

Seizing the Opportunity:

THE 2000-2004 MEDIUM TERM-PLAN
FOR ACCELERATING THE
PHILIPPINE RESPONSE TO HIV/AIDS

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List of commonly use abbreviation and acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBCP	Catholic Bishop Conference of the Philippines
CHED	Commission on Higher Education
CSW	Commercial Sex Workers
DFA	Department of Foreign Affairs
DECS	Department of Education, Culture and Sports
DOH	Department of Health
DOLE	Department of Labor and Employment
DOT	Department of Tourism
DTI	Department of Trade and Industry
HAIN	Health Action and Information Network
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IRR	Implementing Rules and Regulations
LGU	Local Government Units
MIS	Management Information System
MOA	Memorandum of Agreement
MTP	Medium Term Plan
NCR	National Capital Region
NGA	Non Government Agency
NGO	Non Government Organization
NSO	National Statistical Office
OWWA	Overseas Workers and Welfare Administration
PNP	Philippine National Police
PNAC	Philippine National AIDS Council
POEA	Philippine Overseas Employment Agency
PWHA	Persons with HIV/AIDS
RA	Republic Act
RITM	Research Institute for Tropical Medicine
STD	Sexually Transmitted Diseases
TESDA	Technical Education and Skills Development Authority
UP	University of the Philippines

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(AMTP)

Introduction

This is a national plan indicating how the country's institutions and communities will be informed, encouraged, organized, and mobilized to take local and sectoral actions in order to prevent the further spread of HIV/AIDS infection and to manage its impact on those already infected and affected. This is a national plan in the fullest sense of "national" to mean not just national government, but also local government; not just government, but also civil society; not just organized groups, but also communities; not just institutions, but all people.

This plan is primarily a guide for the country's own actions in the period from 2000-2004. As such, it is useful as a basis for determining priorities in cooperation with the country's external partners. Implementation of this plan also comprises the country's contribution to the global efforts against HIV/AIDS.

This plan was prepared under the direction of the Philippines National AIDS Council (PNAC). The preparation involved many valuable contributions of scientists, social activists, government executives, health workers, educators, academics, local leaders and other concerned individuals, groups and agencies.

With the formal approval and adoption by the PNAC, this plan will be presented to appropriate authorities for eventual adoption by the national government in behalf of the whole country.

Chapter 1: Review of the National Response to Date

The country's first cases of AIDS were reported in 1984. Since then, the national AIDS registry has recorded a cumulative total of 1,325 HIV/AIDS cases up to December 1999. The most recent **HIV/AIDS Country Profile for the Philippines** (published by the Philippine National AIDS Council in January 2000) provides the most recent comprehensive review of the national HIV/AIDS situation, its social and behavioral aspects, its regional dimensions, and existing responses by various groups at different levels.

A. Current Consensus on the Status of the HIV/AIDS Epidemic

Available evidence of the unfolding epidemic in the country allows international experts to call the Philippines' HIV/AIDS situation as a "nascent epidemic". While considerable disagreement exists among different groups with informed opinions on the matter, the following points describe the current consensus about the status of the epidemic:

1. Number of Confirmed Cases is Low: The level of confirmed prevalence even among those groups presumed to be the most vulnerable to HIV infection is considered low. Available information about prevalence obviously depends on the extent and quality of efforts to measure it. While organized and systematic efforts to measure actual prevalence have increased, many gaps in the coverage of existing surveillance efforts remain. The gaps introduce some degree of uncertainty in available estimates of low prevalence.
2. Rate of Increase in Number of Cases is Slow: The current growth in the number of HIV/AIDS cases is considered slow. There are many limitations in the reliability of estimated trends in the rate of spread of the infection. Current data are not really comparable with past data. Trends indicated by reported data may lag substantially behind the real underlying trends of an ongoing epidemic. Each time information about the level of infection is available, it is likely that the actual level of infection in the population would have already changed. Thus caution must be exercised in concluding that the slow spread of the infection based on the number of confirmed cases must necessarily mean slow growth in the number of actual cases.
3. No Reason to Expect that Low and Slow Will Remain So: Even if the epidemic in the country were indeed "low and slow" as available data suggest, this does not alter the urgency and imperative for national action. Based on the experience of many other countries, a "low and slow" pattern in the past offers no assurance that the same pattern will continue in the future. In fact, there are many countries that initially showed such "low and slow" patterns for a number of years only to eventually experience an explosive epidemic.

4. Many Reasons to Expect the Infection to Spread: All the known routes of transmitting the infection (through heterosexual and same sex contact; through injecting drug use; through blood transfusion; from mother to child) have already been observed in the country. Many of the risky behaviors that are known to drive the spread of the infection are practiced by large numbers of people at significant levels of frequency. These risky behaviors include: unprotected casual sex with multiple partners, including commercial sex; maintenance of concurrent sexual relationships that mix sexual relations with a steady partner and with other casual partners thereby creating the “bridge” mechanism for HIV infection to migrate from one group to another, repeated and untreated infection with other STD; drug use and to a lesser extent injecting drug use; transfusion of blood under unsafe conditions.
5. Underlying Behaviors Likely to Drive the Epidemic: The known and suspected levels and extent of risky behaviors are such that there is consensus about the potential of the country to suffer a more serious epidemic than available data indicate thus far. Even among those who disagree on the actual extent of the current epidemic, there is agreement that the underlying conditions for a more rapid spread than what had been observed in the past and a much higher prevalence of HIV/AIDS infection in the present already exist, and thus, without effective prevention at sufficient scale soon, the probability for an explosive epidemic is high.
6. Everyone is Vulnerable: While current levels of risk for a higher rate of infection vary from locality to locality, from group to group and from individual to individual, the fact that HIV infection follows multiple routes of transmission in ways difficult for anyone to observe with absolute certainty means that no locality, group or individual is completely safe from being infected. A locality without known HIV/AIDS case can be host to an infected yet undiagnosed person who can transmit the virus. A wife completely faithful to her spouse can be infected by that spouse who gets exposed to the virus through unprotected sex with casual partners who may already be infected.
7. Effective Prevention Efforts Justified: Well documented simulation studies have shown that the sooner effective efforts to prevent infection are undertaken, the higher are the chances for avoiding a potentially catastrophic long-term epidemic and the lower are the likely peak rates of future infection that would be encountered during the course of an epidemic. While preventive efforts against HIV/AIDS always yield substantial benefits at any stage of the epidemic, the sooner such efforts are made the greater are the immediate and long-term benefits in terms of avoided suffering and foregone costs.

The above situation frames the context of this medium-term plan. The plan is titled “Seizing the opportunity” by “Accelerating the Philippine Response”. The apparently “low and slow” character of the epidemic thus far is seen as a transient opportunity for action. It is an opportunity because it allows the country to act now before it is overwhelmed by a rapid increase in the number of infected persons. Yet it is a passing opportunity because high levels of underlying risky behavior, if left to fester, are likely to increase the number of infected persons in the future. The recommended action for seizing this transient opportunity is to accelerate the Philippine response ahead of the potential acceleration of the epidemic. And the period to begin such an accelerated response is in the next 5 years from 2000 to 2004.

B. Current Recognition of the HIV/AIDS Challenge

The country has recognized HIV/AIDS as a serious and important challenge to its people’s health and the nation’s development. The recognition is marked by substantial achievements. At the same time, a number of limitations in the scope of the country response have also been noted. How well has the country understood the nature of its HIV/AIDS epidemic and how far has the country acted on the basis of this understanding? Some key points on this matter:

1. Better Knowledge of the Epidemic: The country’s efforts have increased the availability of better information about the level and extent of the epidemic and about the risky behavior driving the spread of HIV infection. The latest **Country Profile** summarizes a wealth of available information that serves as the current research base of policies and programs.

It is however, recognized that the current surveillance efforts need to be extended to cover more geographic areas and reach more groups in the population. This requires that surveillance activities be increasingly rooted in the institutions of localities while ensuring that technical standards governing these activities are maintained nationally. There are also important gaps in knowledge that need to be filled such as the actual extent and the nature of the determinants of risky behavior, as well as the proven effectiveness of implemented interventions to promote safer behavior.

2. More Extensive Articulation of Government Intentions: The country’s efforts have established a body of explicit and formally adopted policies and plans to address the HIV/AIDS epidemic. The passage of RA 8504 (The Philippine AIDS Prevention and Control Act of 1998) and the issuance of its initial set of implementing rules and regulations exemplified this achievement. These policies provided a clear political signal and a sound legal basis for the country’s intentions to get ahead of the epidemic.

