30%	0	0.00%	0	0.00%	1,714,939
Prog Management	146,137,985	25.50%	140,765,715	24.37%	122,329,314	23.05%	409,233,015
Human Resources	31,157,914	5.44%	5,822,006	1.01%	6,344,181	1.20%	43,324,102
Social Protection	1,713,940	0.30%	529,000	0.09%	2,604,877	0.49%	4,847,817
Enabling Envi	14,575,579	2.54%	10,290,474	1.78%	21,080,937	3.97%	45,946,989
Research	9,277,059	1.62%	6,268,703	1.09%	3,367,617	0.63%	18,913,379
TOTAL	Php573,122,070	100.00%	Php577,558,969	100.00%	Php530,783,114	100.00%	Php1,681,464,153

Figure 2 AIDS Spending by Function, 2009-2011

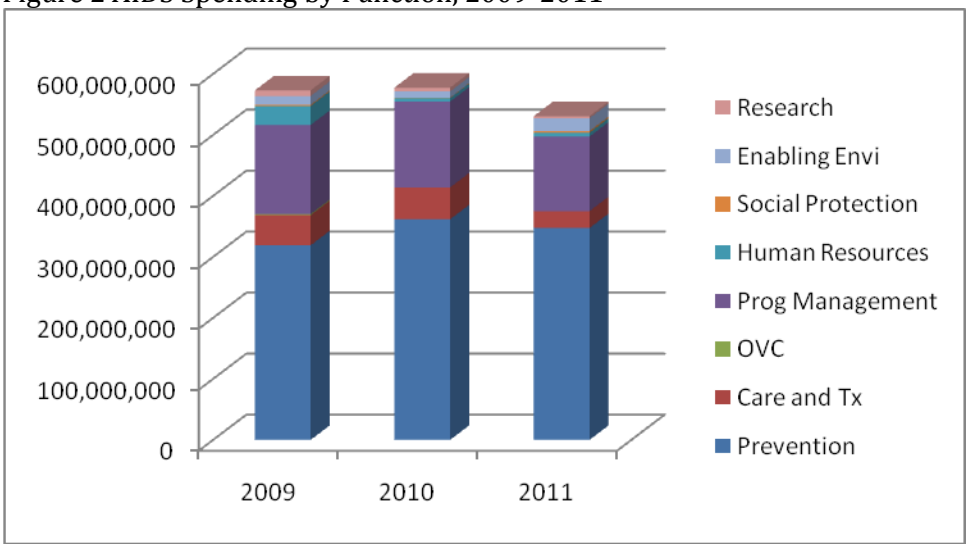


Table 2 shows the annual breakdown of expenditures by activity or function. Prevention programs in the country include: communication for behavior change, voluntary counselling and testing, prevention and management of STIs, interventions for vulnerable population (migrant workers), programs for most at risk populations (MARPs), among others. Care and treatment expenditures, on the other hand, cover anti-retroviral therapy, treatment of opportunistic infections and prophylaxis, HIV-related laboratory monitoring, among others. Resources were also spent on program management and administration. These include: planning and program management, monitoring and evaluation, serological surveillance, administration costs, among others. For the period 2009 to 2011, the country also spent for enabling environment activities (advocacy, human rights, institutional development), human resources (training), social protection (social assistance), and research studies.

It should be noted that there were activities during the period that were not accounted for since these were undertaken through "volunteer work" and services were provide for free. Some of these activities include: Project Headshot Clinic (photo exhibit project); Red Whistle Campaign (For an HIV-free Country); Love Yourself campaign; Take the Test, among others.

In addition, there are hospital-based services (San Lazaro Hospital) that were also provided free of charge and were not fully costed such as: palliative care, provider-initiated counselling and testing. On the other hand, dental services were also provided to patients but these were paid through patients' out of pocket and were not accounted for.

Program and Policy Implications

The results point to the following concerns:

a) There is a need to sustain and intensify current initiatives and mobilize resources for HIV prevention and control, especially from local government units (LGUs), and in areas where most infections are coming from. Commendable initiatives by LGUs (e.g. Quezon City) need to be replicated in other areas to ensure that interventions are in place for most at risk populations (MARPs). Moreover, efforts to engage the private sector are needed to complement the activities of the government. With the completion of the projects financed by The Global Fund and given the increasing number of new AIDS cases, the government should be prepared to absorb the responsibility of providing prevention and treatment services.

b) There is also a need to use available resources efficiently and effectively. Investments should be made towards prevention interventions targeting the MARPs. Special attention should be given to areas where most infections are coming from. Further, there may be a need to revisit program management-related activities given the observed amount of resources being devoted for this based on percentage share to total expenditures.

