Philippine UX Country Report

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LIST of ABBREVIATIONS

DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOLE	Department of Labor and Employment
DSWD	Department of Social Welfare and Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GF3	Global Fund Round 3 AIDS Project
GF5	Global Fund Round 5 AIDS Project
HACT	HIV AIDS Core Team
IDU	Injecting Drug User
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
KAP	Key Affected Populations
LGU	Local Government Unit
MSM and TG	Males having Sex with Males and Transgenders
NASPCP	National AIDS STD Prevention and Control Program
NEC	National Epidemiology Center (DOH)
NEDA	National Economic and Development Authority
PLHIV	People Living with HIV
PNAC	Philippine National AIDS Council
RA 8504	Republic Act 8504 (Philippine AIDS Prevention and Control Act of 1998)
R.A. No. 9165	Republic Act 9165 (Comprehensive Dangerous Drugs Act of 2002)
SW	Sex Workers
TTI	Transfusion Transmissible Infections
UA	Universal Access
UNAIDS	UN Joint Programme on AIDS
UNFPA	UN Population Fund

EXECUTIVE SUMMARY

The Philippines is now one of the seven countries in the world to register an increase of more than 25 percent of new cases between 2001 and 2009 [1] , a clear manifestation that the country has fallen short in achieving Universal Access to HIV prevention, treatment, care, and support.

One major reason for this situation is the inadequate funding that the government has allocated for the prevention and control of HIV resulting to very limited coverage of the targeted populations. While the Fourth AIDS Medium Term Plan (AMTP IV) needed approximately US$44 million per year, only US$11.9 million or less than 27 percent, including amounts mostly secured from external sources have been spent for the program by 2010.

The current HIV situation is best articulated in the Fifth AIDS Medium Term Plan (AMTP V), to wit:

> *"To date, an average of five (5) new HIV cases per day or one (1) in every five (5) hours are reported in the country, a sharp rise from two (2) cases reported per day at the end of 2009 and one (1) reported case per day in 2007. While the national HIV prevalence remains below one (1) percent of the adult population, HIV prevalence among the most-at-risk populations (MARPs) shows a pronounced upsurge from 0.08 percent in 2007 to 0.47 percent in 2009.*
>
> *The current epidemiological profile tells us that:*
>
> - *More are infected. The 4th AMTP commenced with one reported case for every two (2) days. The 5th AMTP is commencing with one reported case for every five (5) hours, or 5 reported cases per day.*
> - *Those infected are young. The median age for persons infected with HIV is 27 years.*
> - *People infected are those in their most productive years. Reported cases are between 20 and 34 years old.*
> - *More males are infected. The mode of transmission is principally through [unprotected] male-to-male sex …"*

This report utilizes the four (4) broad obstacles to UA as the framework for measuring the country's score in achieving universal access to give the reader a clear picture of where the Philippines is in the fight against AIDS.

[1] 2010 Global Report on HIV. www.unaids.org

INTRODUCTION

At the United Nations General Assembly Special Session (UNGASS) in June 2001, 189 Member States adopted the *Declaration of Commitment on HIV/AIDS*[2]. The UNGASS Declaration of Commitment addressed global, regional and country-level responses to prevent new HIV infections, expand access to care, and mitigate the impact of the epidemic.

The *Declaration of Commitment on HIV/AIDS* provided a framework for an expanded response to the global AIDS epidemic. It detailed various strategies to address HIV and AIDS based on human rights and gender equality dimensions including around prevention of new infections; provision of care, support and treatment; reduction of vulnerability; and, mitigation of the social and economic impact of the epidemic. The agreed goals, targets and timelines facilitated monitoring and accountability of Governments as well as of the UN system and all national and international partners engaged in the national response to the epidemic. The UN General Assembly monitored and reviewed progress in realizing the UNGASS goals every two years.

In the series of consultations organized in early 2006 to set the country's Universal Access targets, Philippine government and civil society stakeholders agreed on the following operational definition of "Universal Access":

- Optimal availability and utilization of comprehensive prevention, treatment, care and support information, services and commodities by most-at-risk and vulnerable population, people living with HIV and their affected families and communities, and the general public.
- Provision of equitable and sustainable information, services and commodities to all those who need them.