Yet the law is still primarily words on paper. The law's provisions need to be further articulated in more detailed and operational implementing rules and regulations, which in turn have to be more widely disseminated before these can be more deeply internalized by government instrumentalities, civic groups and the people themselves.

C. Current Mobilization to Respond to HIV/AIDS

Despite limited knowledge and information, the country initiated a number of pioneering efforts that have built the foundations of a more robust national response to the HIV/AIDS challenge capable of mounting long-term nationwide effort. Some achievements and limitations in this regard:

1. Formalization of Organized Multi-Sectoral Response: At the center of the country response to HIV/AIDS, a strong framework for multi-sectoral coordination of multi-level activities has been formally established in the Philippine National AIDS Council. The Council has the broad representation, legal mandate and official policy instructions to lead the country's efforts.

Yet the creation of the PNAC as a legal and administrative body is clearly just the beginning of actual mass mobilization. The Council needs an adequately staffed and financed Secretariat working effectively to support the decision-making of the Council and to carry out the Council's instructions. The national program structure needs to develop functional links with a wide variety of local responses all around the country. The institutions participating in the Council need to put forward and agree among themselves in their respective roles and functions. And finally, a resource mobilization effort needs to generate the funding support necessary for a vigorous national effort by localities and sectors.

2. Increased Recognition of Vital Importance of Local Responses: The leaders and specialists at the core of the country's efforts have increasingly recognized the vital importance of local responses to the epidemic as the veritable front-lines of HIV/AIDS prevention. The task of national mobilization has been translated into the task of mobilizing local responses on a nationwide scale. The magnitude of this task has been recognized as enormous given the many barriers to inducing and internalizing an appropriate local response due to devolution, a short 3-year electoral cycle for local leaders, competing local priorities and the heavy burden of learning and understanding the proper and effective ways to address HIV/AIDS.

The need now is to act on the basis of this recognition. PNAC has to lead in the systematic development and implementation of various functional mechanisms for inducing, informing, coordinating, sustaining and making more effective, the many diverse local responses to HIV/AIDS.

3. Active Engagement of Excellent Individuals and Organizations: The country's efforts in HIV/AIDS have engaged the active participation and substantial contribution of many excellent individuals and organizations. Many of these were the products of the past almost two decades of pioneering work on the epidemic. There are many active and potential champions for various areas of action in national effort. A number of these organizations have built comparative advantages in certain specific functions like research, surveillance, reaching hard-to-reach groups, adolescent sexuality education, and others. These capacities are invaluable assets to a larger national mobilization.

Yet there continues to be a need for a deeper and wider pool of human resources capable of performing important tasks in what will increasingly be local efforts on a nationwide scale. There is also a need to secure the continuing commitment of those individuals and groups already capable of assisting localities and sectors.

D. Specific Responses to Critical Issues in HIV/AIDS Prevention

As the **Country profile** amply documents, Philippine responses to HIV/AIDS challenge are incredibly varied and creative. Without attempting to comprehensively cover the whole field, clusters of responses are summed up below in relation to what have been recognized as critical and priority issues in HIV/AIDS prevention. Within the context of a larger and more diverse national effort to respond to the HIV/AIDS infection, some key points are noted:

1. From Awareness to Behavior Change: The country has attained higher public awareness of the domestic reality of HIV/AIDS infection. There is now an urgent need to make this general awareness of HIV/AIDS more salient to each individual, more strongly related to critical aspects of his or her specific behavior, and more promotive of attitude and behavior change.
2. Making HIV/AIDS Information Inherent Part of Basic Education: A start has been made to integrate information on HIV/AIDS in the formal and non-formal education programs and activities. There is now an urgent need to implement this integration on a nationwide scale by incorporating HIV/AIDS information in instructional materials, textbooks and teacher education/training and guidance counselor training.
3. Mobilizing for Effective Universal STD Care: Great strides have been taken to mobilize the social hygiene clinics of local government health services for more effective STD care and HIV prevention. There is now an urgent need to expand the scope of STD care beyond the small group of registered sex

workers obtaining “pink cards”, to cover all persons in prostitution and, in fact, the whole population, including the wives of STD-infected men.

4. Reaching Groups Considered more Vulnerable than Others: A number of outreach pilots have demonstrated success in serving groups presumed to be more vulnerable to HIV infection, such as persons in prostitution, men who have sex with men and injecting drug users. There is now an urgent need to carefully evaluate these pilots and then expand the coverage of those pilots shown to be cost-effective in order to cover a critical mass of those groups that are indeed more vulnerable. Within the context of focusing efforts on groups with greater probability of exposure to infection while addressing the generalized risk to which the whole population is also exposed, there is a need to consider overseas Filipino workers as possibly among those groups requiring targeted outreach intervention. It is also important to improve the means and basis of identifying and delineating other groups based on actual vulnerability to HIV infection.
5. Strategic Use of Donor Assistance to HIV/AIDS Control: Several useful and important donor-assisted projects have been initiated and executed by government agencies, local governments and non-government organizations. There is now a need to ensure a better fit of these increasingly scarce donor-assisted projects with an improved country strategy that systematically provides for institutionalization and sustainability.

E. Main Conclusion of This Review of the National Response

Given the mix of achievements attained and of needs for improvement identified in this chapter, this review points to the following conclusions:

1. Strong Foundations in Place: Many good things have been done and are still going on. These achievements have advanced the country’s capabilities to confront the issues posed by HIV/AIDS. And these capabilities serve as strong foundations for a much more vigorous and comprehensive response in the future. The on-going activities contribute to preventing the worsening of the epidemic.
2. Right Scope, Inadequate Scale: It is clear, however, that the country’s response thus far is diffused and diluted because it is driven by compromise decisions that are themselves based on an understanding of the problem which lags behind the underlying reality and which only vaguely approximates the complexity, magnitude and severity of behavioral risk factors. The current response has adequate scope in term of its component thrusts, but not adequate scale in terms of their coverage and output.

3. Clear Danger of Losing Ground: If this past pattern of response continues, there is a clear and present danger that the epidemic will continue to spread ahead of the country's ability to prevent it and soon the limitations in the country's response (which may not be obvious) will allow the further increase in those infected and affected until the burden of caring for those already affected overwhelm whatever achievements have been attained.

4. Imperative to Scale Up and Accelerate Response: The most important conclusion of this review is the recognition that the country's response needs to scale up, accelerate and expand ahead of the spread of the infection. This requires that the efforts initially appear disproportionate in relation to the number of actual cases, but are in fact reasonable considering the vast opportunities for prevention that lie ahead. Massive prevention efforts now would eventually be confirmed as the only possible way of avoiding a much greater increase in the future burden of this disease.

Chapter 2: Conceptual Frameworks for AMTP Strategies

A. HIV/AIDS Infection As a Preventable Epidemic

1. HIV as a Viral Infection: HIV is an infection caused by a virus that is transmitted through sexual contact, blood transfusion, and from mother to child. HIV/AIDS initially spread because of ignorance about the nature of the disease and the routes of its transmission. People did not know how the disease is transmitted. Now HIV continues to spread because some people still did not know how it is transmitted or because they do not know enough to alter their behavior and avoid infection.
2. HIV Infection as a Result of Behavior: Scientific research has now established that in the Philippines HIV infection is the result of specific behaviors, not the occurrence of random misfortune. As the HIV virus enters the population, it initially infects those people whose behavior increased their probability of exposure to HIV through unprotected sexual contact, or blood transfusion. An HIV epidemic results when the practice of these behaviors continue without protective measures and each infected person on average is able to infect more than one other person.
3. Preventing HIV Infection as the Outcome of Modified Behavior: Protection from being infected by HIV is as much a result of individual behavior change as of environments supportive of that change. Preventing the future spread of the infection is thus fundamentally behavioral modification effort, i.e., modifying the behavior of everybody likely to be infected so that either they do not infect someone else or they do not allow themselves to be infected. While individual behavior is to some extent the result of individual choice, there are many situations where individual choice is conditioned or circumscribed by the social context beyond the control of the individual. Thus promoting behavior that prevents being infected or infecting someone else entails both an effort to directly influence individual choice as well as to alter those aspects of the social context that induce individual choices.

B. Importance of Preventing the Spread of HIV/AIDS Infection

1. Prevent the Spread to Protect Individual Health: For every individual, the most effective measure against HIV is to prevent from being infected by it. For the infected individual, the choices are different but all of them are less desirable to not being infected at all. Without writing off those who are already infected, but recognizing that the situation is different for them, preventing the spread of HIV infection is the most effective way to attain and preserve individual health.

