Philippine National AIDS Council

7th AMTP 2023–2028

PHILIPPINES:

Fast Tracking Towards 2030

7th AIDS MEDIUM TERM PLAN 2023–2028

7th AIDS Medium Term Plan 2023 - 2028
Philippines: Fast Tracking Towards 2030

December 2022

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Republic of the Philippines
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OFFICE OF THE SECRETARY

MESSAGE

The 7th AIDS Medium Term Plan 2023 to 2028 with the theme "Philippines: Fast Tracking Towards 2030" encompasses our urgent call to turn the tide of the HIV and AIDS epidemic in the country. This national strategic plan outlines a harmonized, fully resourced, and crisis-resilient HIV and AIDS response and brings together stakeholders and resources from the national, subnational, and international levels.

In 2017, the Philippines declared HIV and AIDS a national emergency. The country had the fastest-growing HIV incidence in the Western Pacific region with a 174% increase between 2010 and 2017. From an average of 31 new cases a day in 2017, the country now registers an average of 42 cases a day, or a 35% increase based on the August 2022 HIV and AIDS report. In terms of the UNAIDS 95-95-95 HIV treatment targets, the country has reached 61-65-96 accomplishments, as of June 2022. With the prevailing growth rate, indicators show that the number of HIV and AIDS cases will further increase. Hence, all the more highlighting the need for prevention.

The 7th AMTP is the country's blueprint to harmonize and concretize all actions to address the current HIV crisis along with several factors that fuel the epidemic-like social and gender inequalities, stigma and discrimination, structural barriers that prevent equitable access of key affected populations to prevention, treatment, and care, and challenges placed on health, non-health and community systems.

While outlining our priority objectives, our plan is to fast-track our responses on five strategic pillars namely: Prevent, Treat, Protect, Strengthen, and Sustain. It is only through intensified and concerted 'whole of society, whole of government' approach that we can achieve our goals and sustain the gains we now have.

The message is crystal clear: implementing a multi-sectoral national response to HIV and AIDS requires dedicated and strong leadership and management. The task of the Philippine National AIDS Council now is to establish an enabling environment necessary for effective implementation of the 7th AMTP: ensuring that the requisite inputs are identified, allocated, and utilized, maintaining focus on our shared vision of success, strengthening systems and capacities at all levels, sustaining commitment, and measuring and monitoring our progress.

The Council is committed to the effective management of HIV and AIDS responses and working across all sectors of society to achieve the 95-95-95 HIV Fast Track Goals by 2030. We look forward to the sustained support and action of the Council's government agency members, civil society organizations, private sector, development partners, and communities of people living with HIV. Truly, the DOH and PNAC shall work together to prevent an increase in cases, being able to provide a safer environment for every Juan and Juana.

Maraming salamat, para sa Healthy Pilipinas!

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Chairperson, Philippine National AIDS Council

ACKNOWLEDGMENTS

The Philippine National AIDS Council (PNAC), through the joint Policy and Planning and Monitoring and Evaluation Committees (PPC and MEC), thanks all those who have been involved in various ways in the development of the *7th AIDS Medium Term Plan (AMTP) 2023-2028- Fast Tracking Towards 2030.* .

Developing the 7th AMTP was a large-scale, collaborative effort of so many actors on so many levels. Almost 300 individuals from diverse community, local, national and international affiliations participated in the series of consultations, reviews, and validation to ensure inclusivity, comprehensiveness, and harmony of the strategic plan. Most importantly, we are grateful for the active participation of the communities of key populations of males who have sex with males (MSM), people who inject drugs and people who use drugs (PWID/PWUD), young key populations (YKP), sex workers/ people in prostitution (SW/PIP), transgender women (TGW), children, migrant workers, and people living with HIV (PLHIV) who were at the center of the entire development process.

We deeply appreciate the support of the members of PNAC from the national government agencies and civil society (collectively known as PNAC CSO Caucus) composed of the AIDS Society of the Philippines , Action For Health Initiatives, Inc., Alliance Against AIDS in Mindanao, TLF Share Collective Inc., Positive Action Foundation Philippines Incorporated, Pinoy Plus Advocacy Pilipinas (PPAPI), and Pilipinas Shell Foundation, Inc.

The assistance of DOH-Epidemiology Bureau National HIV/AIDS & STI Surveillance and Strategic Information Unit (NHSSS) ensured the accuracy of the health data from which the **Prevent and Treat** strategies put forward in the 7th AMTP were based upon. Similarly, the technical representatives of various agencies and organizations working on HIV and AIDS response throughout the country played a significant role in the crafting of the 7th AMTP.

Our gratitude also to the City Health Offices representing the local government units and the HIV and AIDS treatment hubs and testing facilities whose experiences and insights profoundly contributed to our understanding of the operational challenges on the ground.

We are grateful to our development partners for their active participation and support, namely: the Joint UN Theme Group (UNAIDS- composed of the WHO, UNICEF, UNFPA, UNDP, UNODC, and ILO) and especially the UNAIDS Secretariat, for their partnership and technical support. We would also like to acknowledge the involvement of the U.S. Agency for International Development (USAID) - Philippines and their implementing partners, such as the Palladium International, American International Health Alliance (AIHA), FHI 360, Management Sciences for Health; and the U.S. Centers for Disease Control and Prevention (CDC) Country Office in the Philippines, and International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University,

The unwavering support of Dr. Maria Rosario S. Vergeire, Officer-In-Charge of the Department of Health and Chairperson of PNAC, and principals of the members of the Council was an essential element in the successful finalization of this national strategic plan.

Special mention and thanks go to the Pilipinas Shell Foundation, Inc. (PSFI) PROTECTS (a Global Fund HIV/AIDS Grant) for the financial support of the entire process, and the AIDS Society of the Philippines who was their implementing partner for the development of the 7th AMTP.

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[1] Mandeep Kaur Ranu contributed the write up on the historical, cultural, and institutional barriers to ending the HIV epidemic in this document.

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2. Alagad	Alagad Mindanao (CSO- Representing Women in Prostitution)
3. ASP	AIDS Society of the Philippines (CSO- Representing the People who Use Drugs Sector)
4. CHED	Commission on Higher Education (Government Agency)
5. CSC	Civil Service Commission (Government Agency)
6. DBM	Department of Budget and Management (Government Agency)
7. DepEd	Department of Education (Government Agency)
8. DILG	Department of the Interior and Local Government (Government Agency)
9. DOH	Department of Health (Government Agency)
10. DOLE	Department of Labor and Employment. (Government Agency)
11. DSWD	Department of Social Welfare and Development (Government Agency)
12. HOR	House of Representatives of the Philippines, Committee on Health (Government Agency)
13. NYC	National Youth Commission. (Government Agency)
14. PAFPI	Positive Action Foundation of the Philippines, Inc. (CSO-Representing the Children Sector)
15. PIA	Philippine Information Agency. (Government Agency)
16. PPAPI	Pinoy Plus Advocacy Pilipinas Inc. (PLHIV Organization)
17. TRR	Project Red Ribbon (PLHIV Organization)
18. PSFI	Pilipinas Shell Foundation, Inc (CSO-Representing the Youth Sector)
19. SOP	Senate of the Philippines, Committee on Health. (Government Agency)
20. TLF-SHARE	The Library Foundation, Sexuality, Health, and Rights Educators Collective (CSO-Representing the MSM and Transpeople Sector)
21. Unappointed	Private org with expertise on standard setting and service delivery)

Abbreviations and Acronyms

ACHIEVE	Action for Health Initiatives
AIDS	Acquired Immune Deficiency Syndrome
AMTP	AIDS Medium Term Plan
ART	Antiretroviral Therapy
ASP	AIDS Society of the Philippines
BJMP	Bureau of Jail Management and Penology
BWC	Bureau of Working Conditions
CBS	Community-Based HIV Screening
CBO	Community-Based Organization
CHED	Commission on Higher Education
CLO	Community-Led Organization
CLM	Community-Led Monitoring
ComCHA	Committee on Children and HIV/AIDS
CSC	Civil Service Commission
CSO	Civil Society Organization
DBM	Department of Budget and Management
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOH-EB NHSSS	DOH Epidemiology Bureau National HIV/AIDS STI Surveillance and Strategic Information Unit
DOH-DPCB NASPCP	DOH Disease Prevention and Control Bureau National AIDS/STI Prevention and Control Program
DOJ	Department of Justice
DOLE	Department of Labor and Employment
DPCB	Disease Prevention and Control Bureau
DSWD	Department of Social Welfare and Development
EB	Epidemiology Bureau
EMTCT	Elimination of Mother to Child Transmission
FSW	Female Sex Workers
eHARP	Electronic HIV/AIDS & ART Registry of the Philippines
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IHBSS	Integrated HIVBehavioral and Serologic Surveillance
IRA	Internal Revenue Allotment
KP	Key Population
LAC	Local AIDS Council
LGU	Local Government Unit
M&E	Monitoring and Evaluation
MOOE	Maintenance and Other Operating Expenses
MSM	Males who have Sex with Males
NGA	National Government Agency
NGO	Non-Government Organization
NSAP	Network to Stop AIDS- Philippines
NYC	National Youth Council
OFW	Overseas Filipino Worker F

OHAT	Outpatient HIV AIDS Treatment (Package of PhilHealth)
PAFPI	Positive Action Foundation Philippines, Inc
PDL	People Deprived of Liberty
PDEA	Philippine Drug Enforcement Agency
PEP	Post Exposure Prophylaxis
PIP	People in Prostitution
PLHIV	People Living with HIV
PNAC	Philippine National AIDS Council
PPATH	Philippine Professional Association for Transgender Health
PrEP	Pre-exposure Prophylaxis
PSFI	Pilipinas Shell Foundation, Inc.
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RA 11166	Republic Act 11166: "The Philippine AIDS Policy Act"
RA 9165	Republic Act 9165: "Comprehensive Dangerous Drugs Act of 2002"
rHIVda	Rapid HIV Diagnostic Algorithm
SDN	Service Delivery Network
SHC	Social Hygiene Clinic
STI	Sexually Transmitted Infection
TESDA	Technical Education and Skills Development Authority
TGW	Transgender women
TLD	Tenofovir, Lamivudine, Dolutegravir
UHC	Universal Health Care
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
TRR	The Red Ribbon
WHO	World Health Organization
YAFS5	2021 Young Adult Fertility and Sexuality Survey (5th)
YNEET	Youth who are Neither in Education, Employment or Training
YKP	Young Key Population
VL	Viral Load

Definition of terms

Child-in-Conflict with the Law (CICL)	Refers to a child who is alleged as, accused of, or adjudged as, having committed an offense under Philippine laws (as defined under RA 9344) A child in conflict with the law is a person who at the time of the commission of the offense is below eighteen years old but not less than fifteen (15) years and one (1) day old.
Civil Society Organization Caucus	The collective name for the members of PNAC from civil society organizations representing HIV key population sectors.
Combination prevention	Defined as the combination of HIV prevention as rights-, evidence-, and community-based programs that promote a combination of biomedical, behavioral, and structural interventions designed to meet the HIV prevention needs of specific people and communities (UNAIDS, 2021)
Community-led monitoring	Is a process of collecting community feedback on the quality, accessibility, availability, and acceptability of services that will be stored, analyzed, and utilized for service improvement and advocacy for better programs and policies; collects experiences of stigma and discrimination, and other human rights violations; a tool that can contribute to the accountability of government and NGO stakeholders
Community systems	Community-led structures and mechanisms used by communities through which community members, CBO,and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Many community systems are small-scale or informal. Others are more extensive – they may be networked between several organizations and involve various subsystems. For example, a large care and support system may have distinct subsystems for comprehensive home-based care, providing nutritional support, counseling, advocacy, legal support, and referrals for access to services and follow-up. (Global Fund - Community Systems Strengthening Framework, 2014)
Community systems strengthening (CSS)	CSS is an approach that promotes the development of informed, capable and coordinated communities, and community-based organizations, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at the community level, including an enabling and responsive environment in which these contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations, communities, and CBO in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis,

	malaria and other major health challenges. (Global Fund- Community Systems Strengthening Framework, 2014)
Concentrated epidemic	A disease has spread rapidly in one or more populations but is not well established in the general population; typically, the prevalence is over 5% in sub-populations while remaining under 1% in the general population, although these thresholds must be interpreted with caution; in a concentrated HIV epidemic there is still the opportunity to focus HIV prevention, treatment, care, and support efforts on the most affected sub-populations, while recognizing that no sub- population is fully self-contained
Crisis-resilient	The ability of a system, community or society exposed to hazards to resist, absorb, accommodate and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.
Differentiated service delivery (DSD)	DSD, previously referred to as differentiated care, is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences, expectations, and needs of people living with and vulnerable to HIV, while reducing unnecessary burdens on the health system. (https://differentiatedservicedelivery.org › about_DSD)
Disaster or crisis	Is a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources. Disasters are often described as a result of the combination of: the exposure to a hazard; the conditions of vulnerability that are present; and insufficient capacity or measures to reduce or cope with the potential negative consequences, Disaster impacts may include loss of life, injury, disease and other negative effects on human, physical, mental and social well-being, together with damage to property, destruction of assets, loss of services, Social and economic disruption and environmental degradation.
Discrimination	Is the behavioral manifestation of stigma; occurs when individuals or institutions unjustly deprive others of their rights and life opportunities due to stigma; it may result in the exclusion or marginalization of people and deprive them of their human rights, such as access to health services, fair housing options, opportunities for employment, education, and full participation in civic life.

Duty bearers	These are institutions (e.g. the State and the government functionaries, private service providers, etc.) and people within these institutions, agencies and offices (e.g. police, health workers, employers, etc.) who have power and resources. Non-state duty bearers are institutions or organizations providing services.
Enabling environment	There are different kinds of enabling environments in the context of HIV; an enabling legal environment is one in which laws and policies against discrimination on the basis of HIV status, risk behavior, occupation, and gender are in place and are monitored and enforced; an enabling social environment is one in which social norms support healthy behaviors and choices.
Epidemic burden	Refers to the median HIV case:population ratio; in the Philippines, it is used to describe the burden in selected geographic areas and is further categorized as: A: high burden areas with a median HIV case: population ratio of 10.5 per 10,000; B: middle burden areas with a median HIV case: population ratio of 4.8 per 10,000; and C: low burden areas with a median HIVcase: population ratio of 2.0 per 10,000
Health system	Consists of all the organizations, institutions, resources and people whose primary purpose is to improve health.This includes efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, promotive, and curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care by both State and non-State actors. The actions of the health system should be responsive and financially fair, while treating people respectably. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction to function. Strengthening health systems thus means addressing key constraints in each of these areas. (https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf)
HIV care cascade	Is the HIV continuum of care starting from prevention, diagnosis, enrolment to treatment and adherence until the PLHIV is virally suppressed.
Human rights	All the rights and freedoms one has as a human being based on human needs; they are usually set out in a constitution, bill of rights, or law.

Individual-based health services	Refers to services that can be accessed remotely or within a health facility can be definitively traced back to one recipient.
Integrated services	Health services managed and delivered so people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, and rehabilitation and palliative care services, coordinated across the different levels and sites of service delivery within and beyond the health sector, and according to their needs throughout the life course. People may receive all or some elements of one service incorporated into the regular functioning of another service.(Integration of Mental Health and HIV Interventions p3)
Key Populations (KP)	Groups of people who are particularly vulnerable to HIV and lack access to adequate healthcare; the Joint United Nations Programme on HIV and AIDS (UNAIDS) considers male who have sex with male (MSM), sex workers and their clients, people who use/inject drugs (PWUD/PWID), and transgender women as the four main groups at risk of being exposed to HIV and at risk of discrimination, stigma, and unfair treatment in society.
Mental health	Mental health includes our emotional, psychological, and social well-being. It affects how people think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. (https://www.cdc.gov/mentalhealth/learn/index.htm#:~:text=What%20is%20mental%20health%3F,others%2C%20and%20make%20healthy%20choices).
Non-health (social determinants of health)	Refers to non-medical factors that influence health outcomes; these are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.
Population-based health services	Refers to interventions like health promotion, disease prevention, and vector control that address population wide-concerns.
Rights-based approach	Means that duty bearers (national and local government institutions, international cooperation mechanisms) provide what rights-holders (people, communities) need to sustain their lives. It means that all people regardless of age, gender, race, class, disability, neurodivergence, etc., deserve food, clothing, shelter, leisure, work, and rest–all the basic ingredients for a dignified and fulfilling life just by virtue of being born and existing in this world. This document is what PNAC and HIV SDNs need to always go back to for guidance on their work. The standards for measuring that the rights-based approach is happening are what is

	called AAAQ of programs and services: - Accessibility, Availability, Acceptability, and Quality. (source: CLM)
Rights holders	Refers to a country's citizens, each of whom should enjoy rights regardless of their socio-economic, physical, and cultural situation.
Stigma	Refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as being different; it also refers to negative labeling or attitudes towards someone because they are seen as belonging to a particular group.
Viral load	Refers to the amount of HIV in the blood.
Viral load test	Viral load tests measure the amount of HIV's genetic material in a blood sample. The results of a viral load test are described as the number of copies of HIV RNA in a milliliter of blood. (https://www.aidsmap.com/about-hiv/viral-load)
Vulnerable populations	In the Philippines, they include migrant workers, people in closed settings, people with disabilities, and partners of KP, women, and children.
Young key population	Refers to young populations between the ages of 10 to 24 years old engaging in behaviors that put them at risk for HIV infection including but not limited to adolescents, young MSM, transgender people, PWUD/PWID, sex workers/people in prostitution.

EXECUTIVE SUMMARY

The AIDS Medium Term Plan is the country's guide for strategic HIV response. The document is written in accordance with the latest internationally and locally approved frameworks, policies, and conventions surrounding the HIV and AIDS epidemic in the Philippines. Each plan runs for six years and is ideally evaluated towards the end of the 6th year to inform the development of the next medium-term plan.

The "7th AIDS Medium Term Plan- 2023 to 2028 Philippines: Fast Tracking to 2030" addresses the gaps identified in the 6th AMTP's evaluation in addition to strategies that were agreed upon in a series of consultations by stakeholders to fast track the country's share to its global commitment to end AIDS by 2030.

The 7th AMTP is a "catch up to the catch up plan that was derailed by the COVID 19 pandemic. The high level targets of the 7th AMTP are linked to the promise of the Declaration on HIV and AIDS: Ending Inequalities and Getting On Track to End AIDS by 2030 (June 2021):

PREVENT	TREAT	PROTECT	STRENGTHEN	SUSTAIN
95% of 10 to 24-year-old key populations have basic knowledge on HIV transmission and prevention Prevent new infections, especially among 10 to 24-year-old key populations Eliminate mother-to-child transmission	95% of PLHIV know their status 95% of PLHIV who know their status are on ART 95% of PLHIV on ART have suppressed viral loads	Less than 10% of PLHIV and KP experience stigma and discrimination Less than 10% of PLHIV and KP experience gender inequality and violence	Responsive governance strengthened Harmonized and crisis-resilient multi-sectoral response	Fully-resourced and sustainable HIV response

Achieving these targets requires a robust shift in the thrust of the response, accelerating the creation and/or enhancements in the enabling environment, and renewed and active commitment from key actors and collaborating stakeholders.

SIGNIFICANT SHIFTS IN THE 7th AMTP

1. Emphasis on mobilization of financing for HIV from different sources, particularly in identifying where these resources are lodged and how to move these to cover the funding requirement of the 7th AMTP.
2. Strengthening governance and accountability of PNAC, its individual members, committees, and Secretariat and through setting up governance and accountability mechanisms from the national, regional, local levels. National government agencies and local government units are principal accountable stakeholders in the response.
3. Adoption of the Life Cycle (or Life Stage) Approach to HIV and AIDS Prevention and Control including gender- and age-specific interventions.
4. Expansion of prevention and treatment coverage of young key populations to include young people at risk from age 10 to 24
5. Intensification of the Combination Prevention strategy
6. Adoption of the person-centered principle through the differentiated service delivery across prevention, testing and diagnosis, treatment, and viral suppression stream of the HIV care cascade, including integration of mental health interventions for PLHIV, KP and vulnerable populations, and a package of services for aging and elderly PLHIV
7. Capacity building of HIV response actors.
8. Harnessing the reach and expertise of CSOs and community-led organizations and funding their HIV and AIDS initiatives.
9. Framing the HIV service delivery at ground level to align with the Universal Health Care Act of 2019.
10. Rationalization of policies and procedure impacting the response.
11. Strengthening the National HIV and AIDS Monitoring and Evaluation System and that of the 7th AMTP's itself, including the creation of an AIDS Data Hub.
12. Harmonizing and/or aligning the individual responses of national, subnational, local, and development partners to share in the fulfillment of the 7th AMTP.