In the United Nations General Assembly resolution A/60/L.43 [3] the UNAIDS Secretariat and its Cosponsors were tasked to *"assist in facilitating inclusive, country-driven processes, including consultations with relevant stakeholders, including nongovernmental organizations, civil society and the private sector within existing national AIDS strategies, for scaling up HIV prevention, treatment, care and support, with the aim of coming as close as possible to the goal of universal access to treatment by 2010, for all those who need it, including through increased resources, and working towards the elimination of stigma and discrimination, enhanced access to affordable medicines and the reduction of vulnerability ..., in particular orphaned and vulnerable children and older persons."* [4]

[2] http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html

[3] Preparations for and organization of the 2006 follow-up meeting on the outcome of the twenty-sixth special session: Implementation of the Declaration of Commitment on HIV/AIDS", 23 December 2005

[4] http://data.unaids.org/Topics/UniversalAccess/universalaccess_issues_jan2006.pdf

Following this process, governments made a commitment to scale up dramatically the AIDS response. In the 2006 UN High-Level Meeting as a follow-up on the UNGASS Declaration of Commitment, countries adopted the *Political Declaration on HIV/AIDS* (2006) and committed to provide universal access to HIV prevention, treatment, care and support services to all those in need by 2010. Both of the *Declaration of Commitment on HIV/AIDS* and the *Political Declaration on HIV/AIDS* [5] support achieving the Millennium Development Goals (MDGs), particularly MDG 6, which seeks to halt and reverse the spread of HIV by 2015. In the Philippines particularly, prevention and treatment targets were set during a UA consultation held in 2006.

The country and regional consultations that kicked off the commitment to universal access in 2006 [6] identified a number of barriers to expanding HIV programming, which can be categorized under four broad areas: (1) inadequate financing for scaled up AIDS responses (including macro-economic constraints); (2) weak human resource capacity, and health, social, and education systems; (3) lack of affordable commodities and low-cost technologies; and, (4) human rights, stigma, discrimination, and gender inequality and marginalization of key populations at higher risk. Nevertheless, countries committed to tackling these obstacles and set national targets for universal access.

Although progress has been achieved in some countries in the areas of prevention of mother-to-child transmission and the provision of antiretroviral therapy, many countries are hindered by insufficient progress in addressing the obstacles identified in the first set of country consultations, as well as the underlying social determinants of HIV risk and vulnerability.

As shown in Section IV of this report, the country has fallen short of achieving Universal Access to HIV prevention, treatment, care and support. The Philippines is now one of the seven countries in the world to register an increase of more than 25% of new cases between 2001 and 2009 [7]. This report utilizes the four (4) broad obstacles to UA as the framework for measuring the country's score in achieving universal access.

[5] http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N05/503/32/PDF/N0550332.pdf?OpenElement

[6] http://data.unaids.org/Topics/UniversalAccess/universalaccess_concept_jan2006_en.pdf

[7] 2010 Global Report on HIV. www.unaids.org

UA COUNTRY REPORT DEVELOPMENT PROCESS

The Philippines submits report to UNGASS every two years since 2003. In 2006, the country submitted a UA report containing country targets for AMTP4. Beginning in 2008, health sector UA reports, an expanded UNGASS Report, are submitted annually through WHO, UNICEF and UNAIDS.

The preparation of 2011 special report on Universal Access to HIV Prevention, Treatment, Care and Support (UA) was initiated by the Philippine National AIDS Council (PNAC) with assistance from UNAIDS Philippines and through the coordination of the Health Action Information Network (HAIN), a non-governmental organization, which is a member of the PNAC.

A core group was formed and a technical writer was commissioned to consolidate the report. The members of the core group were: Philippine National AIDS Council Secretariat (PNAC), National Economic and Development Authority (NEDA), HAIN, Pinoy Plus Association, and UNAIDS. The highlights of the UA Report were prepared by the team and such were validated during a consultative workshop with stakeholders.

The first consultative meeting with stakeholders was conducted on March 22, 2011. The UA Report highlights were further refined and then brought by the Philippine Delegation to the Regional UA Consultation held in Bangkok on March 30-31, 2011. A second and final consultative validation of the UA Report was held among stakeholders on June 3, 2011.