2. Prevent the Spread to Preserve Social Harmony: For people sharing blood and having sexual relations with each other, increased levels of HIV infection have the potential for poisoning social relations and destroying social harmony. Obviously the care and support of those infected and affected will require that communities make critical adjustments to avoid discrimination and marginalization of people living with HIV/AIDS. Nonetheless, those important social adjustments to increase the effectiveness of preventing the further spread of the infection would have to take precedence for their potential for preserving social harmony and customary social relations.
3. Prevent the Spread to Protect Integrity of National Development: The costs of even a much larger effort to prevent HIV/AIDS infection will definitely pale in comparison to the full costs of a much larger epidemic that could have been avoided. In many countries where the number of cases had multiplied into full blown epidemics, the direct costs of care, opportunity costs of those afflicted and the non-monetary suffering of families affected have conspired to adversely alter the course of national development. Investing to prevent a larger epidemic will not greatly diminish the resources available for national development. Not investing in prevention now raises the danger of possibly derailing future development in case the epidemic explodes without effective prevention.

C. Essential Interventions to Prevent the Spread of HIV/AIDS

1. Two Main Types of Interventions: According to reviews of global experience in the past 20 years, there have emerged two basic and complementary generic interventions to prevent the spread of HIV/AIDS:
 - (a) Influencing individual choices within the prevailing socio-economic context by making safer behavior a more attractive option and a consistently selected choice.
 - (b) Changing aspects of the existing socio-economic context that make it difficult for some people to protect themselves from HIV infection.
2. Focus on Individual Behavior: Under influencing individual choices, the key elements include:
 - (a) Increasing awareness and knowledge about levels of HIV infection in the population, about how HIV is transmitted and not transmitted; and about how to avoid contracting HIV infections.
 - (b) Increasing the relevance of these awareness and knowledge in relation to specific behaviors of individuals by changing personal attitudes and assumptions concerning their vulnerability to infection despite the risks associated with their sexual behavior and preferences, by showing how HIV infection would affect them personally, by making them realize how risky their actual behavior is, and by helping them become more skillful or powerful in negotiating safer sexual behavior with their partners or in resisting social pressures.

- (c) Addressing other factors that affect behavior aside from knowledge and attitudes such as lowering the costs of condom use, lowering the costs of prompt effective treatment of STD and lowering costs of safer injecting drug use.
3. Reform Social Structures: Under changing the socio-economic context the key elements include:
- (a) Altering norms concerning sexual relations and underlying attitudes towards sexuality that prevent individual evaluation of risks, reinforce risky behavior, discourage safer behavior and encourage discrimination.
 - (b) Improving gender relations and raising the status of women, particularly addressing those social processes that lead women to become sex workers and lead men to utilize commercial sex.
 - (c) Empowering and enabling adolescents to prepare them for satisfying, safe and responsible sexuality.
 - (d) Reducing poverty, particularly those aspects that increase the vulnerability of the poor to HIV infection.

D. Framework for Accelerating the Philippine Response

1. Twin Changes to Reduce Risks of Infection: The Philippine response will need to encompass efforts to encourage changes in the social context of individual behavior as well as to influence directly changes in individual behavior. These two streams of action will have to be directed to reduce the risk of infection from sexual intercourse, drug use or blood transfusion, with a much larger emphasis on sexual behavior as the overwhelming majority of confirmed HIV infections thus far (75%) were acquired through sexual transmission.
2. Pursuing the Twin Changes Urgently Before the Situation Worsens: Many nations had to undertake the twin efforts of changing the social context and changing individual behaviors in the face of an already raging and mounting epidemic, at which point the changes in both areas had to be much more costly and extensive yet yielded much less benefit in terms of fewer deaths and lower suffering. The Philippines still has an opportunity, although only a transient one, to pursue these same twin changes before the impending worsening of a nascent epidemic and thus secure far greater benefits than if such changes were undertaken under the burden of a rapidly worsening situation.
3. Acting in the Face of Opportunity, Rather than in the Face of Crisis: Without the real crisis of a rapidly deteriorating epidemic, the country will need to act as if such crisis were at hand. In order for this plan to succeed, it needs to break through the change of residual denial and set aside any remaining illusions that the country will naturally avoid a worse epidemic. The plan needs to provoke the country's institutions to act before the window of opportunity to prevent the spread of an infection is closed by the rising tide of

a much worse epidemic that we know can be bred by the current social context and present patterns of individual behaviors.

4. A Leadership by a Core of the Most Aware: This plan is above all the exercise of leadership by a core of people who are most aware of the HIV/AIDS situation in the country. Pursuing the twin changes in social context and individual behaviors begins with those already confronting the issues in these two areas. These influential and concerned individuals from government, civil society, academe, and local government need to use the plan as a platform for leading, motivating and mobilizing their own respective constituency so that communities, sectors and the nation can take the necessary actions now. Before they can do so, however, these influentials and concerned individuals need to make a fundamental shift in attitude so that they start to assign the highest priority to the effort by recognizing the reality and seriousness of the problem, accepting that radical and long-term alterations of current conditions are required for the solution, and committing to take urgent, sustained and large-scale action on what needs to be done.
5. An Unfolding Effort of Much Wider Dimensions: After the core of the country's effort shall have embraced the urgency of accelerating the national response to HIV/AIDS, the pursuit of the twin changes in social context and individual behavior needs to gather steam, widen its coverage, increase its focus and effectiveness, and create increasingly visible impact on the ground. Doing these requires changes at the level of government, in social institutions like the Church and media that have the power and influence to move others, and in communities where individuals live and work, even as separate individuals themselves alter their own behavior in response to the changes in information and material conditions around them.

Chapter 3: Basic Strategies of AMTP for 2000-2004

A. Strategic Targets for the Medium Term

By the end of the medium-term period, the country would have attained the following hallmarks:

1. The PNAC is nationally recognized as a competent, credible, reliable and effective source of technical leadership in preventing HIV/AIDS and providing care for those infected and affected.
2. At least 60% of the nation's local government jurisdictions are associated with an active sub-national coordinating mechanism for HIV/AIDS prevention.
3. A network of organizations, institutions and individuals is regularly interacting in support of the priorities and targets set by PNAC.
4. Public and private tertiary and secondary formal education programs include adequate information on HIV/AIDS in the curriculum, teaching materials including textbooks, and teacher training courses. (Achievement tests among representative samples of high school graduates and college students indicate that they have acquired adequate basic knowledge of HIV/AIDS prevention).
5. Major media organizations assume responsibility for educating and informing their audiences about HIV/AIDS.
6. The main organized churches and religions in the country accept their respective responsibility for educating and informing their members about HIV/AIDS prevention.
7. The available body of current data and knowledge is adequate to satisfy the basic information demands of PNAC decision-making, program prioritizing, design of the most important projects and implementation of these projects.
8. At least 5 specific interventions have been demonstrated and evaluated to cost-effectively reduce any one or all of the following risks: STD infection, unprotected sex among PIP; transfusion of unsafe blood; unprotected sex among single persons under age 20.
9. In each of at least 5 infection risk zones, population coverage of HIV prevention and STD prevention and treatment is near universal.
10. Adequate and sustainable (public and private) minimum provisions for the care of those infected are established and regularly operating.

B. Five Strategies as an Integrated Package

1. In order to attain the above strategic targets, the medium term-plan will pursue an integrated package of five complementary strategies:

- Management and advocacy: Creating an enabling environment for sustained HIV prevention (For strategic targets 1 to 6)
- Research and surveillance: Understanding the HIV epidemic, risky behavior, and factors affecting vulnerability to infection (For strategic target 7)
- Small scale trials in prevention and support: Demonstrating effective approaches to reduce risks from HIV infections and manage its impact (For strategic target 8)
- Large scale preventive interventions: Expanding implementation of effective approaches to reduce risks of HIV infection associated with the most prevalent risky behavior (For strategic target 9)
- Care and support: Managing the impact to those infected and affected (For strategic target 10)

2. Each of these five strategies supports each other.

- Management and advocacy builds the political, social and institutional infrastructure within which all the other four strategies may be pursued.
- Research and surveillance inform all the other four strategies about the technically sound and evidence-based approaches.
- Small scale trials in prevention and support test the most promising ideas that, when validated, can be implemented as large scale preventive campaigns or care and support services.
- Large-scale preventive interventions are expected to yield the results targeted to reducing risks of infection and thus strengthen public support for the whole effort.
- Care and support is expected to protect those who are already infected for their own benefit as well as to enable them to avoid infecting others.