To fulfill the above, the 7th AMTP carries five (5) Strategy Pillars with distinct but interconnected sub-strategies details of which shall be fleshed out in an all- stakeholder-wide operational planning in first quarter of 2023. The five (5) strategy pillars, namely:

PREVENT new infections among key and vulnerable populations including adolescents and pregnant women	**TREAT** people living with HIV and improve their health outcomes and well-being	**PROTECT** the rights of PLHIV, KP, and people at risk of HIV	**STRENGTHEN** governance and leadership accountabilities, and systems for health, non-health, community and strategic information, and	**SUSTAIN** the harmonized, rights-based, fully resourced and crisis-resilient HIV response

They are intertwined and interdependent. An improvement, whether in the form of enrichment, refinement, revision, or amendment to policies, procedures, implementation protocols, leadership and governance, coordination and collaborative mechanisms, crisis-resiliency, and financing will contribute to the overall strengthening of the HIV response machinery.

I. The Variables at Play in the National HIV and AIDS Response of the Philippines

A. The Global HIV and AIDS Situation

Human immunodeficiency virus (HIV) weakens the immune system by destroying vital cells that fight disease and infection. According to the most recent scientific evidence, HIV has been around since the 1800s and has been present in the United States since at least the mid to late 1970s (CDC, 2022).

It became a full-fledged epidemic by 1982 (NPIN, 2022), but it was not only because of how the virus behaved in and among humans. Fear, stigma, and ignorance also fueled the epidemic. (WHO, n.d.). By 1985, the United Nations had found that each region of the world had at least one HIV case (NPIN, 2022).

Effective HIV prevention, diagnosis, and treatment were unavailable at the start of the pandemic, resulting in the loss of so many lives. Over the last 30 years, treatment innovations have greatly improved the quality of antiretroviral (ARV) medicine around the world. Since 1995, antiretroviral therapy (ART), a combination of ARV medicines for the suppression of HIV in the body, has been shown to be effective in preventing AIDS and maintaining the physical health of people living with HIV (Forsythe et al., 2019). Access to and effectiveness of ART improved dramatically worldwide beginning in the 2000s. Single-tablet regimens replaced multiple daily doses. Treatment side effects were dramatically reduced, limiting regimen changes and drug resistance while improving the quality and length of life for people living with HIV (Forsythe et al., 2019). While there is currently no functional cure for HIV, research is ongoing alongside further advancements in treatment.

Despite the achievements, there are still big obstacles to overcome. HIV continues to be a major global public health issue, having claimed an estimated 40.1 million lives so far. In 2021, an estimated 650,000 people died from HIV-related causes, and 1.5 million acquired HIV.[2] According to the World Health Organization (WHO), the world will need to redouble its efforts to avoid the worst-case scenario of 7.7 million HIV-related deaths over the next ten years and increasing HIV infections due to HIV service disruptions during COVID-19 and the slowing public health response to HIV to reach the global 95–95–95 targets.

States committed to the "Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030" adopted during the General Assembly High-Level Meeting on AIDS in June 2021 to achieve the 95-95-95 HIV Fast Track Goals by 2030. It is imperative that from 2022 onwards, the Philippines, along with other UN member states, step up its prevention, testing, treatment, and adherence efforts. Equally important is the improvement of the enabling environment through strengthened governance, policies, systems, financial sustainability, and community engagement. It is recommended that the country re-calibrate its targets on a year-to-year basis to achieve the following by 2030:

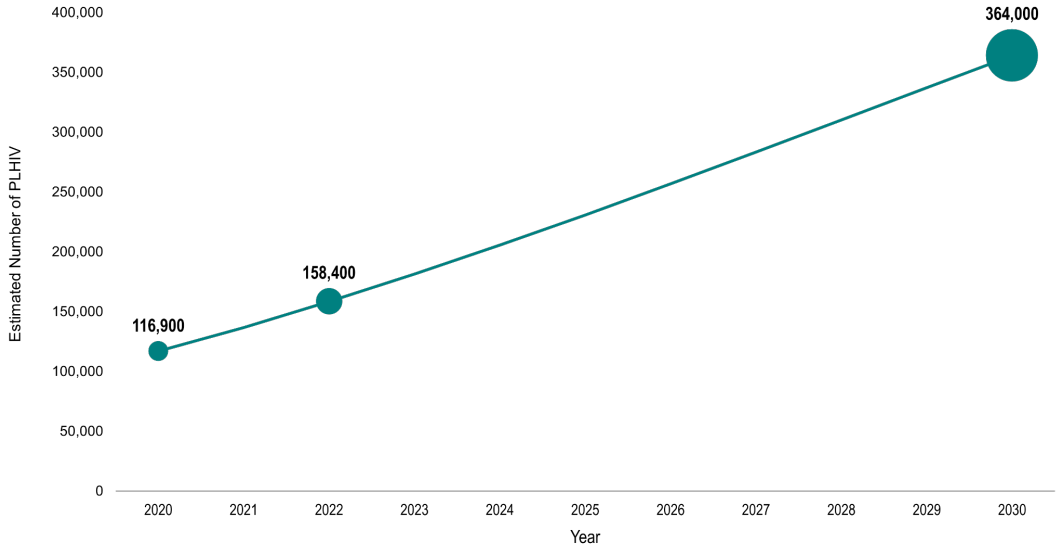
Targets	Results
1. diagnose 95% of all HIV-positive individuals	95% of those living with HIV to know their status
2. provide antiretroviral therapy (ART) for 95% of those diagnosed	95% of those who know their status to be on treatment
3. achieve viral suppression for 95% of those treated	95% of those on treatment to be virally suppressed.

[2] https://www.who.int/news-room/fact-sheets/detail/hiv-aids

B. Philippine HIV and AIDS Situation

The Philippines has one of the fastest growing HIV epidemics in the Western Pacific region (Cousins, 2018) and the world. A 327% increase in annual new HIV infections was observed in the country from 2010 to 2021. Data from the National HIV/AIDS and STI Surveillance and Strategic Information Unit (NHSSS, 2022) of the DOH Epidemiology Bureau show that the estimated PLHIV in 2022 (158,400) is projected to increase by more than two-fold by 2030 (364,000).

Figure 1: Estimated number of people living with HIV, 2020-2030 (DOH-EB & UNAIDS, 2022)



1. Populations at risk for HIV

The Philippine HIV epidemic remains concentrated among key and vulnerable populations who are at high risk for HIV infection. In 2022, majority (92%) of new infections are among KP, including males having sex with males and transgender women (MSM & TGW), sex workers which include trafficked women and girls who are forced to engage in transactional sex, and people who inject drugs (PWID). Moreover, almost half (47%) of new infections in 2022 is among the young key population (YKP) ages 10-24 years old.

Vulnerable populations include migrant workers, people in closed settings, people with disabilities, and female partners of KP. It is important to note that 25 percent of MSM and 68 percent of PWID have female partners (IHBSS, 2015.), resulting to emerging and increasing new HIV infections among pregnant women.

Based on the findings of the 2018 Integrated HIV Behavioral and Serologic Surveillance (IHBSS), practice of risky behavior among MSM and TG starts early. MSM and TGW start to engage in sex at a median age of 16 years old and had their first anal sex with a male at 17 years old. However, protective behavior starts later. Condom use starts two years after their first anal sex at 18 years old, and MSM & TGW had their first HIV testing at a median age of 20 years old. Further, 10% of the MSM & TGW had their first sex even before reaching 12 years old**. It should be noted here that for many, particularly those below 15 years old, their first sex was non-consensual (RM NOTE: INSERT CWC DATA)**

Eighty-two percent (82%) of diagnosed cases from 1984 to September 2022 are among MSM and TGW. This is why many efforts under the national HIV response have been geared towards this key population. The majority of reported cases in recent years are still among MSM.

However, diagnoses among females, including pregnant women, have also been increasing. Newly diagnosed females rose in number from 124 in 2010 to 659 in 2019 and 548 in 2021. From 2011 to September 2022, a total of 696 HIV positive females were reported pregnant at the time of diagnosis.

Moreover, a total of 2,468 cases among people who inject drugs (PWID) had been diagnosed from 1989 to September 2022, and almost all were from Cebu. Newly diagnosed cases per year among PWID had been increasing from 137 in 2010 to 376 in 2016, but a decreasing trend has been observed since (from 376 in 2016 to 137 in 2019, and 96 in 2021) the country's "war on drugs" started. While diagnosis among PWID has decreased in recent years, it was observed that of the diagnosed cases from 2016 to September 2022, 3% had a history of injecting drug use behavior, including among other key populations such as MSM, and was noted to be present across all regions in the country, indicating that this behavior is not limited in Cebu.

In addition to PWID, there had been 5,310 diagnosed cases with history of accepting payment for sex (be it regularly accepting, occasionally, or only once) since 2012, the year when reporting of this risk behavior started to be included in HARP. Most (94%) of these cases were males, and age at diagnosis ranged from as young as 12 years old to 68 years old.

Focusing on female sex workers (FSW), data from the 2018 FSW IHBSS (mostly among registered FSW) show that HIV prevalence was at only 0.1%. However, it was noted that risk behaviors among this KP persist, such as drug use (24% ever used drugs, and 8% used drugs in the past 12 months), condomless sex (15% did not use condom with their last client, and 36% did not use condoms consistently with their male clients in the past 30 days), and nearly 2 in 5 (19%) experienced having sex against their will.

2. HIV Burden by Geography

Aside from the Philippines having a concentrated HIV epidemic among key populations, the burden of the HIV epidemic also varies by geographic areas across the country. All cities and municipalities in the country are classified into three main categories (Category A, B, and C) depending on the magnitude of their local HIV epidemics.

Category A sites are high-burden cities and municipalities (118) with a 10.5 case-population ratio[3], Category B are middle-burden sites with 4.8 case-population ratio*, and Category C sites are low-burden sites with 2.0 case-population ratio*. There are also specific areas in the Philippines with a unique epidemic such as in the National Capital Region (NCR), Cebu province and Cebu City (among PWID), and in Angeles (among FSW).

Looking at the estimated PLHIV by category, the largest epidemic is expected to come from NCR from 2015 to 2025; however, estimated PLHIV in Category A and B sites are also projected to overtake that of NCR by 2026 and 2029, respectively. While it should be noted that the relatively larger populations for Category A and B contribute to the increasing projections, there are also varying levels of effort across sites where we note how current interventions and support have been greatly focused on higher burden sites such as NCR and Category A. It is then highlighted how we should continue to maintain and

[3] *per 10,000 population*

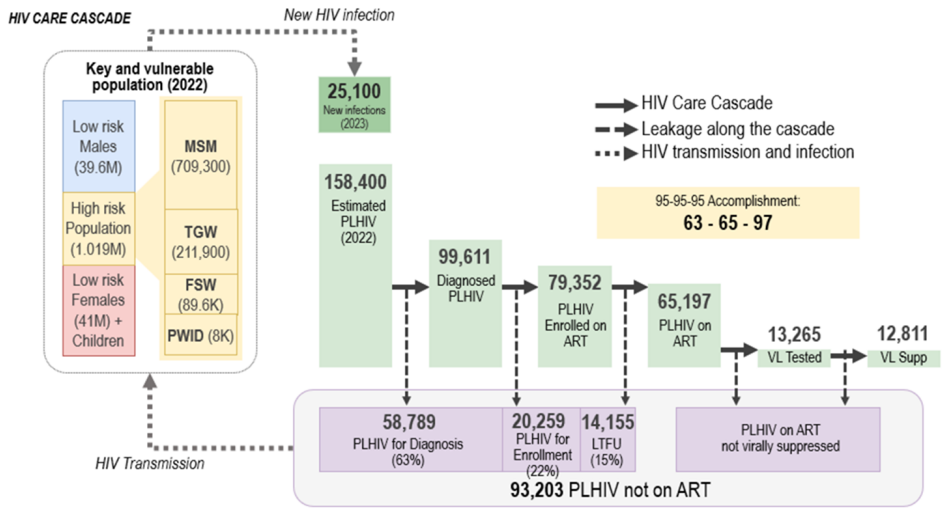
strengthen our interventions in these high burden sites, while in parallel, also expand and improve support and interventions to other relatively lower burden sites like Category B & C.

3. HIV Care Cascade

As of September 2022, progress towards the 95-95-95% targets is at 63-65-97 (with 20% VL testing coverage among PLHIV on ART). Among 158,400 PLHIV by the end of 2022, 63% (99,611) have been diagnosed, of which, 65% (65,197) are alive and on treatment. Among PLHIV on ART, 20% (13,265) were tested for viral load, of which, 97% (12,811) were virally suppressed.

Further looking into the cascade, gaps exist which hinder us from achieving the 95-95-95 targets. There are 58,789 PLHIV who are not yet diagnosed. Among the diagnosed cases, 20,259 are yet to be enrolled to treatment and among those who were enrolled, 14,155 were lost to follow-up and were currently not on ART as of the reporting period. These gaps bring the total PLHIV not on ART to 93,203. The leakages along the cascade, if left unaddressed, can continue to contribute to the ongoing HIV transmission among key and vulnerable populations which will account for the 25,100 new HIV infections in 2023.

Fig 2: National HIV Care Cascade as of September 2022



Source: AIDS Epidemic Model (AEM)-Spectrum, May 2022
HIV/AIDS & ART Registry of the Philippines, September 2022

**The total number of PLHIV not virally suppressed could not be determined at the time due to low VL testing coverage*

As of 2021, There are 91 treatment hubs, 260 SHCs/Primary Health Care, 27 Certified rHIVda confirmatory laboratories, and 833 testing facilities categorized as "Others" doing HIV testing (Source: DOH-EB STIR UP 2021 Briefer)

4. Impact of COVID-19 on the HIV and AIDS Response

When the COVID-19 pandemic hit, the national HIV response was negatively impacted. Prevention coverage among MSM & TGW decreased from 26% in 2018 to 17% in 2020. **Condom use decreased**

from 38% in 2018 to 36% in 2020. **HIV testing decreased** by 61% (2019: 1,216,678; 2020: 477,965). **HIV diagnosis decreased** by 37% (2019: 12,733; 2020: 8,036), **treatment enrollment decreased** by 29% (2019: 11,894; 2020: 8,474), and **treatment coverage among estimated PLHIV decreased** by 2% from 2019 to 2020 which was previously, at 4-5%.

5. Historical, Cultural, and Institutional Barriers to Ending the HIV Epidemic

Consultations with KP communities surfaced countless challenges to ending the HIV and AIDS epidemic. Upon closer analysis, it was seen that underlying the challenges are historical, cultural, and institutional barriers resulting in multiple intersecting vulnerabilities that together drive the HIV and AIDS epidemic in the Philippines.

First is the cultural and religious taboo on sex, gender, and sexuality, brought to our shores by western colonizers that has forced us to look at gender diversity and sexually transmitted infections as moral issues rather than facts of life. This is the root of HIV and PLHIV stigma. This taboo has also kept us from inquiring into gender and sexuality matters since childhood, alienating us from our own bodily instincts and undermining the importance of sexual health when it comes to people's well-being.

This taboo is hinged largely on **cisheterosexist social norms**[4]. In our society, we are classified into two (2) distinct sex categories of male or female, based on a visual examination of underdeveloped external genitalia. This is despite the latest scientific evidence proving that sex is, and has always been, a spectrum[5] determined based on at least four more factors than just genitals namely: "chromosomes, gonads, sex hormones, and secondary sex physical features emerging from puberty" (IOM, 2020). People are usually assigned a sex at birth without examination of these other four characteristics.

Society is structured to accommodate people who affirm their sexes assigned at birth by performing its corresponding gender expression - masculine for males and feminine for females and sexual orientation - heterosexuality. This is not usually a problem for cis people whose lived gender identities luckily matched their sex assigned at birth or heterosexual people who luckily don't feel any attraction towards the "same sex". Because of this, cisheterosexual people can get support from their families, education, jobs, recognition, and gender affirmation with much more ease than their trans and gender non-conforming peers.

Women, including cis women, are also impacted negatively by this, as cisheteronormativity dictates male dominance and female subservience. Male sexuality is celebrated (as long as its cis and hetero) while women's are policed. Those who are seen by society as deviants from these norms are policed back into their assigned categories through discrimination, violence, and in extreme cases, death.

Gender diversity and fluidity is a historic, scientific, and readily observable fact. Women and gender-nonconforming people have a joint interest in changing norms around gender and sexuality designed to invalidate its diversity and fluidity. The recognition of gender diversity must come with structural changes that would enable those who have been previously disregarded and disadvantaged to have a safe and secure place in society. Unlearning cisheteronormativity by key social actors such as government

[4] Cisheterosexism is the societal and institutional privileging of heterosexuality, cisgender identity, and binary sex assignment as the norm. As a result, many people who begin to recognize feelings of attraction or identification that do not align with those expectations experience a sense of dissonance. https://lgbtq.unc.edu/resources/exploring-identities/coming-out/#:~:text=Cisheterosexism%20is%20the%20societal%20and,experience%20a%20sense%20of%20dissonance.

[5] The sex spectrum is the concept of a continuum of people with sexes ranging from people with typical male physiology to people with typical female physiology. https://web.archive.org/web/20201103114503/https://www.usd.edu/diversity-and-inclusiveness/office-for-diversity/safe-zone-training/spectrum-model

institutions, schools, media, churches, families, and other institutions that make up society is crucial to addressing this barrier.

Second is the **lack of recognition of intersectionality of KP identities and concerns**. The Philippine HIV epidemic is characterized as a concentrated epidemic, which is why KP at risk for HIV infection were identified and targeted as recipients of HIV services. But KP belong to different sectors of society and their identities are not always clear cut - there are MSM sex workers, pregnant persons who use drugs, transmen who have sex with men, and countless other permutations and movements along the lines of identities and behaviors among KP. Understanding intersectionality is key in determining which situations, learned behaviors, and shared beliefs actually contribute to risk of infection.

Intersectionality (Crenshaw, K.W. (2017)) is a lens that lets us see individuals as multi-faceted human beings who contain different identities. In societies where some identities are more marginalized than others such as ours, this results in compounded vulnerabilities. This means that a sexually active **Filipino/a/x** trans woman who has sex with men, for example, is not just vulnerable to HIV infection because of her sexual behavior. There are also vulnerabilities that come with being a woman and being trans such as less access to education, resources, and opportunities. Intersecting identities mean intersecting vulnerabilities.

This means that programs for MSM for example, must not just be designed with middle-class able-bodied MSM with social and economic resources in mind, but must be accessible for MSM with disabilities, pregnant MSM, transMSM, urban poor MSM, indigenous MSM, etc. Vulnerabilities of KP also intersect with others such as poverty, land/homeslessness, unemployment, and disability as access to correct and up-to-date information, testing, treatment, and care services is still being impeded by these socio-economic issues. Addressing these issues assigned to the country's non-health sector is crucial to addressing the HIV epidemic.

Third is the **criminalization of drug use, transactional sex, and abortion.** Decriminalization is crucial to eliminating risks of HIV and STI transmission.

Criminalized KP such as PWUD/PWID, sex workers, PIP, CICL, PDL, and persons who sought/may seek abortion are unable to represent themselves or advocate for their needs and concerns because they are criminalized under current laws.

The country's War on Drugs characterized by unlawful arrests and extrajudicial killings is expected to continue, stirring fear among criminalized populations, especially PWUD/PWID and excluding them from public processes that would affect them. This is despite long-standing biological, chemical, and social science evidence pointing to social inequality, economic instability, and absence of support that leads to the harmful effects of substance abuse. Criminalization of the use of some drugs has also kept the country from crafting harm reduction programs such as syringe exchange for PWUD/PWID which have been proven effective globally in maintaining the well-being of people who use drugs. It also remains a barrier for wide-impact community organizing.

While they differ in their analyses of transactional sex, criminalization has impacted both **sex workers and people in prostitution negatively.** They also agree that when it comes to health and well-being, social protection programs such as housing, livelihood, and education are more effective in addressing transactional sex more than criminalization.

People who seek abortions need to be given the same HIV services given to pregnant people who want to carry their pregnancies to term because both are results of unprotected sexual fluid exchange. But

because abortion is criminalized, people who have had or are seeking to have it done are effectively excluded from potentially life-saving health intervention, not to mention counselling and other support they need.

C. The 6th AIDS Medium-term Plan (2016-2022) Evaluation Results

The AIDS Medium-Term Plan is the country's implementation guide for HIV response. The document is written in accordance with the latest internationally and locally agreed upon frameworks, policies, and conventions surrounding the HIV and AIDS epidemic.

The achievement of the deliverables of the AMTP was dependent, to a large extent, on how well the Philippine National AIDS Council (PNAC) performed its mandate and how well it was supported by its Secretariat. Thus, a major part of the evaluation looked closely at the performance of the Council as a collective body, the performance of individual members, and the performance of the PNAC Secretariat in supporting the work of the council.