The complete UA country report was developed over a period of three months to ensure the accuracy of data and obtain stakeholders concurrence through a review and validation process participated in by various stakeholders from the government, civil society, and the positive community.

Four (4) aspects are monitored under the Universal Access. These are: 1) Expenditure, which reflects the commitment of the country in preventing and controlling HIV infection; 2) Coverage; 3) Behavior; and 4) HIV infection. Table 1 shows how the country fared in the prevention and control, treatment, and care in HIV and AIDS.

Table 1: Country Progress

INDICATORS	BASELINE 2006	AMTP 4 TARGETS	2010 POPULATION	2010 PROGRESS [8]	NOTES
1. EXPENDITURE	$2.8 million	$44 million		11.9 million	84% of AMTP IV unfunded
2. COVERAGE (Legend: Off track - no progress/stagnating; not monitored/no data; on track)					
A. Prevention (reached/screened)					
a. MSM	19%	60%	689,529	29%	Off Track
b. FSW	14%	60%	125,795	55%	Off Track
c. IDU	14%	60%	21,567	2%	Off Track
d. Clients of FSW	6%	60%	1,149,215	No data	No targeted intervention
e. OFW	No data	100%	5,033,933	No data	Limited intervention
f. Streetchildren	No data	45%	No data	No data	Limited intervention
g. Out of school youth	No data	45%	No data	No data	Limited intervention
h. Blood units screened	No data	250,000 units	No data	242,047 units	Off track
B. Treatment					
a. ARV - Adults & children	99%	>90%	No data	82%	Off Track
b. Tuberculosis	No data	No data	No data	80%	No target set
c. ARV-Pregnant women	100%	100%	No data	5%	Off Track

[8] 2010 Philippine UNGASS Report

INDICATORS	BASELINE 2006	AMTP 4 TARGETS	2010 POPULATION	2010 PROGRESS [8]	NOTES
3. BEHAVIOR					
A. Condom use					
a. MSM	32%	95%	689,529	32%	Off Track
b. FSW	65%	90%	125,795	65%	Off Track
c. IDU (as FSW client)	No data	85%	No data	22%	Off Track
d. IDU (as sex worker)	No data	85%	No data	11%	Off track
e. Clients of FSW	No data	60%	1,149,215	No data	Not Monitored
4. HIV INFECTION					
A. MSM	0.28% 280/100,000	<1%	689,529	0.99% 990/100,000	Prevalence quadrupled; In some sites 1-4%
B. FSW	0.16% 160/100,000	<1%	125,795	0.24% 240/100,000	Prevalence doubled
C. IDU	0.13% 130/100,000	<1%	21,567	0.21% 210/100,000	Prevalence doubled and 53% in one site
D. Clients of FSW	No data	<1%	1,149,215	No data	No data
E. Adult Filipinos (15-49 years old, both MARPs and general population)	0.008% 8/100,000	<1%	48,799,643*	0.019% 19/100,000	Prevalence is still less than 1% but doubled from baseline

Data Source: AMTP 4 Midterm Review Assessment (PNAC), IHBSS Presentations (NEC), 2006 Philippine UA Country Report (PNAC), 2010 Philippine Country Progress Report (PNAC), *UN Population Division

Table 2: Total AIDS Spending by Source, 2007-2009 (in US Dollars*)

Source	2007	2008	2009	Average	Percent
Domestic	1.61 million	1.68 million	1.7 million	1.67 million	20%
External	3.21 million	4.9 million	8.8 million	5.6 million	67%
Private	0.8 million	1.16 million	1.4 million	1.1 million	13%
TOTAL	**5.6 million**	**7.7 million**	**11.9 million**	**8.5 million**	**100%**

Notes: Figures are rounded off to the nearest thousand.
Exchange Rate: 2007 US$1 = PhP46.15; 2008: US$1 = PhP44.47; 2009: US$1 = PhP47.63)

HIV and AIDS Expenditure

The bulk of spending is from external sources. During the period 2007 to 2009, about 67 percent of the country's total resources spent on AIDS came from external sources, while 20 percent came from domestic sources.

During the same period, most of the resources went to prevention interventions (65%), followed by program management and administration (18%), and care and treatment activities (7%).