Outline of Each Strategy

Management and Advocacy Strategy: Creating an Enabling Environment for Sustained HIV Prevention

- (a) Changing the climate of social attitudes and norms, including gender equality
- (b) Enabling and empowering the youth with attitudes, knowledge, and skills through education and counseling
- (c) Mobilizing popular support, local resources, and wider participation
- (d) Encouraging effective and efficient responses that promote human rights and dignity, discouraging opposite responses.
- (e) Building and strengthening capacities at different levels and sectors
- (f) Institutionalizing desired responses at different levels and sectors

Research and Surveillance Strategy: Understanding the HIV Epidemic, Risky Behaviors, Factors Affecting Vulnerability to Infection

- (a) Building and operating a nationwide network for epidemiological and behavioral surveillance of HIV and STD
- (b) Identification and delineation of different groups at varying degrees of vulnerability to HIV infection
- (c) Understanding the nature and determinants of behaviors among these groups that increase their vulnerability to contracting and spreading the HIV infection
- (d) Development of MIS for HIV and STD
- (e) Packaging and dissemination of research-based information for various purposes through appropriate channels (policy making, planning and allocating resources, informing and communicating, promoting behavior change)

Small Scale Trials Strategy: Demonstrating Effective Approaches to Reduce Risks from HIV Infection and to Manage its Impact

- (a) Pilot and outreach demonstration projects: different interventions, different groups; different behaviors
- (b) Considering ethics, identifying benefits and measuring costs
- (c) Documenting good practices among participating organizations
- (d) Considering wider adaptability of good practices from local and international experiences
- (e) Developing appropriate methodologies for evaluation (e.g., participatory evaluation; cost-effectiveness studies)
- (f) Evaluating the impact of approaches and interventions
- (g) Feeding the results of R & D to wider practice and application

Large Scale Prevention Strategy: Expanding Implementation of Effective Approaches to Reduce Risks of HIV Infection

- (a) Expand outreach to individuals and their partners who practice unsafe sexual behaviors
- (b) Promote use of universal precautions among health care providers
- (c) Intensify STD management and care
- (d) Promote consistent and correct use of condoms among sexually active individuals
- (e) Conduct IEC that promote behavior change
- (f) Support enforcement of blood safety law
- (g) Institutionalize integration of HIV/AIDS prevention in training and employment programs of employers, labor and government

Care and Support Strategy: Managing the Impact of Those Infected and Affected

- (a) Care and support based in a health facility
- (b) Care and support at home and in the community

Chapter 4: Institutional and Effective Resource Management

A. Approach to Functional PNAC Network

1. Description of the PNAC Network: The network consists of the following:
 - (a) The Council itself, with 26 members as defined by law.
 - (b) The Secretariat of the Council staffed primarily by officials and personnel of the DOH.
 - (c) The organizations with representation in the Council, which include 13 government agencies, 2 leagues of local government, 2 committees of Congress, 2 medical professional organizations, and 7 NGOs, including one for people with HIV/AIDS.
 - (d) Cooperating projects assisted by donors or financed by government.
 - (e) Self-financed organizations working in fields related to AIDS.
 - (f) Voluntary organized local AIDS councils.
 - (g) Local governments undertaking HIV/AIDS activities

2. Operations of the PNAC Network: Form the standpoint of PNAC leading the country response to HIV/AIDS, the following proposals are put forward:
 - (a) The Council itself is primarily a deliberative, information sharing, and consensus building body. Although the law empowers the Council to perform a number of functions, the operational reality is that the Council is dependent on the quality and responsiveness of the staff work presented to its meetings. The Council exists only when it meets or when it acts collectively. The unique power of the Council is the ability to speak with one voice and its influence on the directions and actions of its member organizations and agencies.
 - (b) The law mentions the secretariat of the Council almost as an afterthought. The main function of the secretariat is actually to implement an HIV/AIDS prevention and control program as one of the national health programs. Yet the emerging consensus in the country program is for an HIV/AIDS response that is not primarily a bio-medical effort, even though it might include biomedical elements (such as serological surveillance and care and support in the hospitals). The real organizational challenge is to create a secretariat that reflects more fully the multi-sectoral orientation of the Council.
 - (c) Various member organizations of the Council could decide to actively contribute staff and funding to the Secretariat in order to augment what the DOH provides, but more importantly to capture the multi-sectoral intent of the country program. If this is acceptable, a resolution can be drafted in consultation with various agencies that would request selected agencies to provide specific support to the Secretariat.

- (d) In addition, clusters of agencies within the Council could form a sub-Secretariat for example for HIV/AIDS education. For this, DECS, CHED, TESDA, some of the NGOs, with technical assistance from the DOH could establish a regular body that focuses on integrating HIV/AIDS information in all aspects of delivering basic, tertiary and technical-vocational education.
- (e) The Council and its Secretariat need to project a much higher public profile and media visibility if it hopes to influence norms, attitudes and behavior. For this purpose, a public projection plan might be an important contribution of PIA.
- (f) The current office location of the Council and its Secretariat is not in accord with its high priority status and its multi-sectoral nature. It is proposed that a more publicly-accessible office location be considered so that the Council can conduct its activities in a more open and broadly participative manner, allowing various other groups such as provincial organizations to link with it.
- (g) It might be possible to create a network of dedicated and capable volunteers that effectively provides PNAC and its Secretariat with many technical and professional services substantially for free or for negligible amounts. Student internship or fellowship to PNAC and the national HIV/AIDS program might be developed with academic institutions. Linkages with organizations of artists, illustrators, writers, journalists, personnel managers, and others can serve as both channels for HIV/AIDS prevention advocacy as well as potential sources of assistance.
- (h) Based on the demands and requirements of the medium term plan, PNAC might decide to set a quarterly rolling agenda of priority issues that it would seek to tackle and resolve. Based on the items identified by its members, PNAC can then commission an agency or organization to prepare a proposed response to the issue. These items could be scheduled 3 months in advance always to enable those assigned to carry out their assignments.
- (i) It is crucial that PNAC creates a sense of urgency in the implementation of the medium term plan. There are many competing demands on the time and attention of everyone involved. But if PNAC does not provide the leadership to move ahead of the epidemic, the prospects of the country avoiding a catastrophic epidemic would be dim. Human resources are not really a constraint; there are sufficient numbers of excellent Filipino professionals and activists. Information is not really a constraint; what is known now is adequate for what needs to be done. Material resources are not really a constraint, there is really no need for foreign exchange to do any of these tasks in the plan. The greatest constraint is time since the rate of acceleration in the country response is racing against the rate of spread of the epidemic. PNAC can maximize activities, output and impact given the time or it can become the bottleneck to large-scale concerted nationwide action. Its organization and operation will determine its performance.

3. Potentially Important Enhancements to the PNAC Network: In the course of preparing the AMTP, three potentially important enhancements to the PNAC network were identified:
 - (a) A technical resource network composed of experienced analysts, managers, specialists, and scientists needs to be organized. An e-network can be established so that the PNAC can disseminate reports, studies and inquiries. Periodic meetings can be held to consider new information. The network can be increasingly widened so that more and more people in the provinces can join and share their information about program issues.
 - (b) PNAC should also consider the formation of a corporate support group. This can mobilize private contributions for meeting some of the essential out-of-pocket expenses of the program. Corporations are also natural communities whose members may have a high interest in preventing the spread of the infection because they are likely to be the prime victims.
 - (c) A media support group should also be organized to provide valuable suggestions and assistance in projecting the program issues to the public through the media. Preference should be given to media practitioners with a real personal interest and professional commitment to HIV/AIDS prevention.

4. Approach to Sub-National Coordination: Below the national level, a number of proposals emerged during the preparation of the AMTP:
 - (a) It might be possible that the usual organization of government activities into a standard hierarchy composed of a national-regional-provincial-city-town-barangay may not be appropriate for dealing with an issue like HIV/AIDS based on the assessment of varying distribution of risks around the country. An alternative might be to delineate sub-national zones of risks based on the observed channels of population interactions, geographic routes of transmission of HIV infection and the channels for behavior change. For example, zones might be delineated along trucking and bus routes, or according to the movement of people in prostitution, or according to patterns of STD prevalence. These zones become the basic unit of operations of the national program. Institutional arrangements are organized to focus on these zones and data are analyzed based on the context of these zones.
 - (b) Local governments within these zones are then encouraged to cooperate with other LGUs whose jurisdictions share the risks. For example, Angeles City shares the commercial sex market on Mabalacat town and Olongapo City because of the patterns long established by the operation of the former US bases. This might be a natural zone and coordination in surveillance and education might be attractive to the LGUs themselves. Other areas might be delineated because they share common media outlets and thus might be better reached for purposes of IEC and behavioral promotion.