The 6th AMTP is a product of many minds, evidence-based , well-planned, and well written. It is inclusive, the most widely consulted so far and validated with various stakeholders. It was synergized with and informed other strategic plans such as DOH's Philippine Health Sector's Strategic Plan for HIV (2015-2022), NYC's Philippine Youth Development Plan (2017-2022), and the MSM and TG Comprehensive Plan (2017-2022). The Philippine AIDS Epidemic Model (AEM), a modeling tool that can support the decision-making process of countries with low and concentrated epidemics through estimation and measurement of past and future HIV programs, was interfaced with the two processes that facilitated the decision on setting 6th AMTP targets. A panel of experts then reviewed the technical soundness of the document.

The greatest achievement of the 6th AMTP was the passage of Republic Act 11166 and the approval of its IRR.

The 6th AMTP could have achieved more if its implementation has been guided more closely by PNAC through the envisioned implementation mechanism of strategic clustering of Education, Health, Social Protection, and Finance. Likewise, monitoring of the implementation would have been facilitated had the Council been provided better and adequate support by its Secretariat. The implementation mechanism recommended by the 6th AMTP was not formed, thus there was no categorical and official assignments of the cluster technical experts. The PNAC secretariat was not able to do its role effectively. As the workhorse of the Council, it is supposed to provide staff work in ensuring oversight of the overall HIV response

PNAC as a body was not able to steer the implementation of the national strategic plan due to:

1. Absence of costed operational plan
2. Absence of the M&E plan
3. Lack of official assignments of cluster technical experts
4. Limited budget for the council operations itself
5. Limited engagement with key populations being represented
6. Indirect representation of key populations in the council
7. Weak support of the PNAC Secretariat because the new law made the PNAC an attached agency of the DOH which pulls it out of the administrative control of the latter. The PNAC Secretariat has to set up a new set of human resource requirements.

These resulted in an uncoordinated and unmonitored implementation of the 6th AMTP.

D. The Status of HIV Financing

Studies made by health economists point to the conclusion that funding estimates to reach the 95-95-95 target is at Php 32.3 billion from 2021-2023, with 43% allotted for prevention, 8% for testing, and 48% for treatment-related expenditures (DOH, 2021a). Of this amount, 94% is expected to come from domestic sources (with 41% coming from the national government, and 34% from PhilHealth reimbursements) and 6% from external sources. The share of donor funding for the HIV program has been relatively flat and is not expected to increase substantially. An assessment of resources from different funding channels reveal that the total commitment and anticipated resources is only 40% of the financing requirement, resulting in a 60% funding gap at the national level (DOH, 2021a)

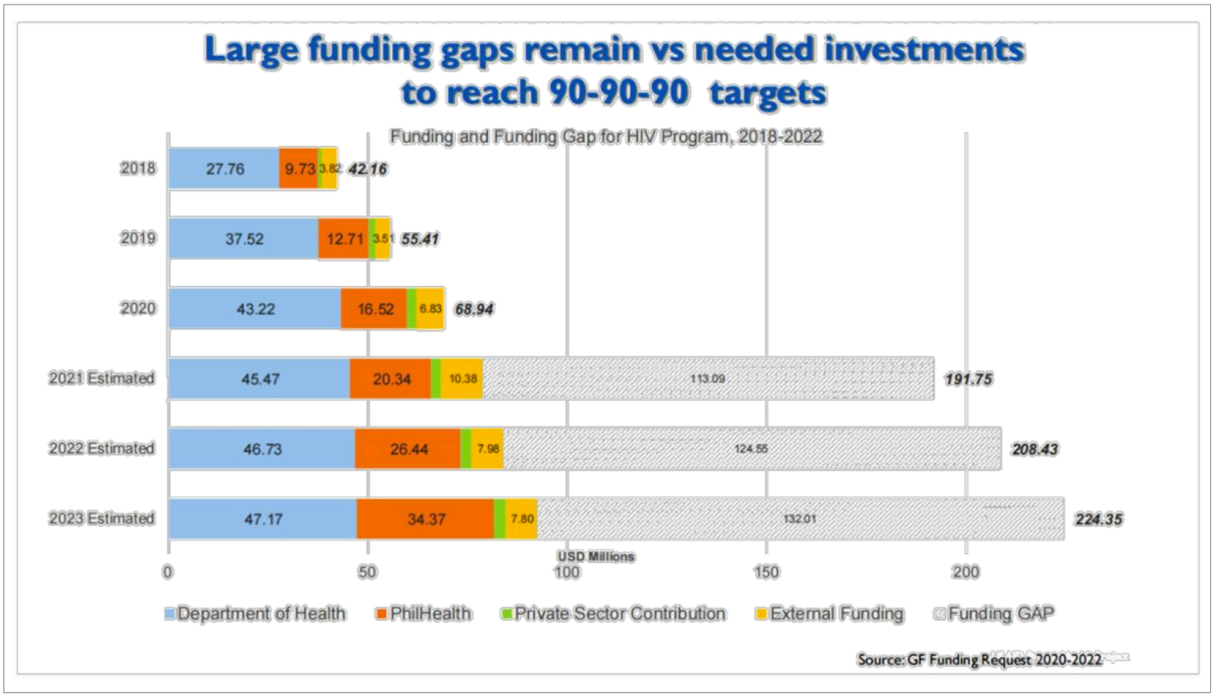


Figure 4. HIV sources and funding gaps, Philippines, 2018-2020, in million USD (Global Fund, 2020)

The fragmented and overlapping funding for HIV and AIDS services result in financing gaps. The Universal Health Care (UHC) Act of 2019 mandates the enrolment of all Filipinos to the National Health Insurance Program with immediate eligibility to benefits, including HIV. PhilHealth and other prepayment mechanisms are expected to fund individual case management. The Department of Health (DOH), local government units (LGUs), and national government agencies must support population-based services.

Existing PhilHealth packages are also not fully utilized. A third of PLHIV on ART are not enrolled in PhilHealth's Outpatient HIV/AIDS Treatment (OHAT) benefit package and there is limited support value of case rates for inpatient HIV services (Caballes and Gomez, 2022).

Commitments and contributions by relevant national government agencies with respect to allocation of funding are also not efficiently tracked, such that funding may not actually match program requirements and thus, hamper attainment of desired health outcomes. If these resources are not properly rationalized according to their funding focus, the impact of increasing the total amount of funding will not be maximized.

Table 1 HIV funding requirement from different sources in billion Philippine peso (PhP)

Reference	2018	2019	2020	2021	2022	2023
6th AMTP OHAT (PNAC, 2016)	2.10	3.20	3.70	4.00	4.70	6.00
HIV Prevention and Control - Costed Operational Plan 2018-2020 (DOH NASPCP, 2017)	4.37	4.96	6.56	-	-	-
Philippine Health Sector HIV Strategic Plan 2020-2022 (DOH DPCB. 2021)	-	-	-	9.92	10.78	11.61
HIV Adaptive Plan (DOH DPCB, 2021)	-	-	-	10.05	10.90	11.69

E. The Philippine National AIDS Council (PNAC)

The Philippine National AIDS Council (PNAC) is the body and mechanism that is tasked with implementing the country's AMTP. PNAC is composed of 21 members - 12 from government, two (2) representatives from organizations of PLHIV, one (1) representative from a private organization with expertise in standard setting and service delivery, and six (6) representatives from NGOs working for the welfare of identified key populations. Following the approval of the IRR In July 2019, five (5) committees, Policy and Planning, Human Rights, IEC, Finance, and M & E were created. The Council will discharge its functions through the committees where their decisions and/or recommendations are for approval of the Plenary. They are composed by the technical representatives of the PNAC members plus co-opted members from other relevant NGA and CSO[6].

The Implementing Rules and Regulations (IRR) of RA 11166 defines the functions of the Council as primarily **developing, reviewing, operationalizing, monitoring, and mobilizing sources of funds** (Investment Plan) for the AMTP. It also expressly directs PNAC to identify government agencies that shall implement the program, including the designated office within each agency responsible for overseeing, coordinating, facilitating and monitoring the implementation of its HIV and AIDS program from the national level to the local level.

In addition to the powers and functions cited, *"the members of the PNAC shall also develop and implement individual action plans which shall be anchored to and integrated in the AMTP. Such action plans shall be based on the duties, powers, and functions of the individual agencies as identified in Rule 4 to Rule 10 of this IRR"*.

Another major function of PNAC is to strengthen the collaboration between government agencies and CSOs involved in the implementation of the national HIV and AIDS response, including the delivery of HIV and AIDS related services.

The achievement of the deliverables of the AMTP is dependent to a large extent on how well the Council performs its mandate and how efficiently it is supported by its Secretariat.[7]

[6] Libatique, R.D. Evaluation Report: Philippines 6th AIDS Medium Term Plan 2017 to 2022: Synergizing the Philippine HIV and AIDS Response. May 2022 p38

[7] Ibid p9

F. Challenges

1. Weaknesses in governance and leadership in the implementation of AMTP

The success of the 6th AMTP (or succeeding AMTPs) is heavily anchored on responsible leadership marked by a strong political will to make strategic decisions and to make itself accountable in the delivery of its commitments.[8]

PNAC
Poor understanding of the roles and responsibilities of the individual members of the Council and irregular and/or non-attendance of some member-government agencies (with some consistently absent) to PNAC meetings and/or activities impair the functioning of the Council.

> *"The members of the committees, meanwhile, were never ever complete during their respective meetings. Not all members are contributing to the function of the committee, either due to their absence or silence during meetings. Not all members have stock knowledge of the HIV response and a vague understanding of their role in the committee.[9]*

PNAC Secretariat
The evaluation of 6th AMTP recommends the capacity building of the PNAC Secretariat (from leadership to staff level) in order to be able to support the Council more competently and efficiently.

> *"There was almost unanimous observation and sentiment from all the committees of the weak support of the current PNAC secretariat to their activities. The weak support manifests in instances of delayed action on or no responses to tasks inherent to the secretariat functions with regard to support and coordination of committee activities. …The committee members observe that there seems to be a misunderstanding on the part of the leadership and new staff on the function of their office".[10]*

2. Weaknesses in the Policy, Structural, and Procedural Systems

The existing literature on governance in the Philippines identifies corruption, misallocation of resources, political instability, and uncoordinated government agencies as some of the key governance challenges that slow down or obstruct developmental progress in the Philippines, including in the health sector.[11] Health service delivery was among the functions that were decentralized or devolved in 1991 to LGUs. 22 years after , the problem of fragmentation of health service delivery remains a major bottleneck. SImilarly, policies are not interpreted/implemented in the same manner at various levels, that result in varying procedures which greatly impacts accessibility, availability, acceptability, and quality (AAAQ) of the HIV response.

> *"Policies are generated at the national level, but the effective dissemination of national policy is the first bottleneck. Policies may be well crafted and aligned with global goals, but it is about the policy being cascaded to local levels that is the problem. We are in a devolved system, and, where the local authorities are the ones that have the power to allocate resources to accomplish that policy, the quality suffers due*

8 AMTP6 p15

9 AMTP6 Evaluation p 39

10 Ibid

11 See e.g. Mendoza, et al. 2017. Governance and Institutions in the Philippines. ASOG Working Paper 17-002. Available at SSRN: https://ssrn.com/abstract=2873942.

to variations in interpretations of the policies. Even for PhilHealth, the national level policies are subject to local interpretation. This hampers the reach of well-meaning policies.

The lack of integration affects access to health care and its quality. When you go down to the [local level], health care delivery falls on the shoulders of the same midwife, the same nurse, the one municipal health officer. The struggle to get out of vertical programme implementation is one obstacle to achieving universal health coverage and quality of care; It is the lack of integration and integrated program development."[12]

Procurement and supply management is a major issue that repeatedly surfaced in the series of consultations relative to the 7th AMTP development. Particularly mentioned were inadequacy of supplies and commodities and delay in the supply chain stream. Warehousing at the local level were also mentioned as a significant concern.

3. Inadequate funding to support the activities of the Response

Only the DOH and DSWD among the government agency members of PNAC have concrete allocations for HIV in their own budgets. Agencies like the DBM, DepEd, CHED, CSC,, DOLE, DILG, NYC, PIA, House of Representatives- Committee on Health, and Senate Committee on Health do not have in-house HIV programs, thus costs for HIV in their respective budgets do not exist. Only a very few LGUs have HIV allocations in their MOOE. Many CSOs and KP community-led organizations rely on external funding to be able to deliver services, only them are capable of delivering due to nature and circumstances of the target populations of the HIV response.

[12] Interview with two Health Officers, Health and Nutrition Section, UNICEF. Tuesday, 13 June, UNICEF Manila

II. The 7th AIDS Medium Term Plan

A. Legal Bases

The 7th AMTP stands firmly backed by existing international and national policies, namely:

1. Universal Declaration of Human Rights (UDHR) 1948

It is the world's mother document in relation to human rights. The Universal Declaration promises to all the economic, social, political, cultural and civic rights that support a life free from want and fear. They are not country specific, or particular to a certain era or social group. Human rights are protective devices designed to shield or protect individuals from random violence and neglect; these are normative standards upon which states are to conduct themselves when relating with their citizens.

2. Beijing Declaration and Platform for Action 1995

Beijing Declaration and Platform of Action embodies the commitment of the international community to achieve gender equality and to provide better opportunities for women and girls. The platform of action responds to the collective effort of women and girls around the globe who have fought to achieve gender equality and women's rights and acts as a continuum of the international community's commitment to address civil, political, social, economic and cultural inequalities. It remains relevant today, affirming that women's rights are human rights and that equality between women and men benefits everyone.

3. Convention on the Rights of the Child (CRC)

CRC, as the document is widely known is the most universally-accepted human rights instrument that declares the rights of a person under 18 years old. These rights are categorized under four (4) broad areas namely: Survival (to live), Development (to grow), Protection (be safe), and Participation (be part of the worldwide family). The instrument also outlines what states must do to enable the child to enjoy these rights. The CRC is relevant to the HIV Response because of the impact of HIV and AIDS on children.

4. Global AIDS Strategy 2021–2026

The strategy recognizes based on evidence that intersecting inequalities "prevent progress towards ending AIDS". As stated in the document, the strategy builds on three interlinked strategic priorities:

A. maximize equitable and equal access to HIV services and solutions;
B. break down barriers to achieving HIV outcomes; and
C. fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

5. RA 11166: Philippine HIV and AIDS Policy Act and its Implementing Rules and Regulations

The law specifies the roles and responsibilities of member government agencies of PNAC, thus allowing for the allocation of HIV and AIDS program budgets in their agency appropriations. The

law assures the operational budget of PNAC and gives the legal basis for NGAs to allocate HIV funds within their own agency budgets without fear of disallowance or cuts by the Department of Budget and Management (DBM). However, the effect of the new law on the budget appropriation of the agencies shall be felt only after the end of 6th AMTP.

6. RA 11223: Universal Health Care Act (UHC)

UHC assures 100 percent population coverage of PhilHealth - from the 98 percent population coverage in 2018 (per the 2018 Socioeconomic Report by NEDA). The law aims to address recurring problems in the health system such as the fragmented and overlapping roles and responsibilities of various health agencies – with the DOH and LGUs responsible for population-based interventions and health services (e.g., immunization programs and health promotion programs). At the same time, PhilHealth will be responsible for financing individual-based health services.

The law however entails the restructuring of functions and/or offices in the Department of Health. The transition from the current system will undoubtedly have an initial impact on the HIV response, particularly in the implementation of the health component of the 7th AMTP.

8. RA 7160: Local Government Code of 1991

This law establishes the system and defines powers of provincial, city, municipal and barangay governments in the Philippines. It also transferred control and responsibility of delivering basic services to LGU. Further, it sought to enhance service provision and improve the efficiency in resource allocation and widen the decision-making space by encouraging the participation of stake holders.

The relevant provisions of this law to the 7th AMTP rest on Sections 15 to 18, to wit:

> *SECTION 15. Political and Corporate Nature of Local Government Units. - Every local government unit created or recognized under this Code is a body politic and corporate endowed with powers to be exercised by it in conformity with law. As such, it shall exercise powers as a political subdivision of the national government and as a corporate entity representing the inhabitants of its territory.*
>
> *SECTION 16. General Welfare. - Every local government unit shall exercise the powers expressly granted, those necessarily implied there from, as well as powers necessary, appropriate, or incidental for its efficient and effective governance, and those which are essential to the promotion of the general welfare. Within their respective territorial jurisdictions, local government units shall ensure and support, among other things, the preservation and enrichment of culture, promote health and safety, enhance the right of the people to a balanced ecology, encourage and support the development of appropriate and self-reliant scientific and technological capabilities, improve public morals, enhance economic prosperity and social justice, promote full employment among their residents, maintain peace and order, and preserve the comfort and convenience of their inhabitants.*
>
> *SECTION 17. Basic Services and Facilities. 8 (a) Local government units shall endeavor to be self-reliant and shall continue exercising the powers and discharging the duties and functions currently vested upon them. They shall also discharge the functions and responsibilities of national agencies and offices devolved to them pursuant to this Code. Local*

government units shall likewise exercise such other powers and discharge such other functions and responsibilities as are necessary, appropriate, or incidental to efficient and effective provision of the basic services and facilities enumerated herein.

SECTION 18. Power to Generate and Apply Resources. - Local government units shall have the power and authority to establish an organization that shall be responsible for the efficient and effective implementation of their development plans, program objectives and priorities; to create their own sources of revenue and to levy taxes, fees, and charges which shall accrue exclusively for their use and disposition and which shall be retained by them; to have a just share in national taxes which shall be automatically and directly released to them without need of any further action; to have an equitable share in the proceeds from the utilization and development of the national wealth and resources within their respective territorial jurisdictions including sharing the same with the inhabitants by way of direct benefits; to acquire, develop, lease, encumber, alienate, or otherwise dispose of real or personal property held by them in their proprietary capacity and to apply their resources and assets for productive, developmental, or welfare purposes, in the exercise or furtherance of their governmental or proprietary powers and functions and thereby ensure their development into self-reliant communities and active participants in the attainment of national goals.

9. RA 11036: Mental Health Act (2018)

The National Mental Health Policy provides a rights-based comprehensive framework for the implementation of optimal mental healthcare in the Philippines for the purpose of enhancing the delivery of integrated mental health services, promoting and protecting the rights of persons utilizing psychiatric, neurologic, and psychosocial health services. The policy provides an opportunity to address mental health among PLHIV and other KP.

10, Supreme Court Mandanas-Garcia Ruling

Section 284 of the Local Government Code of 1991 states that LGUs shall have 40% share from the Internal Revenue Allotment (IRA) while Section 6 of Article X of the 1987 Philippine Constitution states that *"LGUs shall have a just share, as determined by law, in the national taxes which shall be automatically released to them."* Two governors- Hermilando Mandanas of Batangas and Enrique Garcia of Bataan, citing the above in separate petitions, appealed that the IRA share of LGUs be adjusted to include share from the national taxes. The Supreme Court ruled positively on the petitions in early 2022, thus increasing the IRA of LGUs while deducting said increase from the budgets of national government agencies (NGA). With the decrease in the budgets of NGAs and the increase of the IRA of LGUs, many programs and services that the NGAs delivered will be devolved to the LGUs. A positive impact of the ruling is that the LGUs have administrative autonomy to identify the priority programs – they are empowered to determine their own economic development (Villanueva, 2022).

Given this development, the opportunity for funding local HIV responses is present. The 7th AMTP should therefore push for active LGU participation and share in responding to the HIV problem in the country.

B. Development Process

In July 2022, the Policy and Planning and the Monitoring and Evaluation committees of PNAC were tasked to lead the development of the national HIV and AIDS strategic plan. The joint committee convened the 7th AMTP development core team composed of the co-chairs of the five (5) PNAC committees. Consultants were engaged through the support of the Global Fund AIDS project under the Pilipinas Shell Foundation, Inc, to lead the development of 7th AMTP. In a succession of meetings, the core team formed the 7th AMTP framework and planned a series of consultations with key population groups and stakeholders. The lessons learned from the weak implementation of the previous national strategic plan were used to inform the crafting of the 7th AMTP.

Consultation workshops organized by civil society organizations and the PNAC secretariat were conducted in Metro Manila, Pampanga, Cebu, and Davao from 20 August to 23 September 2022. Participating in the development process were communities of MSM, transgender persons, PWID/PWUD, FSW/PIP, YKP, children, PLHIV, as well as civil society organizations, PNAC member agencies, and development partners. Validations with stakeholders were done on November 7 and November 15, 2022.

Alongside the crafting of the 7th AMTP itself is the development of its Monitoring & Evaluation Plan. Spearheading such is the PNAC M & E Committee. The participatory M & E workshop which was conducted on November 2 to 5, 2022 finalized the components, structures and roles of stakeholders of the national M & E system and the targets, outcome, and impact indicators of the 7th AMTP.

C. Guiding Principles

The 7th AMTP is directed by the following principles:

1. Rights and accountability-based
   Underscore the state's obligation to respect, protect, and promote the people's entitlement to basic human rights; while at the same time, putting emphasis on the people's obligation to exercise these rights responsibly. This will ensure that actions and decisions taken by public officials are subject to oversight so as to guarantee that government initiatives meet their stated objectives and respond to the needs of the community they are meant to be benefiting.