Table 3: Total Spending by Function (In US Dollars)

Function	2007	2008	2009	Average	Percent
Prevention	4.63 million	4.58 million	7.24 million	5.49 million	65%
Care and Treatment	151,406	678,635	911,317	580,453	7%
OVC	-	123,500	36,000	53,000	1%
Program Management	472,643	1.3 million	2.7 million	1.5 million	18%
Human Resources	201,227	553,194	480,059	411,493	5%
Social Protection	1,733	47,091	36,000	28,267	0.3%
Enabling Environment	56,610	164,357	255,589	158,852	2%
Research	108,000	245,000	184,744	182,571	2%
TOTAL	**5.6 million**	**7.7 million**	**11.9 million**	**8.5 million**	**100%**

Notes: Exchange Rate: 2007 US$1 = PhP46.15; 2008: US$1 = PhP44.47; 2009: US$1 = PhP47.63)

HIV Prevalence and Prevention Coverage of Key Affected Populations

Prevention coverage of key affected populations remains very low at ranges of from two percent to 55 percent when pitted against the 60 percent targeted coverage of AMTP IV.

While the rate of HIV infection in the Philippines has attained remained at the <1% target among the general population, the infection among MSM and IDUs have grown exponentially in the last year (2010). Granted that the infection among the key affected populations has not breached the <1% target, the country should be wary that among MSM, the prevalence has quadrupled since 2006, with some sites showing from 1% to 4% prevalence. Similarly, among FSWs and IDUs prevalence has doubled.

As of December 2010, the Philippine HIV and AIDS Registry shows that of the 6,015 people with HIV from 1984 to 2010, 90 percent (5,406) were infected through sexual contact, one percent (52) through mother-to-child transmission and three percent (155) through needle sharing among injecting drug users. Cumulative data show that 46 percent 2,485) were infected through heterosexual contact, 34 percent (1,849) through homosexual contact, and 20 percent (1,072) through bisexual contact. From 2007 there has been a shift in the predominant trend of sexual transmission from heterosexual contact (25%) to males having sex with other males (74%)[9].

From 1984 to 2010, there were 857 AIDS cases reported, 71 percent (610) were males. Median age was 35 years (range 1-72 years). Of the AIDS cases, there were 323 (38%) deaths during the reported period[10]. AIDS-related deaths, however, may be underreported. Pinoy Plus Association, an organization of Filipinos living with HIV, reports that most of the time families of people with AIDS pull out their patients from the hospital at the point of death to avoid stigma and discrimination.

[9] Philippine HIV and AIDS Registry, December 2010. Department of Health -National Epidemiology Center, p 3

[10] Ibid, p 2

Broad Obstacles to Universal Access (UA)

Despite the low attainment of Universal Access, the country has accomplished a number of not insignificant accomplishments in improving the response to AIDS. During the country and regional consultations that kicked off the commitment to universal access [11] in 2006, the United Nations has defined four major obstacles that countries are facing to realize universal access. These are constraints in financing; human resource capacity and health, social and educational systems; affordable commodities and low cost technologies; and human rights, stigma, discrimination, and gender equity.

Broad Obstacle 1 to UA	**Inadequate financing for scaled-up AIDS responses (including addressing the macroeconomic constraints)** Note: Refer to financial tables below as reported by the National AIDS Spending Assessment of NEDA.
2006 Baseline Status	US$2.8 million spent on HIV; the bulk of which came from external sources, mostly from GFATM.
Actions Taken by the Country since 2006	• Based on the Operational Plan of the Fourth AIDS Medium Term Plan (AMTP-IV), the financial requirements for 2007 and 2008 was about US$44 million per year. Given the average total spending of about $7 million per year, there was a funding gap of about US$37 million per year. (National AIDS Spending Assessment 2007-2009, NEDA); • While the funding gap was huge, there was an increasing trend in overall health-focused spending for AIDS from 2007 to 2009. The expenditures incurred by the National AIDS/STD Prevention and Control Program (NASPCP) of the DOH significantly increased from just US$ 0.16 million in 2007, to US$1.02 million in 2008, and to US$1.08 million in 2009. Specifically, the NASPCP spent for capacity development activities on STI management and voluntary counseling and testing (VCT), treatment services (procurement of medicines and drugs), policy formulation, among others. It should be noted that the NASPCP complemented the activities of Global Fund especially with regard to treatment and care. Hence the relatively high domestic spending on treatment and care at 17%; • There was also a steady increase in external funding as well as private sector spending.