- (c) PNAC might even consider selecting national agencies, NGOs or academic groups to serve as “technical stewards” of these zones. Modest contracts might be granted to these organizations to engage them in organizing the LGU response in these zones. These contracted “technical stewards” then consult with the LGUs to obtain their support and participation in various program activities.

B. Approach to Resource Management

1. The Resource Management Issues: In terms of mobilizing and utilizing resources to attain purposes of HIV prevention, the following issues were identified:
 - (a) Prior to the introduction of the HIV/AIDS effort all of the country’s resources have been allocated and are being used for other purposes. The resources of government and private individuals are already being utilized for other presumably important and desirable purposes. Once the need to spend for HIV/AIDS activities is accepted, the next issue is how much resources would be required, where would it come from and what other existing purpose would be sacrificed in order to accommodate the spending for HIV/AIDS actions.
 - (b) Yet much of the resources needed for HIV/AIDS activities may continue to be spent for their original purposes while also serving the purpose of HIV/AIDS prevention. For example, existing expenditures for surveys and research may still be used for the same purpose provided that the surveys and the research include the interests and needs for HIV/AIDS prevention. Or, existing expenditures in secondary, technical-vocational and tertiary education may still be used for the same purpose provided that information on HIV/AIDS prevention is included in the context of existing secondary, technical-vocational and tertiary education. This would be an approach that might be called “mainstreaming”, where the goals of HIV/AIDS prevention is included as among the outcomes of already existing expenditures.
 - (c) Some of the existing activities that are already being financed may require some investments before these can adequately serve the purpose of HIV/AIDS prevention. For example, within existing budgets of public hospitals, it might be possible to accommodate the provision of care support of the AIDS patient. But some investment will need to be expended to develop the clinical protocol for such care and support. Or the existing operation of government public information offices may already include information on HIV/AIDS, but they may need some information materials or training modules in order to be accurate and effective providers of information on HIV/AIDS. Or, the existing operation of LGU health services may already cover the diagnosis and treatment of STD, but they may need standard clinical protocols and training modules to effectively expand the provision of STD services. Making these investments would be an approach that might be called “leveraging”, where a small expenditure on a specific item allows the program to

- influence how existing activities funded by existing resources can yield more contributions to HIV/AIDS prevention.
- (d) Donor-granted resources represent a true addition to the country's resources. In so far as these resources support HIV/AIDS prevention, the optimum strategy for using donor resources would be in the "leveraging" approach, making sure that these donor resources do not displace or substitute country resources already being expended for the same purpose.
 - (e) In both "mainstreaming" and "leveraging", it is important that the activities yield impact on the program goals and targets for the resources that were allocated and utilized, regardless of their sources. This is the only way that the program goals can be attained by the currently available resources.
2. Seed Fund, Multiplier Effects and Strategy Implementation: The above issues are reflected in the following operational proposals.
- (a) It is proposed that a "Seed Fund for HIV/AIDS" be established by the PNAC with the explicit purpose of funding new strategic activities that can influence other existing activities to yield greater contribution to HIV/AIDS prevention. The sources of funding would be financial contributions of agencies represented in the PNAC plus whatever specific appropriations might be provided in the GAA for HIV/AIDS. This seed fund might be financed by grants and contributions of other agencies. In turn, the seed fund will finance "leveraging" projects that re-direct, re-focus, or improve existing expenditures by government or individuals towards outcomes that contribute to HIV/AIDS prevention.
 - (b) Projects funded by the seed fund would be carefully selected primarily for their "multiplier effects", or their ability to extend the results beyond the original context of the project. First of all, the target of the project should be those areas where the potential for multiplier effects are large due to the already large existing effort in that area. For example, the potential for multiplier effects are probably great in the following areas: public education; local public health services; employer provided health services; public hospital care; mass media. In all these areas, massive efforts are already being undertaken using existing resources. Then the projects should be carefully positioned to maximize the influence on the area towards HIV/AIDS prevention. Finally, consideration should be given to how far the area could contribute to the attainment of a strategic objective.
3. Illustrative Examples of the Approach: Following are some examples of seed fund activities leveraging larger blocks of activities towards attainment of strategic objectives.
- (a) A seed fund project to develop technical systems and operating procedures for PNAC network would be leveraged with the existing operations of agencies and organizations comprising the PNAC to partly attain Strategic Targets 1 and 3.

- (b) A seed fund project to develop a system of local HIV/AIDS prevention advocates with a module to train these advocates would be leveraged with existing local governance and community development activities in order to partly attain Strategic Target 2.
- (c) A seed fund project to develop a module on HIV/AIDS training for teachers would be leveraged with existing pre-service and in-service training of teachers in order to partly attain Strategic Target 4.
- (d) A seed fund project to develop a module on HIV/AIDS training for media practitioners would be leveraged with existing activities of mass media in order to partly attain Strategic Target 5.
- (e) A seed fund project to establish a regular technical dialogue and research information exchange with the Catholic Bishops Conference of the Philippines would be leveraged with the extensive public education activities of the Catholic Church in order to partly attain Strategic Target 6.
- (f) A seed fund project to develop a set of data requirements and formulate pre-tested questions would be leveraged with existing NSO surveys such as National Health Survey, National Demographic Survey, Labor Force Survey or even the Family Income and Expenditure Survey in order to partly attain Strategic Target 7.
- (g) A seed fund project to design simple and cheap operations research projects can be leveraged so that organizations and agencies involved in HIV/AIDS can carry out these operations research projects using their own resources in order to partly attain Strategic Target 8.
- (h) A seed fund project to prepare a prototype model operational plan for local STD control as an HIV prevention measure would be leveraged with existing LGU health services in order to partly attain Strategic Target 9.
- (i) A seed fund project to develop standard protocols for hospital-based care and support of a person with AIDS can be leveraged with the operations of public hospitals in order to partly attain Strategic Target 10.

Chapter 5: Proposed Activity Package for Five Strategies of AMTP for 2000-2004

The following section presents various project ideas and proposed activity packages that would implement each of the five strategies described in Chapter 3. The items listed here are intended to serve as a guide for carrying out AMTP strategies according to the availability of human, financial and organizational resources. The PNAC shall prioritize specific project ideas from among those listed below for incorporation in annual operational plans during the next 5-year period from 2000-2004.

A. Management and Advocacy Strategy: Creating a Social Environment for Sustained HIV Prevention

- Advocacy project for “de-criminalizing” commercial sex
- Integrated gender considerations in all IEC for HIV-AIDS
- Signing up prominent personalities to serve as volunteer spokespersons for HIV prevention
- Encouraging persons with HIV-AIDS to become spokespersons for HIV prevention
- Plan each year’s World AIDS Day around a relevant theme for the Philippines; use the day to focus on the theme and produce new information or launch new activities according to the theme.
- Schedule regular releases of surveillance data and make each release more high profile, with commissioned analysis of what the data indicate and what it means to the ordinary Filipino
- Organize a “friends from the media” group for HIV prevention; recruit one of the prominent columnists or TV anchorperson or public affairs manager as the coordinator of the friends from the media group; promote professional review and peer criticism of media coverage of sexuality and HIV issues.
- Adopt and implement recommendations on PNAC operations described in Chapter 4 of this Plan.
- Define HIV/AIDS risk zones in the country based on the assessment of local vulnerability to infection and prepare a plan for mobilizing localities that are most vulnerable.

- Develop guiding framework for local response to HIV -AIDS by involving health, social welfare, education, law enforcement, commerce and industry sectors in the locality in promoting safe behavior.
- Promote full participation of PWHAs in national and local responses.
- Developing consensus standards for NGOs working in HIV-AIDS to establish common parameters for considering those organizations with sufficient capabilities for various aspects of HIV-AIDS work.
- Provide mechanisms for NGOs to learn from other NGOs as well as for NGOs to advocate to LGUs.
- Expansion of involvement in HIV -AIDS prevention of women's groups, community groups, and private providers of health care.
- Establish regular communication with CBCP on HIV and STD matters; provide regular briefings on the status of the epidemic, share results of surveillance and studies with focal point of CBCP and with all diocese; invite representatives from relevant diocese to join HIV prevention councils and activities; designate a PNAC lead person for the liaison with the Church so there is continuity of the dialogue; keep inter-actions with the Church private and confidential to avoid grandstanding.
- Organize a corporate round-table discussion involving CEOs and COOs of large corporations. Present the Philippine HIV prevention plan as proposed investment to avoid the greater costs and suffering of a larger epidemic; organize a Corporate Alliance for HIV Prevention to be supported by an existing foundation.
- Prepare a set of materials and organize speakers' bureau to make road show presentation to as many of the corporate and organized groups; make the presentation an orientation on the national issue with a sensitization of the individual behavioral issues, focus on behavioral changes of individuals and solicit individual contributions to the national HIV campaign.
- Link up with the Personnel Management Association of the Philippines and provide them with a briefing on the HIV prevention opportunity; sign a MOA for them to include promotion of responsible and safe sexual behavior among corporate employees.
- Develop and undertake training program of "champions of HIV-AIDS prevention"; cover key sectors and localities with this training of "champions".