2. Community empowerment through participation
   Invoke the rights of citizens (communities, civil society organizations, and networks of people living with HIV) to actively participate in the response and to engage the state in addressing their needs and concerns.

3. Person-centered
   The 7th AMTP shall persevere to provide services that maintain a deep respect for dignity and worth of the individual as human beings who deserve differentiated responses to their discrete and special health challenges.. They should be treated equally regardless of sex, age, race, gender, ethnicity, religion, social, economic status, and HIV status.
   -

4. Gender affirming and transformative
   Recognition of individual rights regardless of sexual orientation, gender identity and expression (SOGIE,) and free from stigma and discrimination.

5. Crisis-resilient
   HIV response must be in a business as usual mode despite conditions of pandemic and calamities.

6. Equity
   Ensure equitable distribution of financing, technical assistance, and services according to the needs and requirements of disease-burdened provinces/cities.

7. Harmonized
   Alignment of programs and activities by all implementers through regular coordination and harmonization meetings and periodic program implementation review to ensure a unified and integrated rights-based HIV response.

D. 7th AMTP Ecosystem

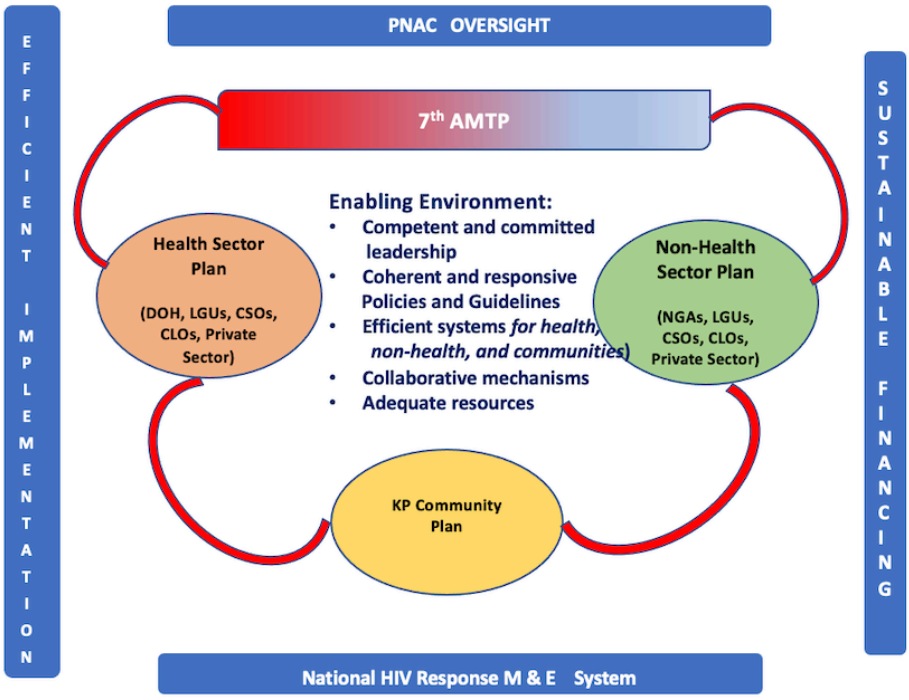
The guideposts of the National HIV and AIDS Response (AIDS Medium Term Plans) are:

1. **PNAC Oversight** - the Council shall continue its steering function in order to provide guidance in the implementation and monitoring of the AMTP which shall be supported by an active and competent Secretariat.
2. **Efficient Implementation** of all interventions and activities by all key players at all levels of implementation.
3. **Sustainable Financing** of HIV programs and activities from the domestic front.
4. **The National HIV Monitoring & Evaluation System** should be able to track progress and inform the AMTP implementation.

To facilitate the efficient and effective implementation of the AMTP, an enabling environment should be present:

- Competent and committed leadership
- Coherent and responsive policies and guidelines
- Efficient systems for health, non-health, and communities
- Collaborative mechanisms from the national and subnational levels across policy, health and non-health service delivery and monitoring points
- Adequate resources

Fig. 3 : 7th AMTP Ecosystem



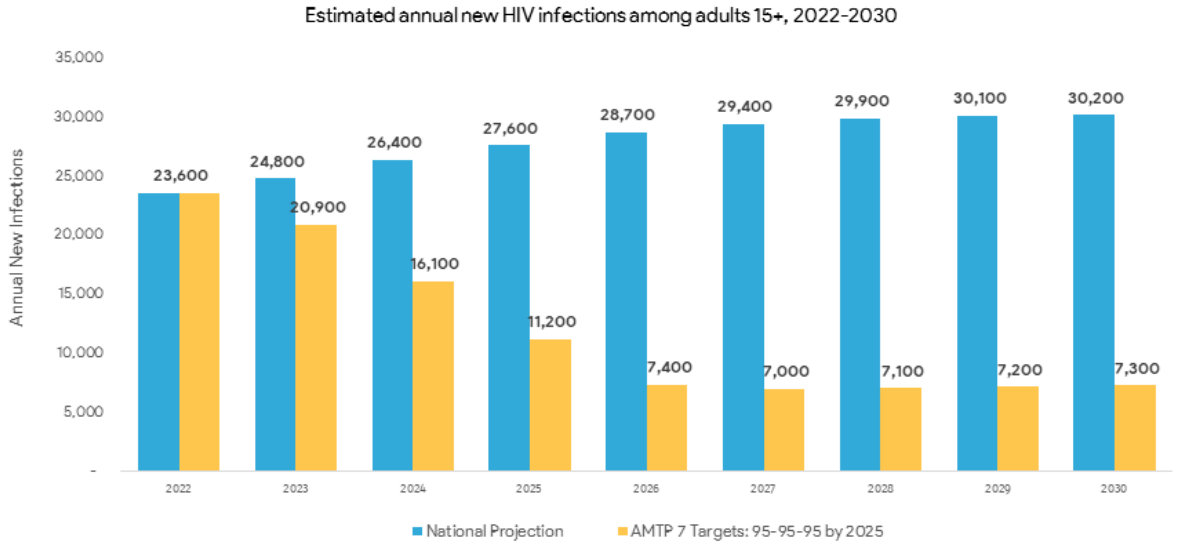
E. High Level Targets

PREVENT	TREAT	PROTECT	STRENGTHEN	SUSTAIN
95% of 10 to 24-year-old key populations have basic knowledge on HIV transmission and prevention Prevent new infections, especially among 10 to 24-year-old key populations Eliminate mother-to-child transmission	95% of PLHIV know their HIV status 95% of PLHIV who know their status are on ART 95% of PLHIV on ART have suppressed viral loads	Less than 10% of PLHIV and KP experience stigma & discrimination Less than 10% of PLHIV and KP experience gender inequality and violence	Responsive governance strengthened Harmonized and crisis-resilient multi-sectoral response	Fully-resourced and sustainable HIV response

Data in Figure 4 shows the estimated annual new infections among ages 15 years old and above. The blue bars represent the projected annual new HIV infections given current observed trends in prevention, diagnosis, and treatment, wherein there will be an estimated 27,600 new infections by 2025 and continue to increase to 30,200 new infections by 2030.

Achieving the 7th AMTP high level targets, specifically on the Prevention and Treatment pillar, and supported by the targets on the Protect, Sustain, and Strengthen pillars, annual new HIV infections is projected to decline to 11,200 by 2025 (a 200% decrease compared to current national projection), and to around 7,000 new infections in succeeding years.

Fig 4: Annual number of new HIV infections among 15 years old and above, 2022-2030

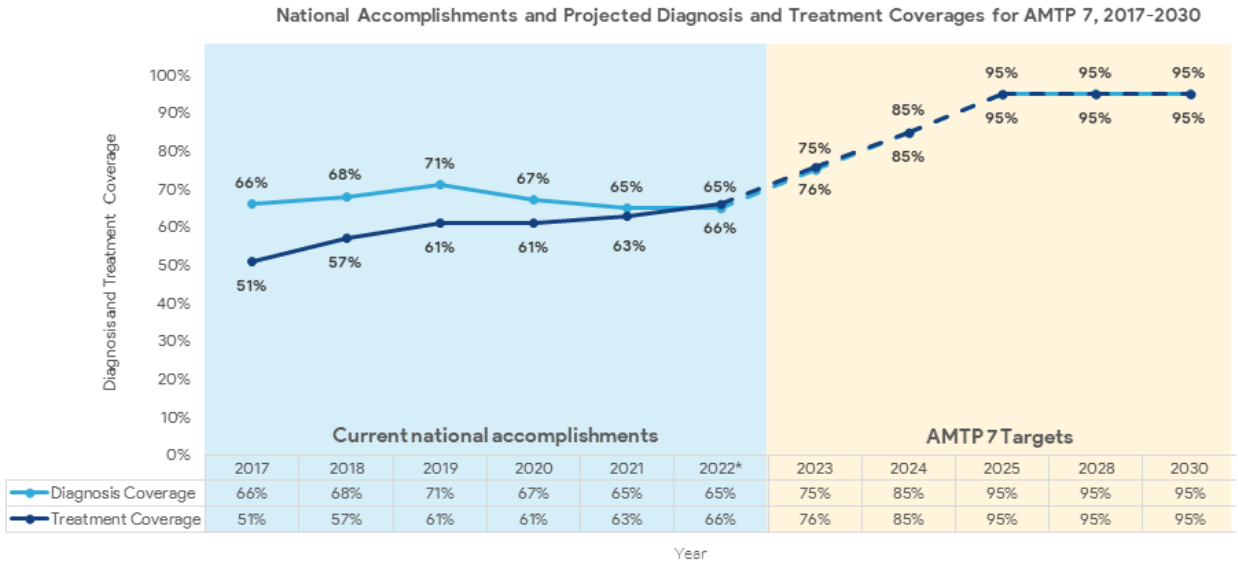


Source: AIDS Epidemic Model, May 2022
Notes:

a. *Estimated annual new infections were modeled through the AIDS Epidemic Model (AEM) using data from the IHBSS, HARP, 2020 Population Census, and other program data. Projections were based on specified assumptions or observed trends for prevention and ART coverage.*

Looking into the historical trend and scale-up needed to achieve the targets, particularly on the Treat pillar, Figure 5 shows that in order to achieve the 95% targets by 2025, a 10% point increase in diagnosis and treatment coverages per year is needed from 2022 to 2025.

Fig 5. National Accomplishments and Scale-up Needed for Diagnosis and Treatment Coverages for 7th AMTP, 2017-2030



Source:
AIDS Epidemic Model, May 2022
HIV/AIDS & ART Registry of the Philippines, September 2022
Notes:

b. For year 2022, diagnosis and treatment coverages are year-end projections based on current observed trends

c. Projected diagnosis and treatment targets from 2023-2025 assumes a linear increase in diagnosis and treatment coverage to achieve the 95% target by 2025.

With the intended scale-up in efforts that will be needed, there is also an increased resource needs. Comparing the investment needs that will be needed to provide prevention and treatment among our key and vulnerable populations and PLHIV, Table 1 shows how much more investments will be needed with the 7th AMTP targets compared to the current projection. From 2022-2025, it is estimated that around 49-82 million USD will be needed per year given current national projections, and an even greater amount will be needed for the 7th AMTP targets at around 58-103 million USD per year. However, looking at the impact on the HIV epidemic, it is evident that there will be much less cumulative infections and AIDS deaths from 2022-2030 if we will be able to achieve the targets. This indicates more infections averted and lives saved. Moreover, while investment needs will be much higher in early years, looking at long-term investment needs, this will be less by 2035.

Table 2. Estimated Resource Needs, Estimated Cumulative Infections and Deaths, 2022-2035

	2022-2030		2022	2023	2024	2025	2030	2035
	Cumulative Infections [a]	Cumulative AIDS Deaths [a]	Resource Needs in USD (Prevention & Treatment) [b]					
Current National Projection	250,620	36,036	48.9 million	58 million	69.4 million	81.5 million	153.1 million	221.9 million
AMTP 7 Targets (95-95-95 by 2025)	107,850	27,445	57.7 million	87.1 million	117.7 million	148.4 million	165.3 million	181.3 million

Source: AIDS Epidemic Model, May 2022
Notes:

a. Cumulative infections and AIDS deaths among 15 years old and above

b. *Estimated resource needs for providing prevention (HIV information, condom, and testing; currently excludes PrEP) and treatment for key populations and PLHIV 15 years old and above, thus costs for children, pregnant women, and MTCT are also not included. It should be noted that resources accounted for the cost are primarily on the health service delivery component plus a 20% overhead for non-direct costs (operations, program and social enablers, quality improvement, etc.) Overall costs for the Protect, Sustain, and Strengthen pillars may not necessarily be accounted for in the projected resource needs. Moreover, a standard cost for prevention and treatment (2022 costing, 1 USD = 56 Php) was used in the projections, and thus does not factor in inflation yet.*

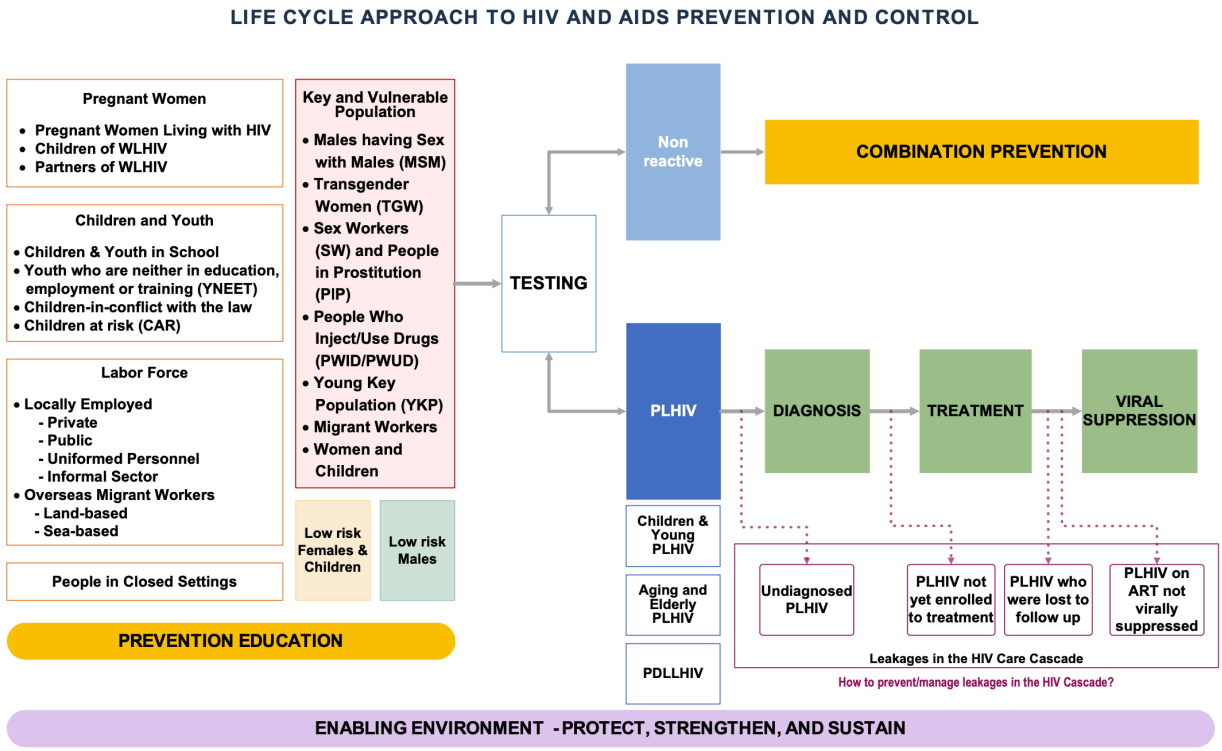
F. 7th AMTP Framework and Strategy Pillars

The goal of the 7th AMTP is to neutralize the impact of HIV and AIDS by preventing new infections, treating PLHIV, and suppressing their viral loads in numbers that are sufficient to turn the tide of the AIDS epidemic in the Philippines by 2025 and onwards to 2030. To be able to do this, the country needs to shift its "health issue only" outlook to a categorical socio-economic development perspective to end AIDS.

Such perspective is applied by the 7th AMTP through the adoption of the Life Cycle Approach to HIV and AIDS Prevention and Control framework, where HIV prevention is the rudimentary and staple feature in every Filipino's fetal, neonatal, child/youthhood, and up to adulthood stages of his/her life. In the life cycle approach, the population further disaggregates to the key and vulnerable groups that are targeted for focused behavior change communication processes within the continuum of HIV care cascade. The response will pay special attention to the 10 to 24 years age group where epidemiological data show new infections happenning, without leaving behind women and children, and other KP, such as PWUD/PWID, migrant workers, sex workers/prostiuted women, and people in prostitutionand FSW/PIP.

The response should also be able to plug the gaps/leakages (PLHIVs who are undiagnosed, unenrolled to treatment, lost to follow-up, and not virally-suppressed PLHIV) in the HIV care cascade. To be able to do the above, systems on health like procurement and supply management, reduction of stigma and discrimination, as well as community systems should be strengthened.

Figure 6: Life Cycle Approach to HIV and AIDS Prevention and Control

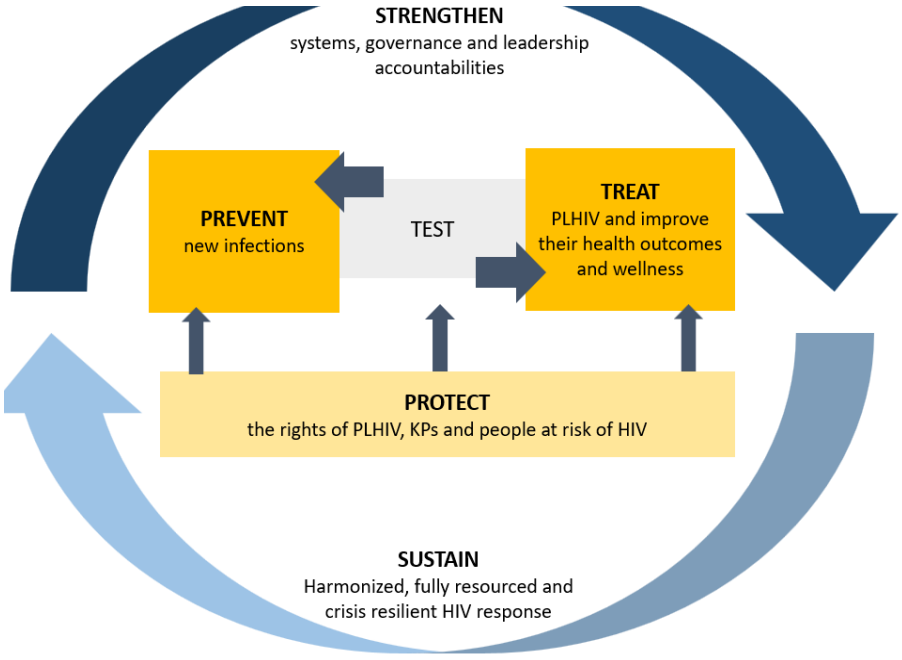


It is often misunderstood that prevention of any health risks can be solved by information, education, and communication (IEC) alone. To protect an individual or a group of people from contracting a disease or falling into dangerous situations, they must be assisted to change their behavior by addressing all the environmental influences that can impact on the behavior.

The 7th AMTP, thus, is designed as a **Social Behavior Change Communications** strategy where interactive, theory-based and evidence-driven communications processes and strategies are applied to effect change at individual, community, and societal levels. Such strategic processes include:

- focused IEC according to audience classification
- advocacy for rights-based policy changes/amendments/clarity where needed
- capacity building at several levels of leadership, governance, and implementation
- resource mobilizations and advocacy for increased HIV investment from domestic sources, and
- harmonizing HIV and AIDS actions and implementation systems at the national, local, and KP communities levels

Fig. 7: 7th AMTP Framework



The 7th AMTP has five (5) strategy pillars – 1) PEVENT2) TREAT, 3) PROTECT, 4. STRENGTHEN, and 5) SUSTAIN. The pillars are intertwined and interdependent. An improvement, whether in the form of enrichment, refinement, revision, or amendment to policies, procedures, implementation protocols, leadership and governance, coordination and collaborative mechanisms, crisis-resiliency, and financing will contribute to the overall strengthening of the HIV response machinery.

1. **PREVENT** new infections among key and vulnerable populations including adolescents and pregnant women.

Data show that 47% of new infections in the Philippines are among young people aged 15 to 24. The rise of HIV infection in this age group cross-validates with the finding of the 5th Young Adult Fertility and Sexuality Survey 2021 (YAFS5, 2021) that the percentage of Filipino youth who are aware of HIV and/or AIDS has declined to its lowest level since 1994 (a 19-percentage point drop from 1994 when awareness stood at 95%). In all, only one in five youth has comprehensive knowledge of HIV. Some 35% of young people also did not believe that a person can reduce the risk of getting HIV infection by using a condom during sex. YAFS5 data show that among youth who have ever had sex, only a fifth have ever used a condom.