[11] http://data.unaids.org/Topics/UniversalAccess/universalaccess_concept_jan2006_en.pdf

Current Status as of 2010	• Resources for the program have been poorly invested. Based on the 2009 National AIDS Spending Assessment undertaken by the National Economic Development Authority, 63% of 2009 AIDS spending went to prevention programs, of which more than half were spent on "high cost-low impact" prevention programs, when based on the recommendations of the Commission of AIDS in Asia . For instance, 34% of prevention expenditures went to blood safety programs when only 0.4% of total HIV cases was through blood or blood products. The country response has been largely externally funded (74% of total AIDS spending in 2009), yet prevention and treatment sustainability plans have not been developed whether by national government agencies or local government units; • The funding gap has become bigger with total funding requirement from 2011 to 2016 using the Low Scenario estimates to be around US$92 million per year. In 2010 only US$11.9 million was spent on HIV and AIDS; • There is lack of political support for the AIDS response at national and local levels. (e.g., only the Department of Health has contributed to the PNAC budget and only a small proportion of the budget has been allocated to carry out HIV and AIDS activities at the local levels); • Due to inadequate resources: coverage of targeted Key Affected Populations (KAP) is very low ; (see UA progress status) • Essential Outreach and education activities by CSOs could not be sustained.
Ways Forward to Achieve Universal Access	• The Commission on AIDS Report recommends a US$1 per capita per year expenditure for HIV prevention and control. Given the current Philippine population of 98 million, this would translate to US$98 M. annually, which obviously the country cannot fund; • A 6-year costed Operational Plan (AMTP V -2011 to 2016) is being developed to serve as a basis for financial projections to be submitted to Congress; • Advocacy to the highest political leaders and government officials for articulation of support to the HIV and AIDS national response. • Increase domestic budget allocation and spending for HIV and AIDS-related programs and interventions with the support of the Executive Branch and the President; • Ensure budget allocation and institutionalize National Response to the epidemic including budget allocation for non-health sectors like DILG, DepEd, DSWD, DOJ. This includes making available the US$0.5 million approved budget of the PNAC Secretariat as provided for in RA 8504; • Proactive promotion and marketing of the AMTP V investment plan as parameters for programming and funding assistance to international development partners; • Localize or popularize AMPT5.

Broad Obstacle 2 to UA	Constraints in Human resource capacity, and health, social, and education systems constraints
2006 Baseline Status	• Lack of human resources compounded by economic migration of trained health and education professionals overseas; • Fast turnover of trained health professionals; • No clearly defined comprehensive prevention strategies for each MARP to guide HR need.
Actions Taken by the Country since 2006	• Capacity building of health service providers: physicians, nurses, medical technologists, social workers in new treatment hubs were done under the support of GFATM; • Community Peer educators were trained in GFATM project sites
Current Status as of 2010	• HIV-trained health service professionals are limited to those working in treatment hubs and project sites supported by GFATM; • Sustainability of human resources at the LGU level remains a problem. Capacity of human resources of relevant stakeholders for program management and supervision, service delivery, monitoring and evaluation at all levels need strengthening; • Still no clearly defined comprehensive prevention strategies for each MARP to guide HR need.
Ways Forward to Achieve Universal Access	• Develop a Level of Competency based training program to build capacity of human resources essential and specific for HIV prevention among key affected populations, treatment, care and support; • Implement provisions of Human Resources for Health (HRH) Plan such as establishment of capacity building mechanism to manage HRH migration and retain HRH in the country; • Build capacities to identify and locate the sources of new infections and evaluate prevention coverage and impact; • Strengthen PNAC and the PNAC Secretariat by establishing focal units on HIV and AIDS within the Member-government agencies that will facilitate mainstreaming of PNAC's programs and activities, There is also need to restructure the Council 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, etc.