Supplemental Tables

International Sources by Function

In Philippine Pesos

	2009	% share	2010	% share	2011	% share	Total
Prevention	229,623,828	55.01%	92,581,910	41.15%	63,021,715	37.58%	385,227,452
Care and Tx	27,175,809	6.51%	17,982,338	7.99%	7,543,338	4.50%	52,701,486
OVC	1,714,939	0.41%	0	0.00%	0	0.00%	1,714,939
Prog Management	108,908,950	26.09%	97,756,299	43.45%	74,352,568	44.33%	281,017,816
Human Resources	27,449,964	6.58%	2,177,074	0.97%	1,803,496	1.08%	31,430,534
Social Protection	1,449,990	0.35%	189,000	0.08%	804,877	0.48%	2,443,867
Enabling Envi	11,858,979	2.84%	9,161,291	4.07%	18,174,365	10.84%	39,194,634
Research	9,277,059	2.22%	5,115,524	2.27%	2,014,131	1.20%	16,406,714
TOTAL	417,459,517	100.00%	224,963,436	100.00%	167,714,489	100.00%	810,137,442

In general, international sources dwindled in all functions except for enabling environment and social protection (from 2010 to 2011). The previous year, Development Partners supported the social protection activities of the Department of Social Welfare and Development, as well as institutional development, human rights programs and various advocacy activities (under enabling environment function).

Public Sources by Function

In Philippine Pesos

	2009	% share	2010	% share	2011	% share	Total
Prevention	23,464,903	26.33%	84,425,446	50.64%	90,032,443	54.85%	197,922,793
Care and Tx	22,236,788	24.95%	34,163,996	20.49%	19,982,000	12.17%	76,382,784
OVC	0	0.00%	0	0.00%	0	0.00%	0
Prog Management	37,229,036	41.78%	43,009,417	25.80%	47,976,747	29.23%	128,215,199
Human Resources	3,200,000	3.59%	3,644,932	2.19%	2,605,685	1.59%	9,450,618
Social Protection	263,950	0.30%	340,000	0.20%	1,800,000	1.10%	2,403,950
Enabling Envi	2,716,600	3.05%	1,129,183	0.68%	1,753,780	1.07%	5,599,563
Research	0	0.00%	0	0.00%	5,900	0.00%	5,900
TOTAL	89,111,277	100.00%	166,712,974	100.00%	164,156,555	100.00%	419,980,806

Public sources generally increased across all functions except for care and treatment, and human resources (from 2010 to 2011). Although there was an observed increase in the expenditures of San Lazaro Hospital (a treatment hub in the National Capital Region) for other treatment costs, it should be noted that the DOH procured ARV drugs in 2010. However, these commodities were funded by The Global Fund in 2011.

Sources of information:

1. ALAGAD Mindanao,
2. Action for Health Care Initiatives
3. Women's Health Care Foundation
4. Philippine NGO Council
5. Department of Interior and Local Government (including Local Govt Academy)
6. Department of Health (National Epidemiology Center, National AIDS/STD Prevention and Control, National Voluntary Blood Services Program)
7. PNAC Secretariat
8. Department of Social Welfare and Development
9. Department of Education
10. Technical Education and Skills Development Authority
11. Department of Justice
12. Department of Tourism
13. Department of Labor and Employment (Occupational Safety and Health Center)
14. San Lazaro Hospital (including STD/AIDS Central Cooperative Laboratory)
15. Jose Reyes Memorial Medical Center
16. Zamboanga City Medical Center
17. Pasay City
18. Makati City
19. Quezon City
20. Centers for Health Development (Ilocos Region, Bicol Region, Davao Region)
21. United States Agency for International Development
22. United Nations Agencies (UNAIDS, UNFPA, UNICEF, UNDP, WHO, WB)
23. Department of Health Bureau of International Health Cooperation (Global Fund recipient)
24. Order of the Ministers of the Infirm – Camillians
25. Pinoy Plus Association