The country therefore has to step up HIV and AIDS IEC using age- and gender -specific strategies. The national government agency-members of PNAC such as the Department of Education (DepEd), Commission on Higher Education (CHED), Technical Education and Skills Development Authority

(TESDA), National Youth Commission (NYC), Philippine Information Agency (PIA) are called upon to execute their responsibilities as defined in RA 11166 within the context of their respective mandates.

The latter agencies should attend to the IEC needs of the youth who are neither in education, employment, or training (YNEET).

There are anecdotal proof that harm reduction initiatives prevent HIV and Hepatitis C among PWUD/PWID in the past. The hesitancy of PNAC and DOH to employ a health package comprehensive service approach including harm reduction on account of RA 9165[13] runs contrary to the pronouncement of the Philippine Drug Enforcement Agency (PDEA). PDEA adopts a three-pronged approach on war against illegal drugs - supply reduction, demand reduction, and harm reduction.

> *"The third part of the strategy is Harm Reduction Approach[14] which is associated with interventions that reduce the acute impacts of drug use. These impacts are likely to be social or economic harms such as crime of desire, corruption, over-incarceration, violence, stigmatization, marginalization or harassment, among others.*
>
> *"This promising approach is a welcome addition to the traditional supply and demand reduction strategy of the government. We are grounded on the reality that many people are finding it difficult to stop engaging in illegal drug activities. That is why we aspire to target each impact of the drug problem," the PDEA chief expressed.*

The pronouncement of PDEA on the harm reduction approach will prove advantageous to the prevention of HIV and AIDS as well as Hepatitis C among the people who use drugs and/or inject drugs (PWUD/PWID).

It can be concluded that a decline in testing will follow the decline in knowledge. HIV testing is a KP's or PLHIV's portal to the healthcare system, where testing negative is also an entry point to preventing seroconversion. Targeted testing for KP and vulnerable population also allows for early diagnosis and initiation to treatment.

While the prevention efforts are mainly directed towards the young people, the HIV response do not discount the prevention efforts for those who engage in transactional sex, mothers and their children, migrant workers, people deprived of liberty, and other vulnerable populations.

2. **TREAT** people living with HIV and improve their health outcomes and well-being.

Besides the usual interventions within the treatment cascade, the 7th AMTP, among equally important activities, point to the need to strengthen person-centered case management for treatment initiation and adherence, as well as the retention and return to care of patients who were lost-to-follow-up.

However, the challenges of procurement and supply management aspects remain to be the most crucial factors that need to be addressed to improve testing and treatment. An emerging concern that needs to be addressed are other services for aging PLHIVs.

[13] Republic Act 9165: "Comprehensive Dangerous Drugs Act of 2002"
[14] https://pdea.gov.ph/2-uncategorised/1376-pdea-adopts-three-pronged-approach-on-war-against-illegal-drugs?fbclid=IwAR0TDVP0SjRSPJkMGYfDmWrWTJQWkUpUYXyw4EEH2iLfB56bW1UCsjzqxQ8

3. **PROTECT** the rights of PLHIV, KP, and people at risk of HIV

The issues of stigma and discrimination are central to the poor uptake of testing and treatment among the key and vulnerable populations. These are also more obtrusive among the people with criminalized behavior in the Philippines like PWUD/PWID and FSW/PIP. The PNAC Roadmap to Address Rights-Based Barriers to Accessing HIV and AIDS Services is a landmark document that articulates the policy direction of the Council to mobilize both rights-holders and duty-bearers to address rights- based barriers by reducing stigma and discrimination through sensitization and training, improving access to legal and social protection services.

4. **STRENGTHEN** governance and leadership accountabilities, and systems for health, non-health, community and strategic information

There are significant pivotal aspects in governance and leadership to ensure that the 7th AMTP is steered well and achieved. There is much to be strengthened In PNAC alone. Foremost is the capacity building of PNAC to be the "supreme authority" in planning, programming, guiding, coordinating, and monitoring the country's HIV and AIDS response. In order for PNAC to become the "AIDS authority", the individual members have to understand and commit to their respective roles and responsibilities in the Council and in the Response. More importantly, the institutional capacity of and leadership in the PNAC Secretariat and competence of its personnel need to be up to par to the call and demand of any AMTP.

The local government units should be assisted technically to be able to mount their own RA 11166 and AMTP - aligned HIV responses subject to their respective disease burdens. The Local AIDS Councils (LACs) should also be capacitated to be able to mirror the functions of PNAC locally. Similarly, there should be a response coordination and monitoring mechanism at the regional level.

Collaborative mechanisms across all points of service delivery are needed to be put in place and/or enhanced through improved health, non-health and community systems across the country. Such collaborative mechanism may also lead to or enable an integrated service delivery system that can address the needs of clients in the continuum of prevention, testing, management of treatment and psychosocial care coordinated across levels and sites of service delivery within and beyond the health sector.

Innovations like differentiated service deliver and community-led monitoring to address the persistent challenges in the HIV care cascade are key to help strengthen systems and make them more resilient.

The role of civil society, especially of the community-led organizations (CLOs) cannot be underestimated for they play a crucial role in advocacy for LGU HIV financing and appropriate courses of action. However, advocacy work for a supportive policy environment entails coordination and mobilization costs which CLOs of marginalized key populations do not have. Providing financial access to these CLOs so they can do active advocacy will contribute to ensuring a supportive policy environment.

5. **SUSTAIN t**he harmonized, rights-based, fully resourced and crisis-resilient HIV response

The big plans of the 7th AMTP will come to naught if the required budget is not provided. Thus the mobilization of resources is crucial - key is increasing investments from local government units and national government agencies, and harnessing the resources from development partners. Equally vital is crisis-proofing the response by putting in place a Crisis-Adaptive Business Continuity Plan, and addressing the procurement and supply management challenges. The policy environment also needs to be conducive in order to harmonize and align the HIV response across all levels of implementation.

The development partner, USAID through its ProtectHealth project (Palladium) recommends evidence-based actions for optimal financing for HIV and AIDS. It is urgent to have greater agency coordination and clear financing commitments from other government agencies, which will be facilitated by the PNAC (Table 1). Prevention services will increasingly have to be funded by LGUs, in line with the provisions of the Universal Health Care (UHC) Act and the recent re-devolution policy (Executive Order 138). Drug procurement will still be financed by DOH in the near term. PhilHealth will have to make its claims processes more efficient. Pre-testing coverage should also be considered, either as part of an expanded OHAT benefit package, or through direct public subsidies. Co-payment schemes with private insurance firms as well as contracting arrangements with nongovernmental HIV service providers can also be explored.

Table 3: HIV-related financing roles of government agencies under RA 11166[15]

Area		Agencies and Roles
Education and Social Behavior Change Communication	Education in Learning Institutions	**DOH, DepEd, CHED, and TESDA**: psychological support and counseling in learning institutions; funds for training and certification of teachers and school counselors
	Education in Communities	**DILG, Union of Local Authorities of the Philippines, League of Provinces, League of Cities, and the League Municipalities, through the Local HIV and AIDSCouncils(LAC)or the local health boards**: implement a locally-based, multi-sectoral community response; GAD funds and other sources may be utilized for these purposes.
Health and Support Services	Access to medical services by indigents	**DOH and DSWD:** establish a program that will support better access to ARV and medication for opportunistic infections to all indigent PLHIV, which includes financial support for necessary medical services related to the person's HIV condition
	Economic empowerment and support	**DSWD, DILG, DOLE, and TESDA:** develop enabling policies and guidelines to ensure economic empowerment and independence designed for PLHIV
	Care and Support for Persons Living with HIV.	**DSWD and DOH:** programs that include care and support for the affected children, families, partners, and support groups of PLHIV
	Care and Support for Overseas Workers Living with HIV	**OWWA, DOH, DSWD, DFA, CFO, Bureau of Quarantine and International Health Surveillance**: provide economic, social and medical support for overseas workers, regardless of employment status and stage in the migration process

[15] CFO - Commission on Filipinos Overseas, CHED - Commission on Higher Education, DepEd - Department of Education, DFA - Department of Foreign Affairs, DILG - Department of Interior and Local Government, DOLE - Department of Labor and Employment, DSWD - Department of Social Welfare and Development, OWWA - Overseas Workers Welfare Administration, TESDA - Technical Education and Skills Development Authority

	Health Insurance and Similar Health Services	PhilHealth: benefit package for PLHIV that includes coverage for in-patient and out-patient medical and diagnostic service; unborn and the newborn child from infected mothers; set a reference price for HIV services in government hospitals; educate the human resource units of companies on the PhilHealth package on HIV and AIDS; mechanism for orphans living with HIV to access HIV benefit package
		Philippine Insurance Commission: policies to ensure that no PLHIV shall be denied or deprived of private health insurance under a Health Maintenance Organization (HMO) and private life insurance coverage; no person shall be denied of his insurance claims if he dies of HIV or AIDS under a valid and subsisting life insurance policy
Appropriations		**DOH:** budget for initial implementation then later inclusion in the annual General Appropriations Act
		LGUs: separate budget item in the annual appropriations allocated for their action plans
		PhilHealth: health insurance package and other services
		Sin tax revenues: upgrade or construct government administered HIV testing and treatment centers and shall be prioritized under the Health Facilities Enhancement Programs of the DOH
		DOH: appropriate distinct funds for the operations of the PNA

DOH - If the DOH were to invest more in HIV-related activities, it will have to either secure more appropriations from the national government or reallocate its own funds. Given the substantial COVID-19-related commitments of the DOH, it will be hard put to mobilize more funds for HIV. The Department already has an estimated annual shortfall of Php200 billion for the implementation of the UHC priority programs until 2023 (DOH UHC MTEP, 2020).

PhilHealth **- In 2019, it was estimated that only 70 percent of PLHIV who were under treatment were able to claim OHAT benefits (USAID ProtectHealth, March 2021).** It is noteworthy that a former forecast from the 6th AMTP estimated that PhilHealth's HIV reimbursements should have reached Php4.7 billion by 2022. According to its income figures for the first half of 2021, PhilHealth has had to increasingly rely on premium collections from indirect contributors, the payments for whom are publicly subsidized (PhilHealth Stats and Charts, 2021). Increased PhilHealth benefit payment for HIV will contribute to more funding requirements from the national government.

There are other areas of care that are also important, such as preventive services, which deserve commensurate funding. These reportedly require less per capita spending. Other national government agencies, and particularly high-incidence LGUs, will therefore have to provide more sizeable funding for the other areas in the HIV care continuum. Again, ultimately, these will require additional appropriations from the national government.

The pandemic has led to reduction in government revenues, increased expenditures and greater reliance in deficit spending (DBM 2021). National government will have to assess options on how to support the 7th AMTP according to the committed roles stated in the HIV law.
Table 2 below shows the five (5) strategic pillars and their sub-strategies. For the detailed Summary go to Appendix 1: 7th AMTP Summary Matrix

Table 4: Five Strategic Pillars

PREVENT
STRATEGIC PILLAR 1: PREVENT new infections among key populations and vulnerable populations including adolescents, and pregnant women
TARGETS: • 95% of 10 to 24 year old key populations have basic knowledge on HIV transmission and prevention • Prevent new infections ***especially*** among 10 to 24 year old KP • Eliminate mother-to-child transmission
1. Universal access to combination prevention for KP
2. Prevention communication plan
3.. Expansion of simplified and differentiated PrEP program in different modalities (e.g. PrEP dispensing model (free / subsidized; public sector, private-led, drug store-led)
4. TransHealth package development and implementation (inclusion in the Health Sector Plan)
5. PWUD/PWID Health Package Comprehensive Service Approach
6. Implementation of Differentiated HIV Testing Service Guidelines
6. Integration of STI and mental health in HIV prevention interventions for KP
7. Elimination of mother-to-child transmission
8. Develop evidence-based, age-appropriate, comprehensive, and life-skill approach to HIV education curriculum for children, youth, and other vulnerable populations
TREAT
STRATEGIC PILLAR 2: TREAT people living with HIV and improve their health outcomes and well-being
TARGETS: 95% of PLHIV know their status (diagnosed) 95% of diagnosed PLHIV are on treatment 95% of PLHIV on treatment are VL suppressed

1. Targeted HIV testing among high risk KP
2. Strengthening and optimizing existing laboratory networks for efficient rHIVda, laboratory testing for clinical management, service quality monitoring, and VL testing referral
3. Strengthening of person-centered case management for treatment initiation and adherence
4. Retention and return to care strategy
5. Early diagnosis (including infants)/ Detection of new infections
6. Optimizing use of GeneXpert machines for TB, HIV (VL testing) and other novel techniques for HIV testing and treatment.
7. Strengthening of TB-HIV Collaboration in support of integration of health programs, UHC and Life Stage Approach
8. Development of program on HIV and Aging, and the elderly
P R O T E C T
STRATEGIC PILLAR 3: PROTECT the rights of PLHIV, KP and vulnerable communities
TARGETS:
<10% of PLHIV and KP experience stigma & discrimination
<10% of PLHIV and KP experience gender inequality and violence
1. Elimination of gender and HIV-related stigma and discrimination in all settings – community, workplace, education, health, justice, and emergency settings.
2. Strengthening of Community Systems
3. Enhancement of Legal and Policy Environment in reference to the IRR RA 11166 Section 5.1 Rule No.2 and 8 and Human Rights Roadmap.
4. Optimization of strategic information for advocacy for Duty Bearers and Rights Holders
5. Improvement of access to social protection measures of KP and PLHIV communities
6. Making Redress Mechanism functional and still available during times of crisis
S T R E N G T H E N
STRATEGIC PILLAR 4: STRENGTHEN governance and leadership accountabilities, and systems for health, non-health, community and strategic information

TARGET: Responsive governance strengthened
Harmonized and crisis-resilient multi-sectoral response

1. Strengthening of collaborative capacity, governance and leadership accountabilities in PNAC and PNAC Secretariat
    a. Harmonize programs, projects, and activities of all stakeholders on HIV Response as well as those that impact 7th AMTP
2. Strengthening capacity of LGUs to lead the local response, specific to their needs, mirroring the role of PNAC such as drafting of policy, coordinating, monitoring, and funding.
3. Forging linkage with subnational actors including LACs, DILG regional offices and other relevant offices
    a. Establishment of linkage with other relevant councils (e.g.: Philippine Council for Mental Health, National Nutrition Council,Council for the Welfare of Children and Committee on Children and HIV, Multi-Sector Governance Council, Inter-Agency Committee on Anti-Illegal Drugs)
4. Properly defined HIV program at all levels of implementation in the context of UHC and resilient systems (includes crisis-resiliency)
5. Rationalization of laws, policies, Administrative Orders, and/or practices that impact HIV and AIDS response
6. Community systems strengthening - service delivery, advocacy and CLM
7. Strengthening the resilience of health systems including skilled and sensitized human resource for health, integrated service delivery systems, procurement and supply chain management, and information systems
8. Establishing a comprehensive and integrated National HIV and AIDS Monitoring & Evaluation System-
    a. National HIV, AIDS and STI Surveillance and Information System in DOH-Epidemiology Bureau
    b. Non-health monitoring
    c. Community-led Monitoring

S U S T A I N

STRATEGIC PILLAR 5: SUSTAIN the harmonized, fully resourced and crisis resilient HIV response

TARGET: Fully-resourced and sustainable HIV response

1. Increase domestic investment in HIV and AIDS response
    - Develop, implement and monitor an HIV and AIDS Response Resource Mobilization Plan
    - PNAC member NGAs' allocating budget for HIV response according to their respective mandate

• LGUs include HIV Investment and Ordinances Planning in their MOOE • Sustained budget advocacy by CSO, especially at the LGU level
2. Development/updating of Transition plan for externally funded initiatives such as in Global Fund, PEPFAR
3. Harness private sector partnerships to complement/augment government resources
4. Advocacy for policies supporting the multi-sectoral HIV response (i.e. SOGIE, decriminalization of drug use, sex work, condoms in jails and prisons, etc.)

G. Operationalizing the 7th AMTP

The 7th AMTP will be expounded in the costed Operational Plan to be developed through a participatory process during the first quarter of 2023. Each stakeholder or group of stakeholders will contribute towards the achievement of the targets and milestones according to their respective mandates in the case of government agencies and offices, and missions of civil society and community-led organizations.

Coordination and Implementation Arrangements

It is a given that implementing the 7TH AMTP will be difficult, due to systemic and structural challenges, and the archipelagic nature of the country which makes travel costly and time-consuming to reach those that need to be reached. To cite the observation in 6th AMTP evaluation, "ensuring the delivery of the AMTP requires a very strong political will, vision, and commitment from mindful and sensible leaders who can positively influence their local counterparts, can make quick and appropriate decisions, take on accountabilities, and work closely with other stakeholders".

The PNAC, per its RA 11166 mandate shall provide oversight to the National HIV and AIDS Response, while its individual members are the implementers of its various aspects. It is also PNAC' primary role to support the implementers (both government and CSO partners) to deliver the 7th AMTP. To be able to do so, the Council requires a strong and competent Secretariat to support it and the five (5) committees through which PNAC works out the technical decisions for deliberation and approval by the Plenary.

The 7th AMTP shall follow the 6th AMTP recommended coordination and implementation scheme, which is strategic clustering where "cluster" acts as a sub-coordinating body to identify and address gaps, identify where synergy and convergence can happen, and monitor and evaluate the progress of the response.

The clusters- 1) Education and Social Behavior Change Communication, 2) National and Local Health Care Delivery Networks, 3) Human Rights, Gender and Social Protection, and 4) Policies, Systems and Financing- are envisioned to work collaboratively and in synergy within the context of their respective agency/organizational mandates for the 7th AMTP.

Fig. 8: Strategic Cluster Approach to 7th AMTP Implementation

PNAC, as the central coordinating and policy-making body at the national level, will closely collaborate with regional and local clusters through its monitoring and evaluation arm. Coordinating each cluster will be a PNAC-mandated technical expert who is adept at addressing related issues to her or his assigned cluster. The PNAC Secretariat should reconfigure itself to assign focal units or persons to assist the strategic clusters in executing their responsibilities. The key agencies will be grouped into implementing/monitoring clusters based on their constituency and mandates.