Broad Obstacle 3 to UA	Access to Affordable commodities and low-cost technologies
2006 Baseline Status	• 11 treatment hubs established across the country; • Access to ARVs, made available for free; • 32 GF3 and GF5 sites for condom distribution.
Actions Taken by the Country since 2006	• Accelerated prevention and treatment and care and support activities in 2006 to 2007; • Advocacy to 15 LGUs on 100% Condom Use Program (CUP) in 2007; • Condom promotion and distribution expanded in 16 GFATM project sites in 2010 (Total of 48); • By 2010, there are 23 health facilities that offer antiretroviral therapy and/or provide related clinical follow-up - 13 of these are public facilities, six (6) are private, health facilities, and four (4) are private individual health service providers; • Sixty-eight (68) hospitals, both public and private have trained HIV and AIDS Core Teams (HACTs); • Community and home based care services are provided by NGOs, peers, and community representatives; • Access to OI drugs; • Development of referral mechanism between LGUs and NGOs; treatment hubs and NGOs (and vice verza); facility based care and home based care; • Less than half (46 percent) of health facilities provide HIV testing and counseling services. One in 2 health facilities provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots and only 15 percent of eligible health facilities offer pediatric ART. Less than 1 percent (0.34 percent) of health facilities provides ANC services that offer both HIV testing and antiretrovirals for the prevention of mother-to-child transmission on site;[12] • 2008 program data from NASPCP - NCDPC, Department of Health, revealed a number of unmet needs: [13] » Not all who needed ART to halt the progress of the disease among those infected and to avert perinatal transmission, received the treatment; » Only 1 in 2 HIV-infected TB cases (est.) received treatment for both TB and HIV; » Only 1 in 2 HIV-infected pregnant women (est.) were assessed to determine ART eligibility through either clinical staging or CD4 testing; Less than 2 of 10 children born to HIV-infected women (est.) received an HIV test in the first year of birth;

[12] Health Sector Response to HIV/AIDS Prevention and Control The Philippines Country Report 2008, p 25

[13] Health Sector Response to HIV/AIDS Prevention and Control The Philippines Country Report 2008, p 15

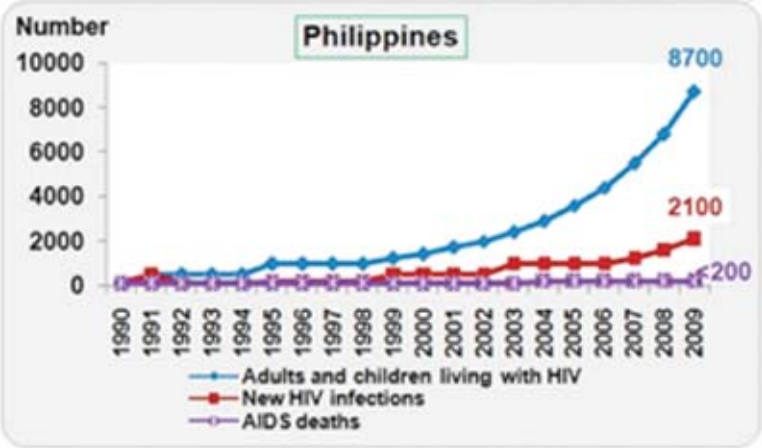
	» Only 6 of 100 HIV-infected pregnant women (est.), or 6 per hundred infants born to HIV- infected mothers received ART to prevent mother-to-child HIV transmission; » About 1 in 2 HIV-infected pregnant women received a complete course of ARV prophylaxis; and » Close to 6 out 10 adults and children with advanced HIV infection received ART (2007); » Cotrimoxazole (CTX) prophylaxis, a highly effective and affordable antibiotic shown to reduce significantly the morbidity and mortality of HIV-infected persons (WHO, UNAIDS, UNICEF, 2008) is provided to only 3 of 10 eligible adults and children. Moreover, only 6 out of 100 infants born to HIV-infected women started on CTX prophylaxis within 2 months of birth.
Current Status as of 2010	• Access to and availability of prevention commodities like condoms, OI and STI drugs and reagents, needles and syringes, and IEC materials is limited, resulting to low coverage; • Support for HIV and AIDS laboratory work - ups for PLHIVs is inadequate; • Referral mechanism between LGUs and NGOs; treatment hubs and NGOs (and vice verza); facility based care and home based care developed and functional in some sites; • Logistical sustainability at the LGU level is a problem; • No access to lubricants
Ways Forward to Achieve Universal Access	• Strengthen outreach and prevention education among MARPs by geographic priorities in view of the increasing prevalence among particular MARPs like MSM and IDUs as well as increasing coverage of the MARPs in relation to the total estimates; • Implement an effective and comprehensive package of interventions for most-at-risk populations especially the source of most new infections; • Strengthen health systems and community systems • Address sustainability in AMTP5; • Promote public-private partnerships to all facilities