B. Research and Surveillance Strategy: Understanding the HIV Epidemic and the Risky Behaviors Driving its Spread.

- Prepare and adopt a national strategy for a surveillance network with a concrete plan for implementation: including basic standards for technical acceptable surveillance capabilities and activities, acceptable parameters for total costs (investment and recurrent) with indicative sharing between central and local government. Operate the surveillance network by collecting data regularly and purposively.
- Review available data and literature in order to develop a technical definition of different groups according to their known vulnerability to HIV infection. Conduct research necessary to revise the official definition of vulnerable groups and the different degrees of vulnerability.
- Based on the data regarding different vulnerable groups, adopt a prioritization of focus of country efforts to prevent HIV infection in these groups, starting with the prioritization of research effort to understand the behavior of these groups.
- Conduct studies on the feasibility of harm reduction practices and risk factors of HIV infection among general population.
- Establish actual levels of correct and consistent condom use, levels of incorrect or non-use, and reasons for both.
- Conduct research on social attitudes and norms on sexual relations and sexuality in relation to the tendency towards practice of higher risk behaviors.
- Conduct tracking surveys and operations research to evaluate effects of IEC
- Conduct of HIV prevention preparedness survey of health providers.
- Organize and assess results of previous studies and use of results of studies already done to guide current work; inventory and archive studies done by RITM, UP College of Public Health, HAIN and others.
- Conduct bio-medical research on the following issues: TB and AIDS; cost-effectiveness of testing and case management as well as care and support protocols; prevalence of risk factors in various localities and groups.

- Conduct behavioral research on following issues: structural factors that shape risk to infection in particular communities or sub-populations; changes in probability to adopt safer behavior in response to various interventions, sustainability of safer behavior when interventions end; sexual patterns and risks of transmission in the different communities, including different types of sex workers; specific aspects by which “bridge mechanisms” transmit the infection from one group to another; mobility of sex workers and relating HIV prevalence to duration and site of sex work.
- Conduct studies on the impact of the infection on the individual, family, community and government.
- Use more qualitative research methods and develop better mechanisms for applying information from qualitative research in education and prevention.
- Include questions on HIV-AIDS in NSO household surveys to generate information from households.
- Release data to different research and analysis groups to enable them to conduct both commissioned and self-initiated studies, provided that they commit to share the result with the PNAC secretariat, which in turn can share it with the system.
- Improve technical and ethical standards of research design and data collection activities (including relevance to operational and policy issues, reliability and robustness of the results; and proper information to research subjects and participants)
- Organize annual conference on research, monitoring and evaluation results of HIV and STD prevention
- Provide regular publications and widespread availability of studies.
- Maintain and use a mailing list (corporate allies, LGUs, volunteer spokespersons, friends in media, etc.) to send updates of latest information from research and monitoring.
- Make research and data dissemination as the key strategy for local prevalence/incidence mobilization; use information on blood safety, STD and HIV prevalence/incidence to raise local awareness and serve as impetus for local action.

C. Small-Scale Trials Strategy: Demonstrating Effective Interventions to Prevent the Spread of HIV/AIDS

- Prepare a list of priority issues for possible pilot projects and outreach demonstration projects for different groups with different behaviors using different interventions.
- Develop methods and standards for measuring costs and benefits of pilot projects and experimental interventions
- Prepare criteria of “good enough practice” and document “good enough practices” among LGUs, NGOs, NGAs, and others.
- Develop evaluation methods that combine the advantages of participatory approaches with the strengths of independent external evaluation.
- Use results of evaluation of pilot and experimental projects to guide the design or the modification of large-scale prevention and education activities.

D. Large-Scale Prevention Strategy: Implementing Interventions Proven to be Effective to Prevent HIV Infection Among the Most Vulnerable Groups.

- Planning and design of campaign on universal awareness of essential HIV-AIDS messages (to include determination of essential messages, assessments of baseline awareness, determination of appropriate channels for delivering messages to target groups, development of indicators and measurements); proposed key messages – there is no cure for HIV/AIDS, HIV/AIDS can be prevented; condoms together with abstinence and mutual monogamy, can prevent HIV/AIDS.
- Implementation of campaigns on universal awareness of essential HIV-AIDS messages to priority targets to eventually cover the whole population (with grouping of population segments according to ease or difficulty of reach and to high or low probability of exposure to HIV infection)

- Adopt approach where everybody is aware of their universal vulnerability to infection but each locality takes actions on the most proximate risks by addressing those factors and behavior that pose the highest risk to exposure to and spread of the infection.
- Provision of mechanisms for subsidized voluntary testing linked with the counseling targeted for walk-in patients in public and private hospitals and laboratories.
- STD and HIV orientation materials for mandatory pre-marriage counseling sessions.
- Expansion of successful pilots in outreach to attain maximum feasible coverage of preventive measures for sub-populations of people in prostitution, overseas Filipino workers, men who have sex with men and injecting drug users.
- Expansion and improvement of STD control to cover the whole population exposed to STD infection to include commercial sex workers, customers of CSW and spouses of customers of CSW.
- Counseling module for couples when one partner becomes infected with an STD.
- Expansion of availability of condoms, wider coverage of condom social marketing, and more vigorous condom use promotion.
- Planning of IEC activities for specific behavior changes among target groups and the implementation of IEC campaigns to promote a sustained adoption of target behavior change.
- Implementation of blood safety measures.
- Complete pre-service training curricula on reproductive and sexual health for health workers.
- Develop training curricula for incorporating HIV-AIDS information into the current orientation programs reaching specific audiences (e.g., overseas workers, seamen, professional drivers)
- Prepare a plan for incorporating HIV-AIDS information into teacher training and textbook contents standards.

E. Care and Support Strategy: Providing Support and Care to Those Already Infected

- Hospital-based care: development of standard protocols and standing provisions for care and support of PWHA in hospitals; training of hospital staff on care and support of PWHA; information sharing among hospital providers on care and support for PWHA.
- Develop a workable continuum of care and support mechanisms that start from testing (assuring anonymity, accuracy and prompt referral) and extending to care using a variety of options such as home and community care, halfway homes and hospitals.
- Community-based care: development of specific standards for community-based care and support of PWHA; mapping of communities for adoption of these standards; provision of support and assistance to communities accommodating PWHA.
- Promote self-help and home-based care for PWHA's.
- Organize local support groups for PWHA's through partnerships with LGUs.

Additional Implementing Rules and Regulations of RA 8504

As part of the AMTP, a number of additional IRRs of RA 8504 have been identified for possible development and promulgation: These include the following:

- Production of a poster containing the declaration of policies to be posted in all LGUs and health facilities.
- IRR governing multi-agency education and information program for schools and teaching and training institutions (DECS, CHED, TESDA, Organization of private colleges and universities): in health facilities (DOH, PHA, PMA); in the workplace (DOLE, DTI, employer associations, labor unions, agricultural network); for Filipinos working abroad (POEA, OWWA, DFA, recruitment and manning agencies); for tourists and travelers (DOT, hotel and restaurant industry, airports and ports); in government media; in cooperating private media (common messages and different presentation for different audiences). Include in testing and assessment standards of students some measures of knowledge of HIV - AIDS.

- IRR to consolidate guidelines for safe practices and procedures to be issued to health professionals and health service institutions (Sec 5 Art 1; Articles 2,3 and 4 and Sections 40 and 41 of Art 7)
- IRR to consolidate and adopt plans for nationwide HIV-AIDS monitoring (Articles 5 and 6)
- IRR that consolidates all plans and proposals for PNAC strengthening (Art 8) to be adopted as a legal basis for budget proposals and for budget expenditures.
- Consolidated IRRs relevant to LGUs (Sections 5 and 9 of Art 1; Sec. 13 of Art 2, Sec. 21 of Art 3; Sec.23 and 25 of Art 4; Sec 28 of Art 5)
- Review other laws and regulations concerning safe blood and issue common IRR complying with RA 8504 and RA 7719 (National Blood Services Act)
- Review existing legislation and common local ordinances concerning commercial sex and prepare IRR to re-define key policies according to guidelines of RA 8504, specifically concerning inter-play of poverty, gender inequality, prostitution and marginalization, as well as standards for operation of social hygiene services and registration of sex workers; use new IRR as basis for working with PNP and Leagues of LGUs to eliminate most harmful aspects of commercial sex.