Table 5.1. Strategic Cluster: Education & Social Behavior Change Communication

Strategic Cluster: Education & Social Behavior Change Communication		
Agency/Organization	Target Constituency	Strategy
PLHIV Organizations	PLHIV and affected families	Peer outreach, treatment literacy, and adherence education
CSOs and KP CBOs	Key populations- MSM, TGW, SWs, YKP, PWUD/PWID, migrant workers, PDL, PLHIV	Peer outreach and education; Community-bBased HIV screening; HIV combination prevention education; capacity building of other CSOs/CBOs
DepEd, CWC	Elementary pupils and secondary level students	General education
CHED	Students in colleges and universities	College education

TESDA	Youth and adults in technical and vocational training	Technical and vocational education and training
DOH	Health workers and` facilities; patients	Policy and program planning and implementation, health education and service delivery
DOLE	Local workers from the private sector;	Worker education through establishments and monitoring of establishments' adherence to the practice
DMW and attached agencies such as OWWA, POEA; Seafarers' manning agencies Bureau of Quarantine, Commission on Filipino Overseas	Overseas Filipino workers; Seafarers	Worker education through Pre-departure Orientation seminars (PDOS) Exercise of regulatory functions
Civil Service Commission (CSC)	Heads of government agencies, government personnel and workers	Enforcement of civil service rules and standards including HIV in the workplace programs in all government functionaries
DILG and attached agencies such as PNP, BJMP	LGU Officials:local chief executives,Barangay and SK Officials, LGU personnel,	Education of Local AIDS Councils and the local health boards HIV and AIDS Workplace Policy and program planning
AFP (all branches)	Uniformed personnel	HIV and AIDS Workplace Policy and program planning
Philippine Information Agency (PIA), Department of Tourism, Department of Transportation, National Council for Disability Affairs, Komisyon ng Wikang Pilipino	General public, including tourists and transients, persons with various types of disabilities, indigenous people and GIDA communities	Information, campaigns planning and implementation
National Youth Commission	Sangguniang Kabataan, LGUs	HIV and AIDS Workplace Policy and program planning
National Commission on Indigenous Peoples	IP tribal leadership and IPs	HIV and AIDS Workplace Policy and program planning Education among IPs

Table 5.2. Strategic Cluster: National & Local Health Care Delivery Network

Strategic Cluster: National & Local Health Care Delivery Network		
Agency/Organization	Target Constituency	Strategy
DOH	Regional and subnational public health service delivery network	HIV continuum of care cascade
DSWD, CWC	Vulnerable and abused children; OSY, YKP, the poor and displaced people; Key populations- MSM, TGW, SWs, YKP, PWUD/PWID, PLHIV	Psycho-social support and financial assistance
PLHIV Organizations	PLHIV and affected families	Peer outreach and education; CBS; HIV Combination Prevention education; community-led monitoring
DILG, Leagues and Law Enforcement Agencies	LGUs	Policy and program planning, local health service provision; HIV continuum of care cascade
CSOs including faith-based organizations, Philippine Professional Association for Transgender Health (PPATH)	Key populations- MSM, TGW, SWs, YKP, PWUD/PWID, migrant workers, PDL, PLHIV	HIV continuum of care cascade Peer outreach and education; capacity building of other CSOs/CBOs; community-led monitoring
Medical and Allied Health Societies	Medical professionals, workers and personnel	Continuing education and occupational discipline protocols

Table 5.3 Strategic Cluster: Human Rights, Gender, & Social Protection

Strategic Cluster: Human Rights, Gender, & Social Protection		
Agency/Organization	Target Constituency	Strategy
Philhealth, Insurance Commission	PLHIV among citizens of the Philippines	Universal health care; Outpatient HIV AIDS Treatment Package of PhilHealth (OHAT)
DSWD	Social Workers, Vulnerable and Abused Children; YKP, OSY, the poor and displaced people; Key populations- MSM, TGW, SWs, YKP, PWUD/PWID, PLHIV	Psycho-social support and financial assistance

Department of Foreign Affairs (DFA),	Foreign Service Officers and personnel	Education and support for Filipino migrants
PLHIV Organizations	PLHIV and affected families	Peer support and advocacy to policy and decision makers
DOLE	Workers in the private sector	Policy development, support, and monitoring of employers' compliance to RA 11166 through DOLE DO 102-10 Guidelines for the Implementation of HIV and AIDS Prevention and Control in the Workplace Program
Civil Service Commission (CSC)	Heads of government agencies, Government personnel and workers	Monitoring and enforcement of CSC and standards including HIV in the workplace programs in government offices
CSOs	Key populations- MSM, TGW, SWs, YKP, PWUD/PWID, Migrant Workers, PDL, PLHIV	Peer support and advocacy to policy and decision makers; community-led monitoring, transgender health
Department of Justice (DOJ)	Attached agencies of DOJ	Policy support and monitoring of compliance to redress mechanism
Commission on Human Rights (CHR)	Ad hoc committee on the investigation of discrimination cases	
Department of Migrant Workers	Land and Sea based workers	Policy support and services for migrant workers
DILG, Leagues and Law Enforcement Agencies	LGUs	Policy and program planning, local health service provision; HIV continuum of care cascade

Table 5.4 Strategic Cluster: Policies, Systems, & Financing

Strategic Cluster: Policies, Systems, & Financing		
Agency/Organization	Target Constituency	Strategy
DOH, FDA	Regional and subnational public health service delivery network	HIV continuum of care cascade; Strengthening of Procurement and Supply Management
Philhealth	PLHIV among citizens of the Philippines	Funding for OHAT
National Youth Commission (NYC)	Youth (15 to 24 years old)	Policy and program planning for the youth

Civil Service Commission	Government agencies, organizations, and functionaries	Monitor implementation of issuance including resource allocation for the program in Government Offices.
National Economic Development Authority (NEDA)	Government agencies and LGUs; regional and local development councils	Social protection policy and program planning
DILG and Leagues, Bureau of Jail Management and Penology	LGUs and Local Chief Executives	Policy and program planning and funding, local health service provision; Prevention and treatment of people deprived of liberty and living with HIV
Department of Budget and Management (DBM), Senate, and House of Representatives	Government agencies and functionaries	HIV budget allocation for PNAC member-NGAs; Operational Budget allocation for PNAC and its secretariat
Department of Justice (DOJ)	Attached agencies of DOJ	Policy support and monitoring of compliance to redress mechanism
Commission on Human Rights (CHR)		
PLHIV Organizations	PLHIV and affected families	Peer support and HIV financing and social protection inclusions advocacy to policy and decision makers; community-led monitoring
CSOs including faith-based organizations, PPATH, PEPh	Key populations- MSM, TGW, SWs, YKP, PWUD/PWID, migrant workers, PDL, PLHIV	HIV financing advocacy to policy and decision makers; community-led monitoring; capacity building of CBOs for social contracting; Transgender Health
Development Partners	NGAs, LGUs, and CSOs	Support to systems strengthening
DepEd	Heads of public and private schools, elementary pupils and secondary level students	General education
CHED	Heads of public and private schools, students in colleges and universities	College education
TESDA	Youth and adults in technical and vocational training	Technical and Vocational education and training

III. 7th AMTP Monitoring and Evaluation Plan

M&E is a critical aspect of the national HIV response and is among the core functions of the PNAC. The comprehensive strategic plans laid out in this document must be supported by a monitoring and evaluation plan and system which enable the PNAC and others involved in the response to effectively monitor the progress, outcomes and impact of implementing the 7th AMTP's strategies.

M&E as core functions of the PNAC as stated in Section 5 of RA11166:

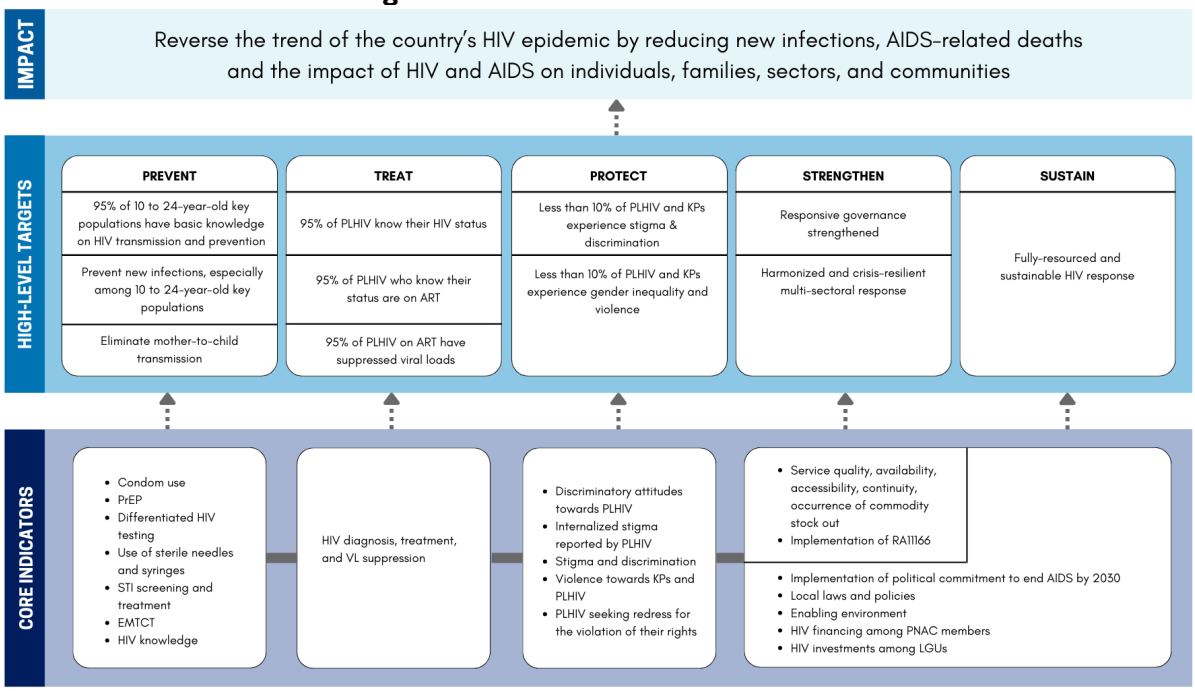
- Monitor the progress of the response to the country's HIV and AIDS situation
- Monitor the implementation of the AMTP, undertake midterm assessments and evaluate its impact
- Mobilize its members to conduct monitoring and evaluation of HIV-related programs, policies and services within their mandate
- Submit an annual report to the Office of the President, Congress, and the members of the Council
- Identify gaps in the national response on the part of government agencies and its partners from civil society and international organizations, in order to develop and implement the initial interventions required in these situations

This section contains core indicators along with data flow structures and systems identified during the 7th AMTP strategic plan development. The detailed M&E guidance and complete set of indicators aligned with the strategies and their relevant actors will be developed with the 7th AMTP's operational plan.

7th AMTP M&E Framework

Anchored on the 7th AMTP Framework, the M&E framework highlights the core indicators, high level targets and impact which the 7th AMTP aims to achieve.

Figure 9: 7th AMTP M&E Framework



Core M&E Indicators

Thirty core indicators were identified to monitor the outcomes of the five strategy pillars. Previous M&E plans from past AMTPs, the DOH Health Sector M&E plan, the CLM Roadmap, and the Human Rights Roadmap were referenced in crafting the indicators. Further, these indicators were aligned with global definitions. Necessary adjustments were made to fit the country context.

Capacity to measure the indicators, through current or future methods/systems, were considered. 13 of the 30 indicators, mostly from the protect, strengthen, and sustain strategy pillars, have no current means of measurement. Potential data sources were listed for the council's reference and consideration.

It is important to note that analyses of these indicators must include disaggregation per demographic characteristics, SOGIE, risk behavior, geographic areas, mode of service delivery (DSD), and other relevant factors to have a detailed sense of the achievements. Moreover, trends analyses through years of implementation, and triangulation from multiple sources will aid in enriching insight from the measurements. Also, cross-analyses of the indicators with each other (for example: the 95-95-95 indicators analyzed withservice quality, stigma and discrimination, amount of investments) will be helpful in getting a holistic status of the response.

Table 6.1 IMPACT INDICATORS

	Indicator	Source
1	**New HIV Infections** Estimated number of annual new HIV infections	DOH-EB, Estimation projections (Spectrum-AEM)
2	**AIDS-related deaths** Estimated number of AIDS-related deaths	

Table 6.2 INDICATORS FOR STRATEGY PILLAR 1: PREVENTION

	Indicator	Source
3	**Condom Use** Percentage of KP who used a condom at last sex	IHBSS, DOH-EB
4	**PrEP** • 4.1 Number of individuals newly enrolled to PrEP • 4.2 Number of individuals, not newly enrolled, who return for a follow-up visit or re-initiation visit to receive PrEP	OHASIS, DOH-EB
5	**Differentiated HIV testing** Percentage of KP tested for HIV by mode of reach and testing modality	IHBSS / OHASIS, DOH-EB
6	**Use of sterile needles & syringes** Percentage of PWID reporting using sterile injecting equipment the last time they injected	IHBSS, DOH-EB Operations Research
7	**STI screening and treatment** Percentage of individuals with reported STI symptoms who received care	OHASIS, DOH-EB
8	**EMTCT** • 8.1 Percentage of pregnant women are tested for HIV, syphilis, and hepatitis B surface antigen at least once • 8.2 Percentage pregnant women living with HIV diagnosed, percentage on ART among diagnosed antiretroviral therapy, % VL suppressed • 8.3 Percentage of HIV-exposed infants receive a virologic test and parents are provided with the results by age 2 months	OHASIS, DOH-EB
9	**HIV knowledge** Percentage of individuals with comprehensive knowledge on HIV transmission and prevention	YAFS Survey IHBSS Other national surveys

Table 6.3 INDICATORS FOR STRATEGY PILLAR 2: TREAT

	Indicator	Source
10	**HIV Diagnosis** Percentage of PLHIV who know their status by mode of reach and testing modality	HARP, DOH-EB
11	**HIV Treatment** • 11.1 Percentage of diagnosed PLHIV on ART • 11.2 Percentage of PLHIV on ART on multi-month dispensing (MMD) • 11.3 Percentage of PLHIV on ART at 12 and 24 months after initiating ART disaggregated by dispensing modality	HARP, DOH-EB
12	**VL Suppression** Percentage of PLHIV on ART who are virally suppressed	HARP, DOH-EB

Table 6.4 INDICATORS FOR STRATEGY PILLAR 3: PROTECT

	Indicator	Source
13	**Discriminatory attitudes towards PLHIV** Percentage of women and men 15–49 years old who report discriminatory attitudes towards people living with HIV	NDHS
14	**Internalized stigma reported by people living with HIV** Percentage of people living with HIV who report internalized stigma	Stigma Index
15	**Stigma and discrimination experienced by people living with HIV and key populations** • 15.1 Percentage of people living with HIV who report experienced stigma and discrimination in the last 12 months – per 6 settings • 15.2 Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months • 15.3 Percentage of key populations who avoided health care because of stigma and discrimination	Stigma Index *Survey among KP, CLM*
16	**Violence towards KP and PLHIV** • 16.1 Percentage of key populations who experience physical or sexual violence • 16.2 Percentage of people living with HIV experience physical or sexual violence	*Survey among KP, CLM*
17	**People living with HIV seeking redress for violation of their rights** Proportion of people living with HIV who have experienced rights abuses in the last 12 months and have sought redress	*Survey among PLHIV or case reports*

18	**Social Protection** Percentage of people living with HIV with access to one or more social protection benefits	*Survey among PLHIV or case reports*

Table 6.5 INDICATORS FOR STRATEGY PILLAR 4: STRENGTHEN

	Indicator	Source
19	**Service quality** Percentage of clients who received quality service during their last access of HIV services Quality defined through a) service availability, commodity availability, wait time, staff demeanor, provision of HIV information	CLM
20	**Service availability** Percentage of clients who received needed services (per type of service)	CLM
21	**Service accessibility** Percentage of KP who were able to access needed HIV services in the past 6 months/12 months	CLM
22	**Service continuity** • 22.1 Percentage of clients who receive HIV testing, treatment, and other services during the period of crisis or conflict • 22.2 Number of reports of stock outs within a reporting period	DOH, CLM, Special surveys
23	**Integration of HIV services** Percentage of people living with HIV linked to people-centred and context-specific integrated services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being	*PLHIV Survey*

Table 6.6 INDICATORS FOR STRATEGY PILLAR 4 & 5: STRENGTHEN & SUSTAIN

	Indicator	Source
24	**Implementation of the RA 11166** Percentage of completion of mandated policies stipulated in RA 11166	PNAC, CLM
25	**Implementation of Political Commitment to End AIDS by 2030** Percentage of recommended global policies adopted	PNAC-NCPI, CLM
26	**Local HIV Response Implementation** • 26.1 Percentage of LGUs with local AIDS ordinances aligned with RA 11166 • 26.2 Percentage of LGUs with anti-discrimination ordinances	PNAC, CLM

	• 26.3 Percentage of LGUs with active local AIDS councils • 26.4 Percentage of LGUs with established societal enablers *Societal enablers including programmes to reduce/eliminate HIV-related stigma and discrimination, advocacy to promote enabling legal environments, programmes for legal literacy and linkages to legal support, and reduction/elimination of gender-based violence • 26.5 Percentage of LGUs with effective HIV response Effective response defined through a combination of sub-indicators on ordinance implementation, quality services, HIV care cascade accomplishments,	
27	**Community-led services** • 27.1 Percentage of service delivery for HIV prevention programs for key populations to be delivered by community-led organizations • 27.2 Percentage of testing and treatment services to be delivered by community-led organizations	*PNAC, CLM*

Table 6.7 INDICATORS FOR STRATEGY PILLAR 5: SUSTAIN

	Indicator	Source
28	**HIV financing among PNAC Members** Percentage of PNAC government agency members with HIV budget appropriations	PNAC
29	**HIV investments among LGUs** • 29.1 Percentage of LGUs with HIV budget appropriations • 29.2 Percentage of LGUs with HIV fund allocation meeting investment needs	PNAC
30	**Total HIV expenditure** Total expenditure from all sources spent on HIV and AIDS at the national level, including health and non-health ● Combination HIV prevention ● HIV testing and counselling ● HIV treatment ● TB and HIV ● EMTCT ● Social enablers	PNAC-NASA

National HIV M&E System

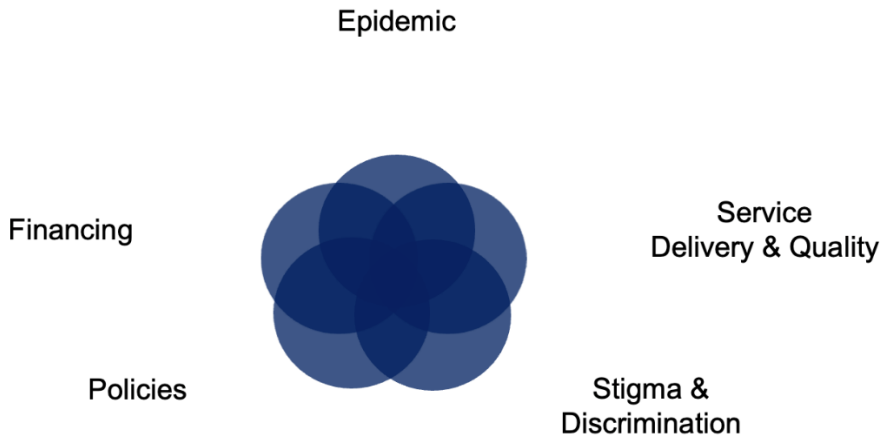
To effectively measure the 7th AMTP indicators as well as continuously provide strategic information to the PNAC, and other actors and stakeholders involved in the HIV response, a comprehensive and robust M&E system must be set in place.

Objectives of the National HIV M&E System

- Systematically **track** the progress of the epidemic and the results of the programmatic inputs, outputs, outcomes and impact of HIV and AIDS interventions
- Provide timely and accurate information to meet national and international **reporting** requirements
- Provide **strategic guidance** to the PNAC and all other agencies and organizations contributing to the national HIV response

HIV M&E Domains. Areas of the HIV situation and response which the PNAC should monitor can be summarized into five domains (Figure 10). Data from each domain should be cross-analyzed to have a holistic measurement of the HIV situation and response in the country.

Figure 10: HIV M&E Domains



Epidemic. The magnitude and trajectory of the Philippine HIV epidemic is being monitored through the National HIV/AIDS and STI Surveillance Systems of the DOH-Epidemiology Bureau. Data from these systems include number of reported HIV cases as well as estimates of the total number of people living with HIV in the country, annual new HIV infections and AIDS-related deaths. These systems also monitor the demographics where most infections occur as well as the level of burden of different LGUs and regions in the country.

Service Delivery and Quality. This domain represents the measurement of the type and quality of services provided for people and communities affected by HIV. Data on HIV program accomplishment from different sectors, as well as service quality, accessibility and availability will fall in this domain.

Stigma and Discrimination. Apart from the number of PLHIV, and status of the 95-95-95, levels of stigma and discrimination among PLHIV and KP are important indicators of the quality of the HIV response and its implementation.

Policies. This domain reflects the policy monitoring work of the PNAC. Policy monitoring should include tracking policies that enable effective implementation of the HIV response, as well as those

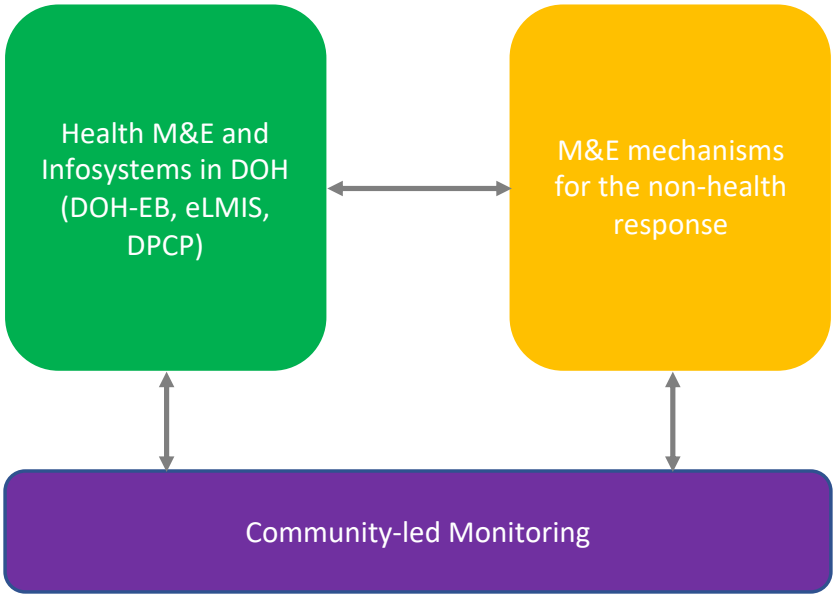
that hinder it. It also includes monitoring the status of implementation of existing policies across areas and sectors.

Financing. This domain involves monitoring the amount of HIV investment needs of the various areas of the response across different levels of implementation. It also includes measurement of actual spending vs. the need as well as cost-effectiveness of interventions implemented.

System Components and Tools. The Philippines has been successful in having a robust and comprehensive HIV surveillance and response monitoring system in the health sector through the HIV system of the DOH-Epidemiology Bureau. However, to ensure a comprehensive and holistic approach to M&E, the national HIV M&E system must have components beyond that of HIV epidemic surveillance and health sector program monitoring.