Broad Obstacle 4 to UA	Human rights, stigma, discrimination, and gender equity
2006 Baseline Status	• The 1995 Administrative Order (DOH) addresses the reduction of stigma and discrimination of PHIVs by promoting IEC and social programs that fosters "a spirit of understanding and compassion for them. It also recognized their right or those suspected to have the infection to be free from discrimination or stigmatizing practices in the provision of services, employment and travel; • RA 8504 stresses the right of privacy of HIV-infected persons. HIV/AIDS facilities and all persons dealing with HIV-infected persons and their records, are mandated to observe confidentiality of records and identity of PHIVs. IEC campaigns on HIV/AIDS also include information on respecting their right of privacy and on inculcating the right attitude towards them; • Lack of mechanism to raise awareness on and to address stigma and discrimination.
Actions Taken by the Country since 2006	• Development of the Stigma Index Report, 2009; • Revision of hospital-based care guidelines to include gender sensitivity in treatment, care and support services; • Policy Statement on Drug Harm Reduction has been drafted but was freezed. Lack of a sustained and comprehensive harm reduction program is currently a huge problem due to the laws of the country.
Current Status as of 2010	• Still a challenge; no change from 2006; • No monitoring of stigma and discrimination incidence is in place; • While a Human Rights Commission exists, it is neither pro-active nor reactive towards HIV and AIDS-related cases; • Stigma and discrimination against PLHIV remain a major problem in the country. The initial findings of the PLHIV Stigma Index Report (2009) revealed that one of two PLHIV surveyed had their rights abused in the prior year of the study. Six out of ten have lost their jobs; one out of ten was denied job promotion; and a tenth was forced to change residence or denied to rent a place mainly because of their status. This is in addition to persistent reports of physical and social abuse and isolation suffered by PLHIV from family, friends, co-workers and the community. And of those who suffered abuse, most did not try to seek legal redress because either they were scared to take action, had no financial resources to do so, had no or little confidence on the outcome, or perceived the legal process to be too bureaucratic; • Absence of pro- active enforcement mechanisms to promote and protect human rights, and provide legal assistance and access to justice mechanisms for people living with HIV, most- at-risk and vulnerable populations;

	• "Ambivalent and/or Conflicting Views and Policies on Condoms and Needle Use; • The policy inconsistency between R.A. No. 8504 and R.A. No. 9165 is a major concern that must be addressed in light of the rising number of HIV infections in the country. To some extent, R.A. No. 9165 criminalizes the possession and distribution of drug paraphernalia such as needles/ syringes, thereby hampering the formulation and implementation of a sound and rational harm reduction or infection control policy for preventing HIV infection and compromising HIV-prevention initiatives to curb the impact of needle use and sharing." *(AMTP V)*
Ways Forward to Achieve Universal Access	• Sensitize health service providers, education and labor personnel and the general public on HIV and AIDS to minimize stigma and discrimination; • Implement national guidelines on treatment, care and support. For example, Guide to ARV, Pediatric Guidelines, • Develop mechanisms and guidelines for addressing HIV related human rights violations; • Amend punitive laws that block effective responses to AIDS; (e.g, laws against Vagrancy, Drug abuse and Human trafficking) and/or harmonize implementing rules and regulations of related laws and policies, • Need to establish enforcement mechanisms for the promotion and protection of human rights, provide legal assistance and access to justice mechanisms for people living with HIV, most-at-risk and vulnerable populations. • Disseminate and implement revised Guidelines for hospital-based care • Implementation of an Operations Research – IDU – in aid of developing policy on harm reduction • Confront challenges like strengthening the monitoring of human rights issues in HIV and AIDS by establishing enforcement mechanisms for the promotion and protection of human rights; and poor/inadequate provision of legal assistance and access to judicial mechanisms for PLWHA, most-at-risk populations, and vulnerable populations.