ANNEXES:

- 1) Monitoring and Evaluation
of the AMTP 2000-2004

- 2) Review of Activities of
Previous Medium-Term Plans on AIDS
Prevention and Control

Annex 1: Monitoring and Evaluation of the AMTP 2000-2004

Overall target of the AMTP: By end of 2004, HIV prevalence does not exceed 2%. (The situation does not deteriorate from the current low and slow condition.)

- **Primary prevention target:** By the end of 2004, a comprehensive package of essential preventive measures substantially cover the population in 4 of the risk zones of the country, namely:
 - (a) southern side of Luzon along the national Highway from Batangas to Sorsogon;
 - (b) western side of Luzon along the national highway from Bulacan to Ilocos;
 - (c) central and eastern Visayas covering Cebu, Bohol, Leyte and Samar islands;
 - (d) south-eastern side of Mindanao covering Socsargen and Davao.

KRAs: definition of comprehensive package of essential preventive measures; determination of target population in 4 risk zones; provision of the defined package to the defined target population
- **Primary care and support target:** By the end of 2004, all localities with confirmed cases of HIV-AIDS have adequate and sustainable minimum provisions for the care and support of those infected and affected

KRAs: definition of localities with confirmed cases of HIV-AIDS; definition of adequate and sustainable minimum provisions for the care and support; definition of those infected and affected; provision of the defined package to the defined persons in the defined localities
- **Secondary advocacy, organizational and networking targets:** By the end of 2004, the PNAC provides leadership to which LGUs, NGOs and other organized groups respond in terms of preventing HIV-AIDS and providing care and support of those infected and affected

KRAs: technical guidelines and policies issued, medium term plan approved and updated; councils; networks and organizational mechanisms for coordination established; participating groups complying with guidelines, policies and plans.
- **Secondary educational, informational and awareness target:** By the end of 2004, the following segments of the population, namely, couples, workers and youth, have appropriate essential knowledge concerning HIV-AIDS.

KRAs: For each target segment: appropriate essential knowledge defined; activities to transmit appropriate essential knowledge implemented by educational, church, media, workplace and other channels; and knowledge gained measured.
- **Secondary research and development target:** By the end of 2004, scientific data information and knowledge necessary to achieve overall, primary and secondary targets have been made available.

KRAs: definition of scientific data, information and knowledge necessary; activities to produce such scientific data, information and knowledge implemented; scientific data, information and knowledge produced disseminated.

Annex 2: Review of Activities of Previous Medium-Term plans On AIDS Prevention and Control

The Philippines has been actively responding to the HIV/AIDS infection since the first AIDS case was diagnosed in 1984 and was officially reported in 1986. Serological surveys conducted by Naval Medical Research Unit (NAMRU), Research Institute for Tropical Medicine (RITM) and Bureau of Research and Laboratories (BRL) detected the first person infected by HIV in May 1985.

Since those years, sero-prevalence surveys continued to be undertaken on a regular basis. NAMRU worked on sex workers in Olongapo and Clark and diagnosed 7 female sex workers as sero-positives in December 1985 with confirmation done several months later by RITM. The University of the Philippines - Philippine General Hospital (UP-PGH) and Philippine Veterans Hospital (PVH) worked on vulnerable groups (e.g.; male and female sex workers, returning contract workers and men who have sex with men) in Metro Manila. BRL focused on monitoring HIV infected blood transfusions. In 1986, World Health Organization (WHO) supported a one-year HIV surveillance effort covering patients with hepatitis and cancers, blood transfusion recipients, and sex workers.

In 1987, the DOH declared the government's initial official response to the HIV/AIDS problem.

The First Medium-Term Plan (MTP-I): 1988-1993

Declaring HIV/AIDS as a major health problem, the DOH formulated the first medium term plan (MTP-I) for the period 1988-1993. This plan was approved in August 1988 and was revised in October 1990. The plan spelled out five program components, namely (1) surveillance; (2) care and support for HIV-infected persons; (3) diagnostic/laboratory facilities; (4) information, education and training; and (5) program management.

Two activities were critical in the development of this first AIDS medium-term plan. One is the infection surveillance activities of NAMRU, RITM and BRL, which together provided regular serological and behavioral surveillance of high risk persons in Metro Manila, Olongapo and Clark. HIV/AIDS testing concentrated on sex workers, men who have sex with men and overseas contract workers as well as on blood transfusions. The other critical activity was a 1988 workshop assisted by WHO, Family Health International (FHI), DOH and RITM which first drafted the initial versions of MTP-I.

In the implementation of MTP-I from 1988-1993, the following five major events are worth noting: (1) the creation of the National AIDS Prevention and Control Program (NAPCP) in 1988 leading to the eventual creation of the Philippine National AIDS Council (PNAC) through Executive Order No. 39 in 1992; (2) drafting and approval of twelve policy guidelines of HIV Infection/AIDS Prevention and Control in 1989; (3) formulation of the National HIV Sentinel Surveillance in 1991; (4) signing of the bilateral agreement for AIDS Surveillance and Education Project (ASEP) between the Philippines

and the USA, and (5) integration of the Sexual Transmitted Diseases (STD) Control Program into NAPCP in 1993 and the emergence of what would henceforth be called the National AIDS/STD Prevention and Control Program (NASPCP).

During the MTP-I, the following accomplishments were attained:

1. Operationalization of a National HIV Surveillance System and the HIV/AIDS Registry; undertaking of the first AIDS-specific clinical, social and behavioral research; undertaking a study on the prevalence of STDs among male and female sex workers in Metro Manila revealing a high prevalence of STDs among the study cases with gonorrhea and trachomatis ranking as top pathogens; undertaking a study to present baseline information on the (1) effects of HIV/AIDS on the Filipino family/household, (2) estimates of medical costs and related expenses; and (3) nature of the family's coping mechanisms.
2. Care and support extended to some HIV/AIDS cases seeking service in two hospitals (i.e., San Lazaro and RITM).
3. Description of the clinical picture of HIV infection among Filipinos correlating the progression of the disease with other laboratory markers.
4. Involvement of private organizations (e.g. KABALIKAT) in the control and prevention of HIV/AIDS.
5. Conduct by RITM and BRL of a series of training/workshops for health care professionals (doctors, medtechs, nurses, social workers) on laboratory HIV testing.
6. Emergence of PNAC as a policy-making and coordination body of the NASPCP; recognition of HIV/AIDS prevention and control as an urgent and priority national concern; increased awareness of the HIV/AIDS problem among the general public, increased access by persons in vulnerable situations to information, education and campaigns (IEC) services of NGOs; involvement of both private non-government organizations and public sectors in reaching people in vulnerable situations.
7. Successful demonstration of the use of peer education and counseling; completion of training modules and materials for DOH health workers; development of AIDS Education Strategy for Health Care Workers in private STD clinics in Metro Manila; development and evaluation of an innovative education strategy for Filipino overseas workers; demonstration of an AIDS prevention program for public high schools students in Metro Manila developed by public high school teachers together with local AIDS experts, social scientists and health educators indicating a sizeable number of Filipino high school students being sexually active but very few of them using condoms.
8. Closure of commercial blood banks.

The Second Medium Term Plan (MTP-II): 1993-1999

While awareness raising was the first thrust on MTP-I, prevention of transmission and reduction of HIV/AIDS were the priority strategies of the second medium term plan (MTP-II). The main events in the implementation of MTP-II are summarized as follows:

YEAR	EVENT
1994	<ul style="list-style-type: none"> • Communication Plan drafted • Pinoy Plus organized – an organization of people with HIV/AIDS in the Philippines
1995	<ul style="list-style-type: none"> • Bahay Lingap (Halfway Home of Asymptomatic HIV Positive Filipinos) inaugurated • Philippine National HIV/AIDS Strategy developed and endorsed by President Fidel V. Ramos • STD Treatment Guidelines formulated • Policy Guidelines on HIV/AIDS Prevention and Control revised • Hosted the 3rd ASEAN Task Force on AIDS (ATFOA)
1996	<ul style="list-style-type: none"> • National STD Case Management Guidelines formulated • Presidential Proclamation No. 888 signed – declaring 1997 as National AIDS Prevention Year • Decision to host the 4th International Congress on AIDS in Asia and the Pacific made • Commencement of implementation of foreign-assisted projects, namely : <ul style="list-style-type: none"> ➢ European Union Support for HIV/AIDS and STD in the Philippines ➢ AusAID Model Community Health/STD Facilities in Commercial Sex Areas in the Philippines ➢ Japan International Cooperation Agency Project for the Prevention and Control of STD ➢ SEAMEO – GTZ control of HIV/AIDS/STD Partnership Project in the Asian Region (CHASPPAR) Monitoring STD/AIDS Service Delivery Through Information System
1997	<ul style="list-style-type: none"> • STD/AIDS declared a priority program of the Secretary of Health • Policy and Strategies for STD/HIV/AIDS Intervention in the Workplace launched by the Department of Labor and Employment (DOLE) • Implementation of Memorandum no. 495 s. 1996 Integrating of HIV/AIDS education in all schools nationwide by the Department of Education, Culture and Sports