BREAKDOWN OF TABLES

2009

AIDS SPENDING CATEGORIES	(F + P+Z) PUBLIC SUBTOTAL	DOH NASPCP	DepEd	CHD 7	SAN LAZARO HOSPITAL	DOH-PNAC SECRETARIAT	DOH-NEC	DOLE-OSHC	DILG	DSWD	(Q:W) SUB-NATIONAL
TOTAL	**89,111,276.99**	**50,000,000.00**	**5,049,000.00**	**326,600.00**	**4,081,691.00**	**5,915,916.00**	**11,000,000.00**	**157,481.00**	**339,798.50**	**97,500.00**	**12,143,290.49**
ASC.01 **PREVENTION sub-total**	23,464,903.49	12,700,000.00	0.00	93,400.00	0.00	0.00	0.00	157,481.00	0.00	0.00	10,514,022.49
ASC.02 **Care and Treatment sub-total**	22,236,788.00	18,000,000.00	0.00	0.00	4,081,691.00	0.00	0.00	0.00	0.00	0.00	155,097.00
ASC.03 **Orphan and Vulnerable Children (OVC) sub-total**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ASC.04 **Program Management and Administration sub-total**	37,229,035.50	16,900,000.00	2,049,000.00	33,200.00	0.00	5,915,916.00	11,000,000.00	0.00	339,798.50	0.00	991,121.00
ASC.05 **Human Resources sub-total**	3,200,000.00	0.00	3,000,000.00	200,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ASC.06 **Social Protection and Social Services sub-total**	263,950.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,000.00	258,950.00
ASC.07 **Enabling Environment sub-total**	2,716,600.00	2,400,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	92,500.00	224,100.00
ASC.08 **HIV-related Research (excluding operations research)**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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AIDS SPENDING CATEGORIES	(AB+AG+AR+AV) INTERNATIONAL SUBTOTAL	(AC:AF) BILATERALS	MULTILATERALS (AH:AM) UN AGENCIES	(AO:AQ) GLOBAL FUND TOTAL	(AS:AU) DEVT BANK (GRANT)	(AW+AX) ALL OTHER INTERNATIONAL	(AZ:BB)) PRIVATE SUB-TOTAL
TOTAL	**417,459,517.25**	**36,174,004.24**	**58,283,552.55**	**318,590,463.19**	**3,461,812.27**	**949,685.00**	**66,551,275.66**
ASC.01 **PREVENTION sub-total**	229,623,827.75	25,151,928.33	32,133,671.44	170,996,996.64	391,546.34	949,685.00	66,043,325.58
			0.00		0.00		
ASC.02 **Care and Treatment sub-total**	27,175,809.28	0.00	2,608,289.14	24,567,520.14	0.00	0.00	0.00
ASC.03 **Orphan and Vulnerable Children (OVC) sub-total**	1,714,939.20	0.00	1,714,939.20	0.00	0.00	0.00	0.00
ASC.04 **Program Management and Administration sub-total**	108,908,949.67	10,257,810.75	2,323,841.60	93,257,031.39	3,070,265.93	0.00	0.00
ASC.05 **Human Resources sub-total**	27,449,963.88	201,112.00	0.00	27,248,851.88	0.00	0.00	507,950.08
ASC.06 **Social Protection and Social Services sub-total**	1,449,990.02	0.00	1,449,990.02	0.00	0.00	0.00	0.00
ASC.07 **Enabling Environment sub-total**	11,858,978.67	563,153.16	8,775,762.37	2,520,063.14	0.00	0.00	0.00
ASC.08 **HIV-related Research (excluding operations research)**	9,277,058.78	0.00	9,277,058.78	0.00	0.00	0.00	0.00

2010 AIDS Spending Categories	Public Sub-Total	DEPED	DOH	DOJ	DOT	TESDA	DSWD	San Lazaro Hospital + SACCL	NEDA	Sub- National	State Insurance Funds (SSS and GSIS) DOLE-OSHC
TOTAL	166,712,974.16	0.00	119,212,595.75	0.00	39,750.00	29,433.33	370,000.00	32,582,000.00	0.00	13,689,195.08	790,000.00
1. Prevention (sub-total)	84,425,446.02	0.00	61,230,600.00	0.00	0.00	0.00	0.00	13,000,000.00	0.00	9,429,846.02	765,000.00
2. Care and Treatment (sub-total)	34,163,995.75	0.00	14,581,995.75	0.00	0.00		0.00	19,582,000.00	0.00	0.00	0.00
3. Orphans and Vulnerable Children (sub-total)	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4. Program Management and Administration Strengthening (sub-total)	43,009,416.67	0.00	41,650,000.00	0.00	0.00	0.00	30,000.00	0.00	0.00	1,304,416.67	25,000.00
5. Incentives for Human resources (sub-total)	3,644,932.40	0.00	750,000.00	0.00	0.00	0.00	0.00	0.00	0.00	2,894,932.40	0.00
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	340,000.00	0.00	0.00	0.00	0.00	0.00	340,000.00	0.00	0.00	0.00	0.00
7. Enabling Environment (sub-total)	1,129,183.32	0.00	1,000,000.00	0.00	39,750.00	29,433.33	0.00	0.00	0.00	59,999.99	0.00
8. Research (sub-total)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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Currency expressed in:	PhP
Average Exchange Rate for the year (local currency to USD)	45.1097