Figure 11 summarizes three main components of the HIV M&E system: 1) the health sector, 2) the non-health, and 3) the community-led monitoring system which will interact with each other, as shown by the arrows in the figure, to provide strategic information coming from all sectors for the Philippine HIV and AIDS response.

Figure 11: HIV M&E System Components

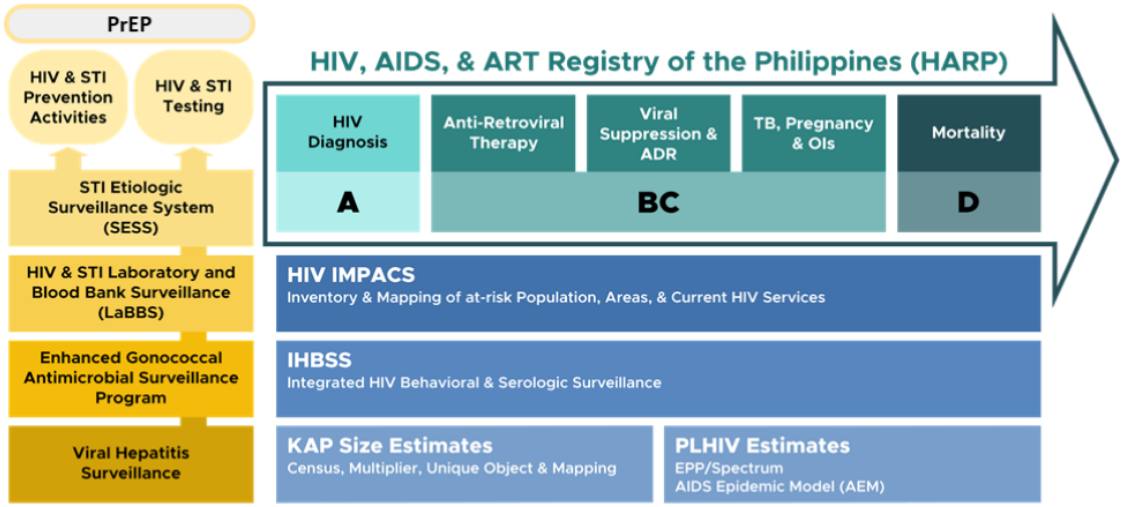


National HIV, AIDS and STI Surveillance System in DOH-Epidemiology Bureau. The Department of Health – Epidemiology Bureau (DOH-EB), pursuant to the Republic Act 11166, also known as the HIV and AIDS Policy Act of 2018 of the Philippines, is mandated to "maintain a comprehensive HIV and AIDS monitoring and evaluation program" that will monitor the magnitude and progression of HIV and AIDS in the Philippines and provide information to guide the HIV response, through the National HIV, AIDS, and STI Surveillance System (Figure 10) and its sub systems managed by the National

HIV & STI Surveillance & Strategic Information Unit (NHSSS) of DOH-EB. Specifically, DOH-EB monitors:

- Epidemiologic trends
- Progress and outcomes of the health response
- HIV epidemiology and case surveillance
- Health program accomplishments

Figure 12. The National HIV/AIDS & STI Surveillance System



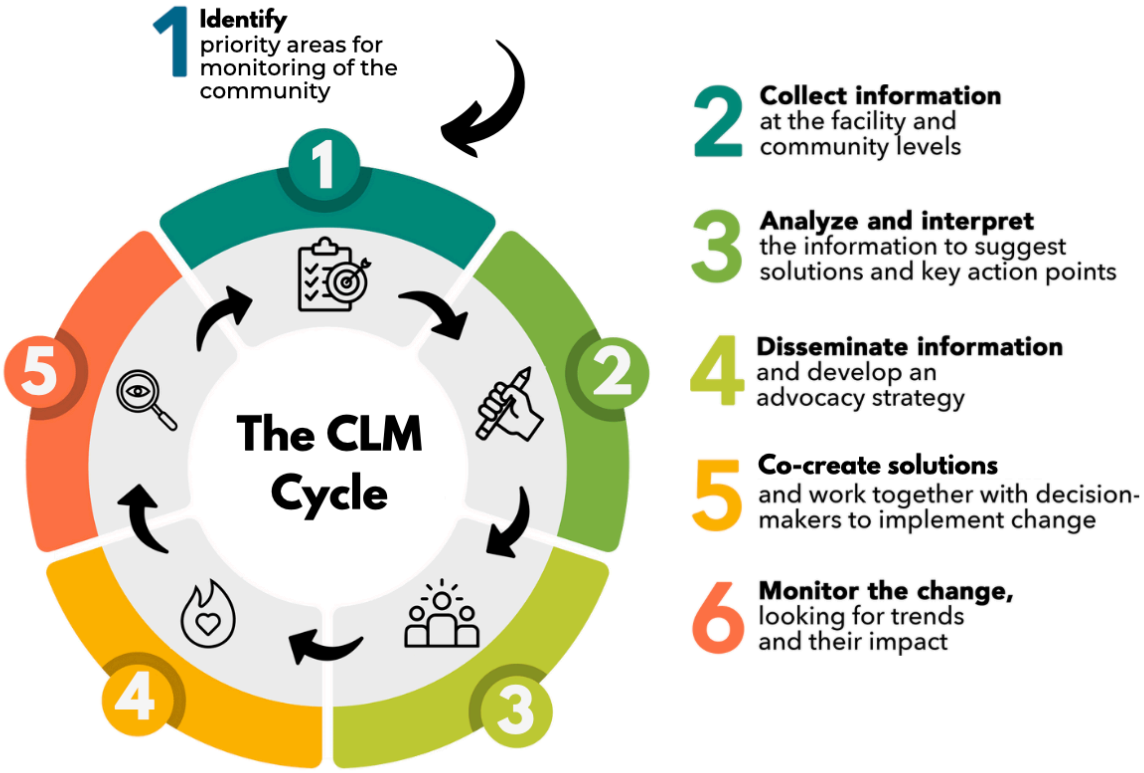
In monitoring the epidemiological trends and progress of the response, various surveillance systems are maintained, including, but not limited to, the HIV, AIDS, and ART Registry of the Philippines (HARP), HIV & STI Testing, Pre-exposure Prophylaxis (PrEP) Surveillance, STI Etiologic Surveillance System (SESS), Laboratory and Blood Bank Surveillance (LaBBS), Enhanced Gonococcal Antimicrobial Surveillance Program (EGASP), and Viral Hepatitis Surveillance. The One HIV, AIDS and STI Information System (OHASIS) serves as the national electronic reporting platform for HIV, viral hepatitis, and other STIs in the Philippines.

In addition to being used for epidemiologic monitoring and program improvement, information from the various surveillance systems feed into other surveillance tools and products of the NHSSS to develop estimates and projections of the HIV epidemic, which is then used for monitoring and evaluation, target setting and program planning for national and sub-national areas, budget projections, and advocacy. This includes the AIDS Epidemic Model (AEM) - SPECTRUM, the Integrated HIV Behavioral and Serologic Survey (IHBSS), Key Population Size Estimates, and the determination of Priority Areas for HIV Intervention (PAHI).

Community-led Monitoring. CLM is a monitoring system owned and led by communities of KP, PLHIV, and civil society organizations working in HIV. It's composed of composed of four-interconnected pillars: *service quality, stigma and discrimination, policies* and *finance* which generates and uses HIV-related strategic information to support the community in policy advocacy, program quality improvement, and more effective engagement in the multisectoral HIV response.

CLM aims to 1) document evidence, experiences and trends related to service quality, stigma and discrimination, policies and finance in HIV, 2) improve community capacities to generate and use data for advocacy, and 3) trigger co-creation of solutions by the different rights holders and duty bearers of the multisectoral HIV response. To meet these objectives, CLM follows a cycle of data collection, analyses, dissemination and co-creation of solutions (Figure 11).

Figure 13. The CLM Cycle



Key M&E Activities.

Table 7. Key M&E Activities

TRACK	• Data generation (i.e. modelling & estimation, behavioral surveys among KP and PLHIV, HIV care continuum, CLM) • Policy Tracking (NCPI) • National AIDS Spending Assessment (NASA)

	• Field monitoring • Internal and external reviews at different levels of implementation • Mid-term and end evaluation
REPORT	• Annual report to the Office of the President, Congress, and the members of the Council • Global AIDS Monitoring • Other relevant reporting • Data Dissemination Forums
GUIDE	• Regular M&E sessions (data deep dive) between committees & other relevant stakeholders • Feedback mechanisms (to council plenary, committees, communities, other relevant stakeholders) • Strategic information and response planning workshops (i.e. STIR-UP of DOH-EB) • Modelling of policy and investment scenarios • Multidisciplinary research on various aspects of the HIV response (i.e. cost effectiveness of interventions, implementation science of new technologies, innovations, etc.)

PNAC AIDS Data Hub. *A* comprehensive (one-stop shop) web-based platform that can serve as the PNAC's public accountability mechanism on the council's work and progress. The data hub can also serve as a resource repository the public can access to view archives of policies, data, and other significant documents about the Philippine HIV response. It can also serve as a tool to streamline reporting and data sharing among PNAC members and others involved in the HIV response. The data hub can also interface with data systems of the M&E system components such as OHASIS of DOH-Epidemiology Bureau, and comusta.ph of Community-led Monitoring to consolidate data gathered from these systems for the council's consumption. Plans for the platform's development should be detailed in the 7th AMTP operational plan.

M&E Structure and Data Flow. Figure 12 shows the initial suggested structure for M&E and data flow in the PNAC. This structure can be enhanced further, especially after the completion of the input and output level indicators from the 7th AMTP operational plan, and once the PNAC M&E Unit has mapped out systems and M&E units which can contribute information to the national system.

PNAC M&E Committee. The M&E Committee will serve as the oversight of the national HIV M&E system, and all the M&E activities of the council. For example, the Committee will oversee

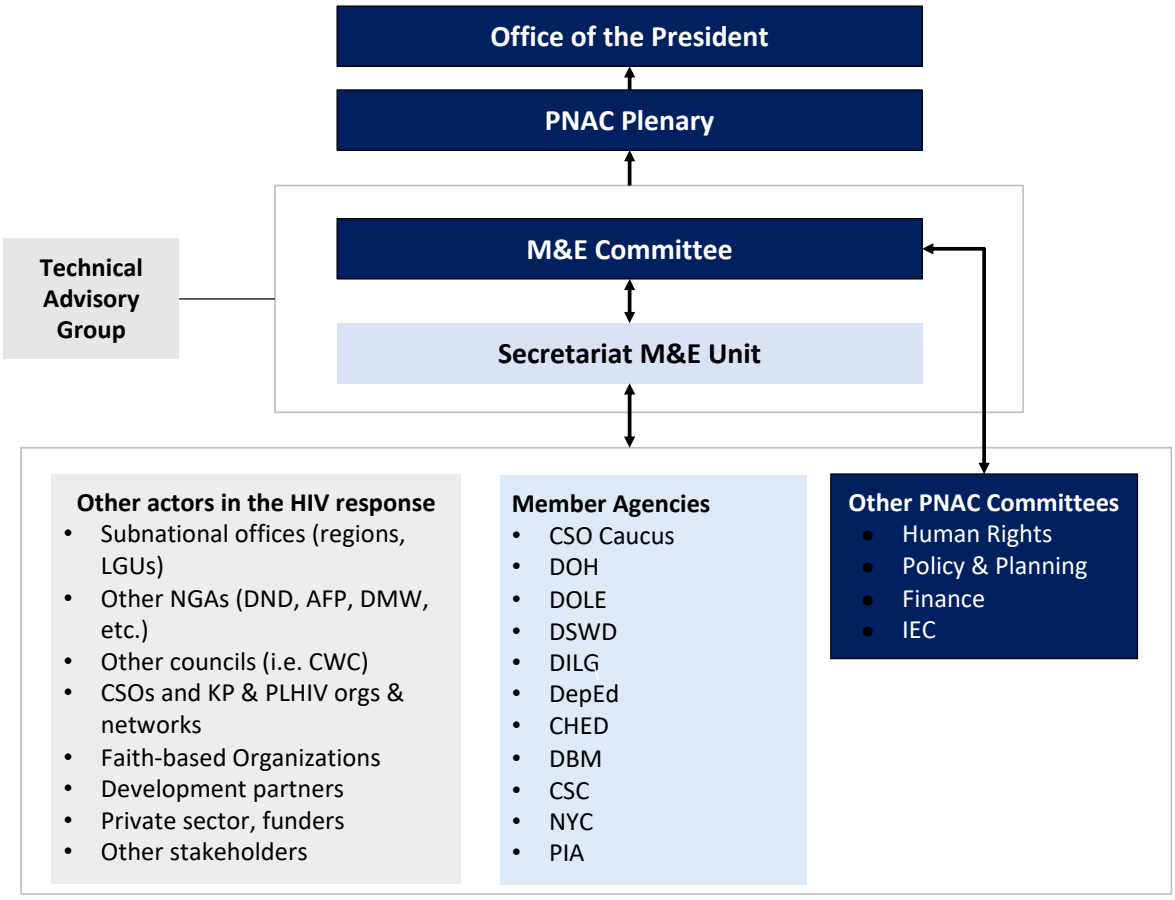
the completion of the council's annual progress report and submission to the Global AIDS Monitoring among others. Further, the committee will also stir M&E discussions in the council, and facilitate implementation of the strategies identified to strengthen the M&E system.

Secretariat M&E Unit. Aligned with the Secretariat's function as workhorse of the council, the M&E unit within the PNAC Secretariat will manage the PNAC AIDS Data Hub,

Technical Advisory Group. This multisectoral and multidisciplinary advisory group will serve as a source of expertise for the M&E Committee in the process of strengthening the national HIV M&E system and building

Other PNAC Committees, member agencies and other actors in the HIV response

Figure 14. PNAC M&E Structure and Data Flow



Strategies to strengthen the national HIV M&E system

BUILD and ENHANCE (SYSTEMS & TOOLS)

- Develop a detailed and costed M&E plan along with the 7th AMTP operational plan – input and output indicators per sector
- Develop a research agenda and mobilize resources for its implementation
- Establish PNAC Data Hub (digital platform)
- Map M&E systems and/or mechanisms of other PNAC members to determine how HIV-related indicators can be incorporated and reported
- Update the M&E Manual written in 2006, and develop standard tools for routine monitoring by PNAC members
- Enhance existing systems, tools, and implementation of M&E activities – ex. Comprehensiveness of NASA
- Strengthen reporting from all sectors and levels of implementation

BUILD and ENHANCE (CAPACITIES)

- Enhance capacity of PNAC for M&E
- Improve analyses paradigms and frameworks – multiple risks, gender inclusivity and sensitivity, intersectionality, DSD, granular (local units)
- Improve data use culture at all levels of implementation and across sectors

PARTNER & COLLABORATE

- Convene a multisectoral and multidisciplinary technical advisory group for M&E and research
- Foster partnerships and collaborations among PNAC members and other agencies (public and private) for M&E and research activities
- Identify monitoring units at the local level (regional and/or LGU); leverage existing mechanisms among PNAC members

FUND and SUSTAIN

- Mobilize resources for M&E activities
- Establish sustainability mechanisms for M&E systems, structures, and activities
- Institutionalize good practices and systems from different sectors including communities and external grants

IV. Ways Forward

PNAC should spearhead the development of the six-year Operational Plan of the 7th AMTP within the early 2023. The members of PNAC and program implementers (for health and non-health components) at all levels should be tasked to expound their respective HIV and AIDS initiatives under the aegis of the 7th AMTP.

Further, the members of the four (4) strategic clusters should be convened so they can also define the collaborative arrangement, firm up the concerted mechanism, and plan for the task ahead of them.

The 7th AMTP, its operational plan, monitoring and evaluation plan, and the implementation arrangements should also be widely disseminated to achieve stakeholders' common understanding of the strategies, programs and activities, as well as the standards against which their respective initiatives shall be measured.

APPENDICES

Appendix A: 7th AMTP Strategy Matrix Summary AMTP7 Summary Matrix

Appendix B: 7th AMTP Monitoring and Evaluation Plan Indicators (AMTP7 M&E Plan Indicator Appendix)

Appendix C: List of Participants in the Development of the 7th AMTP

Table x: Consultation Workshop Participants from CSOs and KP communities

Organization	Name/s
Action for Health Initiatives Inc. (ACHIEVE)	1. Aquino, Elma 2. Boyles, Bernadette 3. Capid, Leo 4. Cruz, Bjon 5. Cua, Caren 6. De Leon, James 7. Figuracion, Roberto Jr. 8. Igcasinza, Liza 9. Paje, Gloria 10. Raymundo, Alain 11. Santos, Jerome Ernest
	12. Flores, Alcain 13. Pegarido, Juno
AIDS Society of the Philippines (ASP)	14. Cabreros, Gem 15. Chia, Elsa 16. Dychinco-Sevidal, Nelia 17. Esguerra, Ramil 18. Fonacier-Felizar, Irene 19. Galay, Lady Santha 20. Ramirez, Jesus
Al Keire Support Group	21. Querimit, Leslie
Alliance Against AIDS in Mindanao Inc. (ALAGAD-Mindanao)	22. Mahinay, Michael Jesus 23. Tolop, Jeanethe
Alliance of Living Individual Visioning Empowerment Support Group	24. Ouano, John Michael De Lara
Amoma Caraga, Inc.	25. Orosia, Anmarc
AMSG	26. Eroles, Neri

Association of Positive Women Advocates Inc. (APWAI)	27. Cruz, Bunso 28. Morales, Maria Cristina 29. Padilla, Rica Joy
Bahaghari Advocacy Group	30. Dofitas, Van August
Bahaghari San Pablo	31. Amado, Basil
Batangas Barako Pride Inc.	32. Villapando, AJ
Cagayan Valley Support Group	33. Tarun, Marvin
Caloocan Equality Coalition	34. Pascual, Cody
Candon Youth for Empowerment Movement Inc. (CYM)	35. Rances, Nigel
Cavite Positive Action Group (CPAG)	36. Honra, Joseph
Cebu United Rainbow LGBTQIA Sector Inc. (CURLS)	37. Cabije, Joyce
Center for Migrant Advocacy (CMA)	38. Ocado, Rowena
Center for Youth Advocacy & Networking (CYAN)	39. Rodriguez, Jeza
Community and Family Services International (CFSI)	40. Dizon, Patricia 41. La Torre, John Patrick
Courage Pilipinas PLHIV Advocacy, Care and Support Inc.	42. Mendoza, Jose Rommel
Cross Breeds Plus Negros Inc.	43. Makilan, Arnulfo
DANGAL Pilipinas	44. Robinson, Magdalena
DAYAW Community Center	45. Remotin, Mark Roche 46. Sagun, John Bryan 47. Sinadjan, Jaziel
DIOSSA	48. Navarra, Sam
Family Planning of the Philippines (FPOP) Iloilo	49. Guillermo, Kris Anne 50. Sa-ato, Patrick Ivan
Family Planning of the Philippines (FPOP) Metro Manila	51. Constantino, Abigail 52. Hernandez, Paul 53. Nadarisay, Sydney

FSH	54. Lustestica, Mark Anthony
Gabay sa Pulang Laso Inc. (GPLI)	55. Calizo, Herman
GANDA Filipina	56. Lee, Yasmin
Gayon Albay LGBT Organization	57. Rivac, Toots
Gays And Transgender Advocates (GATA)	58. Echavez, Ligaya
GentleMen Bicol for Sexual and Reproductive Health and Rights, Inc.	59. Hayag, Richard
GenZine/Teen Support Group (TSG)	60. Condesa, John Paul 61. Pacheco, John Dave
Health Action Information Network Inc. (HAIN)	62. De Vera, Emilyne
HIV AIDS Support House (HASH)	63. Hing, Desi Andrew 64. Singson, Prince 65. Santos, Dhevon 66. Tiamson, Blue
IDUCARE/DIC	67. Amiel Abarquez
Indigo	68. Torres, Jaybee
IPS	69. Barangot, Ronald Kevin
Kabalikat ng Migranteng Pilipino, Inc. (KAMPI)	70. Calderon, Luther
Kagay-an PLUS Inc. (KPLUS)	71. Tangcalagan, Aurora
Kakampi ng mga Kamag-anak ng Migranteng Manggagawang Pilipino, Inc. (KAKAMPI)	72. Nicodemus, Fe
KAUBANAY	73. Enanoria, Jon Voie 74. Luison, Mayrick
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Lawig Bubai	77. Alanonay, Genna 78. Amba, Marianne