	<ul style="list-style-type: none"> • STD/AIDS information system and AIDS Home Page developed • 4th International Congress on AIDS in Asia and the Pacific held in Manila on October 25-29 at the Philippine International Convention Center • Guidelines on the Entry of People with HIV/AIDS to the Philippines endorsed by the Department of Foreign Affairs through Circular No. 214-97 • Commencement of HIV/AIDS education among the Department of Interior and Local Government Staff • Strengthening of Collaboration with the Philippine Information Agency on STD/AIDS mass media campaign • Collaboration with NGOs targeting vulnerable groups • Unveiling of the AIDS monument • Hosting of the AIDS Prevention, Education and Treatment on November 20-22, 1997
1998	<ul style="list-style-type: none"> • Enactment of the Philippine AIDS Prevention and Control Act of 1998 or Republic Act No. 8504

MTP-II achieved the following:

1. The adoption of RA 8504 is a result of the productive partnership between government and civil society organizations.
2. The inter-sectoral character of the PNAC and the participatory processes and consultations it adopted in drafting the Philippine National AIDS Strategy have ensured the involvement of a wide spectrum of organized groups
3. A condom social marketing program adopted by the DKI International utilized new ways of selling target clients through the use of commercial mass media.
4. Another “good practice” was demonstrated by the Philippine Business for Social Progress in its HIV/AIDS program in the workplace implemented in three companies in Mindanao
5. The University of the Southern Philippines Foundation’s harm reduction and prevention in Cebu showed how to cover barangays with high drug incidence with innovative outreach strategies for gaining access to high-risk groups.
6. PNAC’s guidelines for the development, evaluation and dissemination of IEC materials on HIV/AIDS are considered another “good practice.”

Summary of Previous Review Studies

All studies (Miralao et al., 1999: 46; Lim-Quizon et al., 1998; Almario et al., 1997) consistently reveal that HIV prevalence has remained generally low (less than 1 percent).

Miralao et al. (1999) point out the other following points:

1. Data on STD infection, condom use and attitudes and behavior of sentinel groups raise questions about the real extent of HIV infections. Sentinel populations may face much higher risks of contracting HIV/AIDS than shown by the results of serological surveys.
2. Serious deficiencies in design and data collection methodologies must be addressed promptly and properly in order to improve the data-base for planning and formulating HIV/AIDS control and prevention programs.
3. While awareness and knowledge of HIV/AIDS is high among the general population, certain misconceptions persist regarding its transmission. Most Filipinos generally do not perceive themselves as at risk to HIV/AIDS. This could make them even more vulnerable to the infection.
4. Prevailing social values and norms (e.g. familism, religiosity and conservatism) with high proportions disapproving relations outside a marriage, same-sex relationships, divorce and abortion may account partly for both the "low and slow" spread of HIV/AIDS in the country as well as the unpopularity of condom use among Filipinos.
5. Tests in some blood banks show that much of the blood supply is not screened for HIV and other pathogens.
6. Available studies by RITM and HAIN on the socioeconomic and demographic correlates of HIV/AIDS are not nationally representative and there is a need to come out with a national picture for better planning and implementation.
7. The promulgation of RA 8504 is only the beginning. The Philippine National AIDS strategy is only a statement of principles and does not offer a specific plan of action. PNAC has yet to formulate a real national strategy which will operationalize RA 8504. Specific targets and priority areas must be identified, taking into account limited resources, the level of prevalence and threat of the disease in particular localities and the need for NASPCP to be better known and supported by the chief executives of local government units.
8. Since the national response is still a centrally directed program, the current response has no clear mechanisms explicitly linking national and local responses to HIV/AIDS. There is a need to transform PNAC, which is a policy-making and coordinating body into a well synchronized organization

composed of several partner organizations who have agreed to move towards the same goals and follow a clear delineation and complementation of their tasks, roles and responsibilities.

9. A rational distribution of tasks among government agencies, NGOs and the private sector is likewise an important issue. The relevant program thrust is the institutionalization of NASPCP at the national and local levels.
10. Given the high cost of care and treatment of HIV/AIDS and the limited public funds available for this, there is a need to mobilize more resources and devise ways of developing less costly modes of extending care and treatment. The level and nature of donor funding/technical assistance for various aspects of NASPCP need to be more rationally determined.
11. Since knowledge and awareness of how the disease is transmitted is basic to prevention, there is a need to mainstream HIV/AIDS through primary health care programs and through non-health concerns.
12. There is hesitation of the local executives to give priority to the HIV/AIDS problem. The fact that the Filipinos do not generally identify themselves as at risk to the disease impedes the solicitation of popular support for HIV/AIDS program.
13. Also, the prevailing social values and sexual conservatism of Filipinos do not easily allow bolder promotion of condom use and the use of explicit graphic sex illustrations in HIV/AIDS public education campaigns.

Given these issues the following were then recommended by the study of Miralao et al. (1999):

- The development of a national strategy which includes as its key elements a specification or description of its general thrusts and objectives, setting its targets in terms of affected persons, sectors and regions; and a rational distribution of tasks among the government agencies, NGOs and the private sector. The strategy must establish implementing and coordinating mechanisms for NASPCP at the national and local levels.
- Multi-sectoral collaboration and key institutions in the response should be strengthened and sustained. In particular, PNAC and its secretariat should be bolstered.
- Local AIDS councils or similar local organizations must be assisted in terms of resource building and policy development. Capacity building for LGUs, NGOs and the private sector particularly in technical skills and training related to prevention and control and clinical services for private hospitals and clinics must be addressed.

- Support for capacity-building for organizations for PLWA such as Pinoy Plus Association, Inc. and Positive Action Foundation must be given especially in aspects related to organizational expansion, networking and resource generation.
- Resource mobilization and utilization must be rationalized. To avoid duplication and overlapping of donor-funded and government financed programs and projects, government must organize a forum/fora with donors, where the former coordinates and directs donor contribution, rather than vice-versa. Government presents a strategy and a set of priorities and asks donors to assist them in areas where its resources are limited.
- Prevention and control of HIV/AIDS can be further strengthened in key government programs such as community-based primary health care and reproductive health programs (DOH and LGUs), in educational systems (DECS, CHED and TESDA), the poverty alleviation program (NAPC) through decentralization and local governance (SK, DILG, and League of Provinces and Cities), and through overseas and migrant workers (POEA, DFA and OWWA).
- Sangguniang Kabataan and Leagues of Provinces and Cities, local NGOs, and people's organizations can be tapped to link and coordinate the national and local response.
- More resources and systematic attention must be given to the care and support program of the response. Given the small number of PLWHAs at the present time, government should be able to show an adequate and respectable level of care and support for HIV/AIDS patients and cases amidst the vast resources available for HIV/AIDS in the country and the world. Government's limited budget must be augmented by contributions from both the private and NGO sectors.
- Surveillance methodology and data collection must be improved. A reliable data-base must be established since this is an important basis for future planning and program development.
- Data analysis and research on the determinants of HIV/AIDS prevalence rates and the socioeconomic impacts of HIV/AIDS must be undertaken to improve the understanding of the disease in the context of the Philippines.
- Involve Health Care Professional societies
- Develop basic skills for HIV management and integrate HIV/AIDS education in the curriculum of medical students

The study of Monzon, et al., 1991 reveals a high prevalence of sexually transmitted diseases (*N. gonorrhoea* and *C. trachomatis* ranking as top pathogens) among male and female commercial sex workers with multiple partners, indicating the urgent need to improve the level of awareness and coverage of laboratory services necessary for better STD management and the establishment of an effective STD control program as an integral step in HIV/AIDS prevention programs.

The 1998 annual project report of the STD component of the DOH-European Union (EU) project notes a high prevalence and incidence of untreated sexually transmitted diseases in the general population. The STD prevalence was found to be high especially for asymptomatic STI such as chlamydia. There are strong indications that the majority of STI cases are being treated in the private sector through self-medication (Tadiar and Cabigon, 1999).