2010 AIDS Spending Categories	International Sources								Private Sources (optional for UNG
				Multilaterals					
	International Sub-Total	Bilaterals	USAID	UN Agencies (Sub-total)	Global Funds (Round 5)	Global Funds (Round 6)	All Other International	Bread for the World-Germany and German Doctors (Implemented by: Alliance Against AIDS in Mindanao, Inc. [ALAGAD-Mindanao, Inc.])	Private Sub-Total
TOTAL	224,963,435.71	26,949,436.57	26,949,436.57	45,437,485.12	30,457,258.57	116,740,296.44	5,378,959.00	5,378,959.00	185,882,559.34
1. Prevention (sub-total)	92,581,909.62	786,061.90	786,061.90	5,386,359.82	11,860,907.37	73,167,200.54	1,381,380.00	1,381,380.00	184,709,380.69
2. Care and Treatment (sub-total)	17,982,338.40	0.00	0.00	0.00	2,666,669.02	14,824,229.38	491,440.00	491,440.00	20,000.00
3. Orphans and Vulnerable Children (sub-total)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Program Management and Administration Strengthening (sub-total)	97,756,298.82	25,897,170.67	25,897,170.67	27,202,914.67	15,929,682.17	27,624,677.31	1,101,854.00	1,101,854.00	0.00
5. Incentives for Human resources (sub-total)	2,177,074.00	266,204.00	266,204.00	0.00	0.00	0.00	1,910,870.00	1,910,870.00	0.00
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	189,000.00	0.00	0.00	0.00	0.00	0.00	189,000.00	189,000.00	0.00
7. Enabling Environment (sub-total)	9,161,290.53	0.00	0.00	7,732,686.30	0.00	1,124,189.22	304,415.00	304,415.00	0.00
8. Research (sub-total)	5,115,524.34	0.00	0.00	5,115,524.34	0.00	0.00	0.00	0.00	1,153,178.65

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Average Exchange Rate for the year (local currency to USD)	43.3131										
		Public Sources									
2011 AIDS Spending Categories	Public Sub-Total	DEPED	DOH	DOJ	DOT	San Lazaro	TESDA	DSWD	NEDA	Sub- National	State Insurance Funds (SSS and GSIS) DOLE-OSHC
TOTAL	164,156,555.30	0.00	109,630,600.00	59,250.00	136,700.00	36,582,000.00	45,380.00	2,459,700.00	5,000.00	14,152,925.30	1,085,000.00
1. Prevention (sub-total)	90,032,443.27	0.00	61,230,600.00	0.00	0.00	17,000,000.00	5,000.00	16,700.00	0.00	10,720,143.27	1,060,000.00
2. Care and Treatment (sub-total)	19,982,000.00	0.00	0.00	0.00	0.00	19,582,000.00	0.00	0.00	0.00	400,000.00	0.00
3. Orphans and Vulnerable Children (sub-total)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Program Management and Administration Strengthening (sub-total)	47,976,746.67	0.00	46,650,000.00	0.00	0.00	0.00	0.00	0.00	0.00	1,301,746.67	25,000.00
5. Incentives for Human resources (sub-total)	2,605,685.37	0.00	750,000.00	59,250.00	135,200.00	0.00	0.00	30,500.00	5,000.00	1,625,735.37	0.00
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	1,800,000.00	0.00	0.00	0.00	0.00	0.00	0.00	1,800,000.00	0.00	0.00	0.00
7. Enabling Environment (sub-total)	1,753,779.99	0.00	1,000,000.00	0.00	1,500.00	0.00	40,380.00	612,500.00	0.00	99,399.99	0.00
8. Research (sub-total)	5,900.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,900.00	0.00

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Average Exchange Rate for the year (local currency to USD)	43.3131							
		International Sources						s (optional for UNG
2011 AIDS Spending Categories		International Sub-Total	USAID	Multilaterals			All Other International	Private Sub-Total
				UN Agencies (Sub-total)	Global Funds (Round 5)	Global Funds (Round 6)		
TOTAL		167,714,489.32	27,042,087.10	50,722,941.86	311,312.52	84,369,120.84	5,269,027.00	198,912,069.70
1. Prevention (sub-total)		63,021,714.61	1,161,764.86	2,671,827.48	0.00	58,110,434.27	1,077,688.00	194,371,691.72
2. Care and Treatment (sub-total)		7,543,338.33	0.00	0.00	311,312.52	6,718,132.81	513,893.00	105,000.00
3. Orphans and Vulnerable Children (sub-total)		0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Program Management and Administration Strengthening (sub-total)		74,352,567.68	25,880,322.24	31,854,101.80	0.00	15,063,186.65	1,554,957.00	0.00
5. Incentives for Human resources (sub-total)		1,803,496.00	0.00	0.00	0.00	0.00	1,803,496.00	1,935,000.00
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)		804,876.86	0.00	648,916.86	0.00	0.00	155,960.00	0.00
7. Enabling Environment (sub-total)		18,174,364.77	0.00	13,533,964.66	0.00	4,477,367.11	163,033.00	1,152,792.00
8. Research (sub-total)		2,014,131.05	0.00	2,014,131.05	0.00	0.00	0.00	1,347,585.98

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