IMPLICATIONS TO COUNTRY RESPONSE

The 2010 UNAIDS Report on the Global AIDS Epidemic, reported fewer people are becoming infected with HIV and fewer people are dying from AIDS globally. However, seven countries, including the Philippines and Bangladesh, reported that between 2001 and 2009 incidence of new HIV infections has increased by more than 25%. Our epidemic is no longer low in prevalence and slow in transmission. The graph below shows the annual increase of infection from 1990 to 2009.



Source: 2010 Global Epidemic Report, UNAIDS

With the low performance in achieving Universal Access, the country needs to invest considerably in prevention and control of HIV, as the estimated financing requirement for 2011 to 2016 is US$ 587.43 million. This amount covers human resource capacity building; making affordable commodities and low cost technologies available and accessible; and outreach, education, referral and treatment services to key affected populations.

The amount, however, does not include the development and installation of systems like enabling policies to facilitate the provision of services to the targeted populations.

Moreover, the country also need to set realistic targets, implement a comprehensive package of prevention interventions, strengthen monitoring, build a pool of competent human resources and develop a capacity building plan across all sectors to enable the program to provide appropriate response.

Financing Requirements for the National Response to HIV and AIDS [14]

Costs of HIV/AIDS activities Philippines	Menu 2011	2012	2013	2014	2015	2016	TOTALs
Prevention	32.72	45.99	61.91	80.84	103.18	129.36	454.01
Priority populations							
Youth focused interventions	11.17	18.25	26.97	37.57	50.29	65.40	209.65
Female sex workers and clients	2.91	3.47	4.12	4.88	5.75	6.76	27.89
Workplace	3.50	5.68	8.18	11.07	14.36	18.12	60.91
Injecting drug users	0.04	0.06	0.07	0.09	0.09	0.10	0.45
Men who have sex with men	7.02	9.26	11.93	15.11	18.87	23.30	85.49
Migrant Workers	2.04	2.10	2.15	2.20	2.24	2.27	12.99
Service delivery							
Condom provision	2.42	3.07	3.82	4.69	5.69	6.85	26.54
STI management	0.10	0.14	0.17	0.18	0.18	0.16	0.94
VCT	0.33	0.53	0.76	1.03	1.33	1.68	5.65
Health care							
Blood safety	3.19	3.45	3.73	4.04	4.37	4.72	23.51
Care and treatment services	4.87	6.29	8.41	11.36	15.03	19.41	65.37
ARV therapy	3.28	4.23	5.65	7.62	10.09	13.04	43.92
Non-ART care and prophylaxis	1.59	2.06	2.76	3.73	4.94	6.37	21.45
Policy, admin., research, M&E	4.92	6.85	9.21	12.08	15.49	19.49	68.04
Total Millions of USD	42.52	59.13	79.54	104.28	133.70	168.27	587.43

There is a need to intensify current initiatives and mobilize resources domestically to finance current and future AIDS interventions. [15]

The Fifth AIDS Medium Term Plan 2011 – 2016 (AMTP V) presents strategies and activities to accelerate the implementation of the national response to avert new infections and provide treatment, care and support services to those who are already infected. With adequate financing and firm political will from its leaders, the Philippines would be able achieve the expected outcomes of the AMTP V which are:

1. Persons at risk for, vulnerable to, & living with HIV avoid risky behaviors to prevent HIV infection
2. People living with HIV live longer, more productive lives
3. The Country AIDS response is well governed and accountable

The AMTP V aims to realize the above outcomes through the following strategies: a) improving the quality and coverage of prevention programs for the most-at-risk, vulnerable, and living with HIV; b) improving the quality and coverage of the treatment, care, and support package for persons most-at-risk, vulnerable, and living with HIV and their affected families; c) enhancing policies for scaling up implementation, effective management, and coordination of HIV programs at all levels; and d) strengthening capacities of the PNAC and its members to oversee the implementation of the 5th AMTP.

[14] Costed Aids Medium Term Plan 2011-2016 (AMTP5)

[15] National AIDS Spending Assessment (NASA), 2007-2009, NEDA p 8

[16] http://www.pnac.org.ph/index.php?page=the-5th-aids-medium-term-plan-2011--2016

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