	79. Briones, Juyeth 80. Gregorio, Mary Grace 81. Jaca, Sweet Lyka Joy 82. Pabunag, Lory 83. Pabunag, Lory 84. Quimbo, Aloha Maxine 85. Tabasan, Sheila Mae
LGBT Rainbow Pride	86. Dacones, Anthony Carl
LIKHAAN Centers for Women's Health Inc.	87. Dela Cruz, Jose Andrelin
Mindanao AIDS Advocates Association Inc. (MAAAI)	88. Velasco, Manuel
National Young Heroes League (NYHL)	89. Dela Cruz, Eula Genrill 90. Olilang, Francis Wilfred
Network Plus Philippines	91. Felix, Elena 92. Figuracion, Roberto Jr.
Northern Sanctuary MCC	93. Sotero, Michael Angelo
PAMAQ	94. Santiago, Winston
PANTAY	95. Manuzon, Rye
PEPA	96. Goopio, Dondy Pugales
Pilipinas Shell Foundation Inc. (PSFI)	97. Abenoja, Jeri 98. Angluben, Ray 99. Aporador, McDan 100. Mortel, Rob 101. Norella, Loyd Brendan 102. Oliveros, Oscar 103. Tenoria, Darwin 104. Trudeau, Marvi
Pink Salmon Plus Association Inc.	105. Octavio, Zyrnx John
Positibong Pasigueño	106. Cruz, Karen 107. Mata, Kael
Positive Action Foundation Philippines Inc. (PAFPI)	108. Concepcion, Deymos 109. Garcia, Emmanuel 110. Lim, Robert Ignatius 111. Navarra, Rodel

Rajah Community Center	112. 113.	Secular, Franz Luigi Secular, Matt Andrew
REDx	114.	Eloso, Russell
Region Eight HIV Advocacy Group Inc. (REHAG. Inc.)	115.	Bartolome, Eduardo
Regional TB Health Support Network (RTHSN)	116.	Cabuso, Mac Russelle
Roots of Health	117.	Gerona, Jayson
San Julian Pride Advocacy Group	118.	Casis, Vergel
SHC Makati	119.	Cancillar, Basha
SHINE	120.	Lopera, Cris
Society of Trans Women of the Philippines (STRAP)	121.	Rebong, Vashti
SOS	122.	Agawin, Orly
Sustained Health Initiatives of the Philippines (SHIP)	123.	Ogues, Aloysius Gerrardo
TAHAS	124.	Espinosa, Erwin
The LoveYourself Inc.	125. 126. 127.	Araña, Yanyan Dee, Jhay Rosos, Bubbles
The Project Red Ribbon (TRR) Care Management Foundation Inc.	128. 129.	David, Anthony Louie Rodulfo-Johnson, Ico
The Project Red Ribbon (TRR) Duyan	130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141.	Alice, Malate Aluan, Princess Rose Ann Arroyo, Christine Arroyo, Fernan Jacob Arroyo, Jhustine Cody Barredo, Marco Angelo Busico, Ashley Joie Busico, Joebert Busico, Lawrence Castillo, Edmond Castillo, Edmond Dale Dua, Jacqueline

	142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159.	Dua, Serendra Farro, Ronalyn Geneta, Jay Geneta, Teresita Lucas, Princess Nicole Magdaluyo, Pamela Mamaril, Elmma Manalo-Ramos, Adelina Noda, Shantal Leigh Ocray, Maria Czarina Ohaya, Bhetina Marie Ongjoco, Precious Ongjoco, Psyrish Nicole Pilar, Grace del Pore, Elisa Ramos, Ruzzelle Anthonie Santelices, Jessy Sibuyas, Anita
The Red Whistle Inc. (TRW)	160.	Bernabe, Benedict
Tingog sa Kababayen-an	161. 162. 163. 164. 165.	Bungabong, Bless Janiel Orillaneda, Jhonamae Pelias. Sylvia Sible, Joy Tignawan, Mary Ann
Tingog sa Kasanag Inc. (TISAKA)	166. 167. 168. 169. 170. 171. 172.	Abella, Jessel Estremos, Queenan Lijesta, Laddiane Faith Maamor, Sahrah Oficiar, Annabel Sabella, Jenny Quiamco, Mirasol
TLF Share Collective Inc.	173. 174. 175. 176.	Bona, Renier Buenviaje, Ferdinand Dimaisip, Jessie Leis, Noemi Bayoneta
Transpinay of Antipolo Organization (TAO)	177.	Ibardolaza, Kristine
Tropical Disease Foundation Inc.	178.	Kihom, Harley Ronniekson
UNICEF	179. 180.	Balibago, Mar Emee Lei Valduhuesa

UP Babaylan	181.	Melo, Justin
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Wagayway Equality Inc.	189.	Alcantara, Trebbie
Young Advocate for SRHR	190.	Erjas, Rovie
Youth for Mental Health Coalition	191.	Aquino, Rachelle Collen
Unaffiliated/unlisted	192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221.	Abarguez, Arneil Aldenita, Ann Marie Aquino, Ruby Jane Arucan, Ramil Batucan, Philip Bayani, Terence Blanco, Marlon Brobo, Sherwin Cabatingan, Miraflor Caratao, Rogelio Jr. Chin, Jan delos Santos, Hannah Dinopol, Reyven Encarnacion, Marisol Evangelista, Margiel Garcia, Emmanuel Huguete, Janice Igot, Marlon Jacalan, Crisel Laridio, Jennifer Jean Las-Duce, Romulo Lotino, Jimielou Luba, Filmar Miñoza, Frederick Onpoc, Vincent Purca, Gilbert Ramos, Nelson Ramos, Rosemarie Sario, Ramil Ylana, Sam Ryan Victor

Table x: Consultation Workshop Participants from LGU, NGA, and development partners

Development Partners	222.	Amoroso, Mark Angelo (WHO PH)
	223.	Apilado, Ced (UNFPA)
	224.	Behino, Cecil (UNDP)
	225.	de la Cruz Katherine (UNODC)
	226.	Gracia, Joshua (UNICEF)
	227.	Navarro, Mikael N. (USAID)
	228.	Maranan, Clarence (USAID)
	229.	Ocampo, Louie (UNAIDS)
	230.	Ortega Nenet (AIDS Healthcare Foundation)
	231.	Quintos, Malou (UNAIDS)
	232.	Tilout, Katherine (USAID)
	233.	Valdehueza, Emee Lei A. (UNICEF)
	234.	, Angel(UNICEF)
	235.	Reyes, Katherine (Palladium-PROTECTHealth)
	236.	Lacson, Rommel (US Center for Disease Control)
	237.	Zuniga, Yves Miel (United for Global Mental Health)
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	239.	Gagan, Flordeliza
	240.	(CHO-SHC, Mandaue City)
	241.	Guevarra, Christine (CHO BALE-Angeleño)
	242.	Guzman, James C. (LGU of Tuguegarao)
	243.	Loma, Maria Chona (SHC Cebu)
	244.	Manaligod, Diane (CHO)
	245.	Monico, Romulo R. (LGU of San Fernando)
	246.	Ordoña, Amor A. (LGU of San Fernando)
	247.	Retuya, Teodulfo Joselito A. Jr. (CHO- SHC, Cagayan de Oro City)
	248.	Raneses, Joan (CHO-SHC, Pasay City)
	249.	Roque, Rocylene (CHO-SHC, Pasig City)
	250.	Sescon, Jose Narciso (Sta Ana Hospital, Manila)
	251.	Verona Guevarra, (CHO BALE-Angeleño)
	252.	Villaruel, Ma. Odeta (SHC Iloilo City)
National Government Agencies and Councils	253.	Baton, Van Philip (Region 7 CHD-DOH)
	254.	Bautista, Daryl (DOLE-OHS)
	255.	Belimac, Gerard (DOH-DPCB)
	256.	Bulatao, Mike (DOH-HPDPB)
	257.	Cabreros, Margareth (DOH-EB)
	258.	Cañares, Carlo (PIA)
	259.	Cayabyab, Aaron, (CHR)
	260.	Develos, Maricel (AFP)
	261.	Fernandez, Ma. Teresa C. (CSC)

	262. Fontanilla, Nicole Rose B. (DSWD) 263. Galban, Dexter (Asst Secretary, DepEd) 264. Labarda, Felix Jr. (DOLE-BWC) 265. Laxamana, Ma. Francia (Undersecretary for Special Concerns-DOH) 266. Obien, Jennifer (DOLE-BWC) 267. Osia, Carol Mae F. (AFP) 268. Leocario, Ryan (DOJ) 269. Malagad, Gianne (DOH-DPCB) 270. Morin, Mary Joy (DOH-NASPCP) 271. Omlang, Caryl (NYC) 272. Ordovez, Paolo (Council for th Welfare of Children) 273. Palaypayon, Noel S. (DOH EB) 274. Pamittan, Krystal Gayle (DOH EB) 275. Santos, Dan Paul (DepEd) 276. Santos, Ryan Eljan (DILG-BJMP) 277. Sardan, Roland L. (DOH-NASPCP) 278. Tanghal, Nookie (Office of Sen Bong Go- Senate of the Philippines) 279. Tiongson, Butch (Office of Usec Laxamana- DOH)

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pronged-approach-on-war-against-illegal-drugs?fbclid=IwAR0TDVP0SjRSPJkMGYfDmWrWTJQWkUpUYXyw4EEH2iLfB56bW1UCsjzqxQ8

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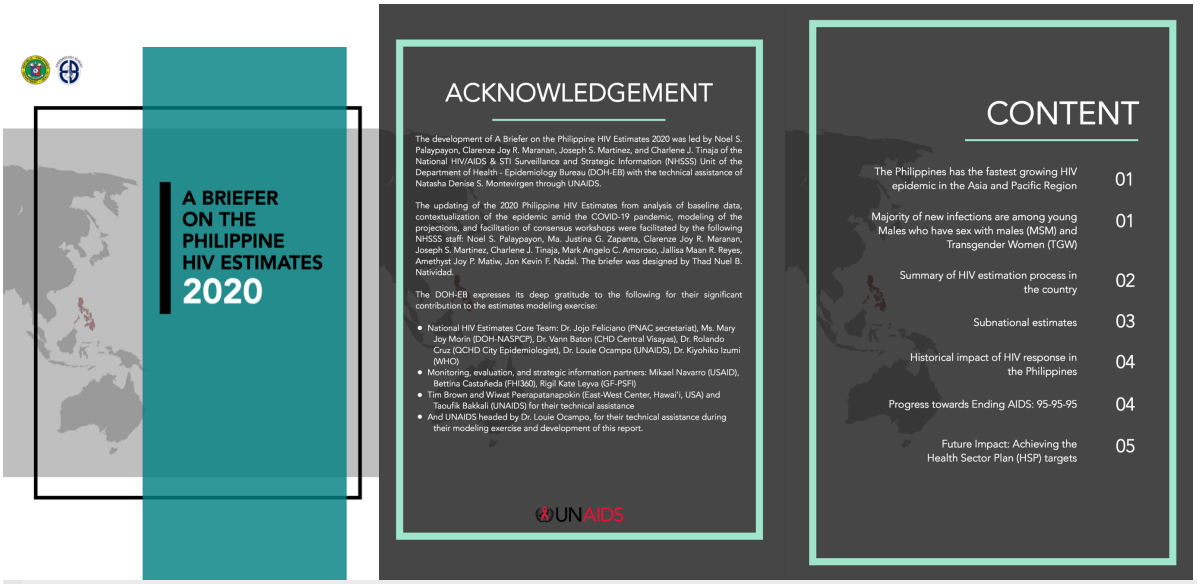
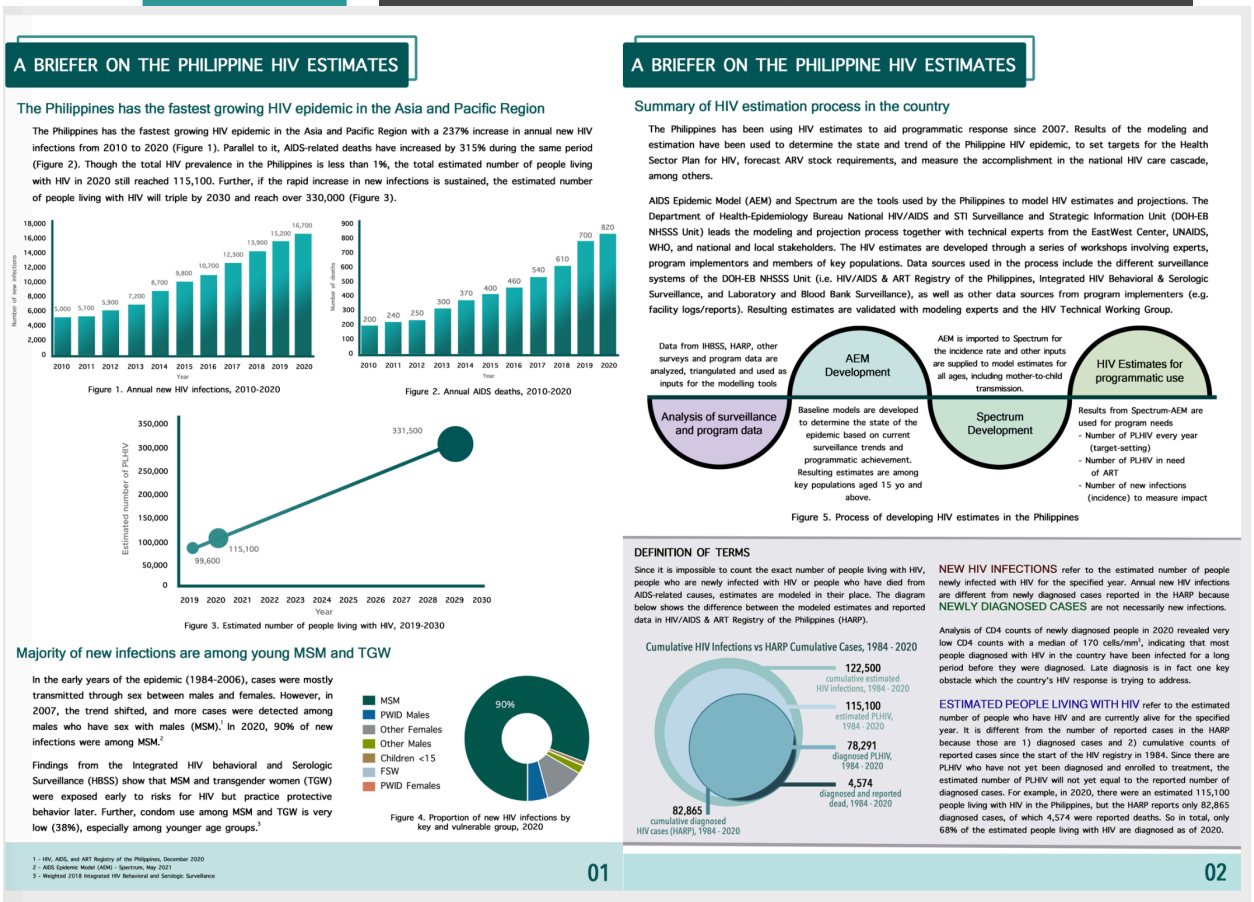
ANNEXES

Annex 1: A Briefer on the Philippine HIV Estimates 2020 DOH-EB and UNAIDS





A BRIEFER ON THE PHILIPPINE HIV ESTIMATES

Subnational Estimates

In order to simulate the different magnitude of the HIV epidemic across different areas in the Philippines, the country models its national HIV epidemic by first creating separate subnational AEMs and combining them for the national AEM.

All cities and municipalities in the Philippines are distributed to three main categories depending on the magnitude of their local HIV epidemics:

Table 1. Subnational Model Categories

CATEGORY	DEFINITION
A	A total of 117 local government units were categorized into high burden areas which have a median HIV case-population ratio of 10.5 per 10,000, including all cities and municipalities in the National Capital Region (NCR) and Cebu Province (See List of 117 High Burden LGUs in Annex). In AEM, NCR and Cebu Province are modeled separately from the rest of Category A given the unique characteristics of the region and province respectively.
B	Middle burden areas with a median HIV case-population ratio of 4.8 per 10,000 or around half the magnitude of the Category A HIV epidemic.
C	Low burden areas with a median HIV case-population ratio of 2.0 per 10,000 or a fifth of Category A's HIV epidemic.

Figure 6 shows the proportion of estimated PLHIV among 15 years old and above by subnational model category. NCR comprise 33% (38,300), other high burden areas (other Cat. A areas) comprise 39% (44,100), Middle burden areas (Cat. B) make up 17% (19,200), and Low burden areas (Cat. C) make up 11% (12,200).

Local AEMs are also produced for Angeles, Cagayan de Oro, Cebu, Davao, Iloilo and Quezon City.

Meanwhile, the Regional estimates are computed using the proportion of diagnosed HIV cases per city and municipality in HARP, results of subnational and local AEMs, and the national estimates. Figure 7 shows the estimated number of PLHIV per region for 2020.

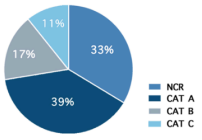


Figure 6. 2020 Estimated PLHIV among 15 years old and above

National	115,100
NCR	38,700
4A	19,300
3	11,900
7	11,400
11	6,900
6	6,600
12	3,200
10	2,800
1	2,800
5	2,200
9	1,700
8	1,700
2	1,700
4B	1,600
CARAGA	1,300
CAR	1,000
BARMM	300

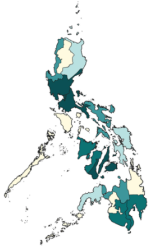


Figure 7. Heat map of estimated number of PLHIV per region for 2020, all ages

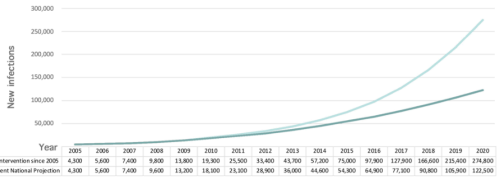
A BRIEFER ON THE PHILIPPINE HIV ESTIMATES

Historical Impact: No intervention vs. Current National Projections

Modelling shows that a total of 152,300 HIV infections were averted by the Philippines because of the interventions established in the HIV response since 2005. If no interventions were put in place between 2005 and 2020, the total cumulative HIV infections for 2020 would have reached 274,800, double the amount projected for the current estimates which is at 122,500 as seen in Figure 8. This shows the impact of the HIV response in the Philippines in the past 15 years. With continuous improvement in the country's HIV response, more HIV infections could be averted and more lives saved from HIV and AIDS.

152,300
infections averted

Cumulative HIV Infections among 15 years old and above, 2005-2020



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
No intervention since 2005	4,300	5,600	7,400	9,800	13,800	19,300	25,500	33,400	43,700	57,200	75,000	97,900	127,900	166,600	215,400	274,800
Current National Projection	4,300	5,600	7,400	9,600	13,200	18,100	23,100	28,900	36,000	44,600	54,300	64,900	77,300	90,800	105,900	122,500

2020 Cumulative HIV Infection
274,800 — No Intervention Scenario
122,500 — Current National Projection

Figure 8. HIV infections averted, 2005-2020

Progress towards Ending AIDS: 95-95-95

Having HIV estimates allows the country to assess its progress towards the accomplishment along the HIV Care Cascade or what is commonly known as the 95-95-95 targets. The estimates provide a denominator or first pillar to the cascade allowing the measurement of the First 95 or the diagnosis coverage.

As of December 2020, a total of 78,291 PLHIV out of the 115,100 total estimated number of PLHIV for 2020 have been diagnosed based on HARP data. This means that the diagnosis coverage for the Philippines as of December 2020 is at 68%. Among them, 59,933 were enrolled to treatment and 47,977 are currently on Antiretroviral Treatment (ART). From the first pillar to the last, a total of 67,123 PLHIV were lost along the cascade of care, and were, therefore, not given access to life-saving treatment. Moreover, since these PLHIV are not on ART, they are not virally suppressed and may transmit HIV to other people through unprotected penetrative sex, sharing of infected needles or mother-to-child transmission.

Though the estimated 980,000 members of the key population are at highest risk of getting infected with HIV, there are also a number of non-key population (KP) males, females, and children who are at risk for HIV if they engage in risk behavior which exposes them to the virus. The graph (figure 9) depicts a crucial message about the HIV epidemic in the country. It shows the never-ending cycle of HIV infection that the Philippines is currently experiencing. If the prevailing HIV transmission is not prevented, an estimated 20,200 new infections will be added to the existing pool of PLHIV by 2021. A combination of prevention and treatment strategies are needed in order to break this vicious cycle, and prevent more people from getting HIV or dying from AIDS (Figure 9).

A BRIEFER ON THE PHILIPPINE HIV ESTIMATES

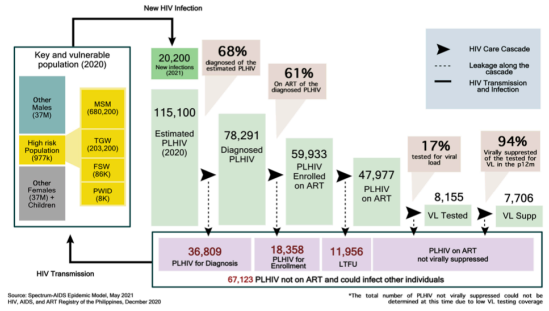


Figure 9. National HIV Care Cascade

Future Impact: National projection vs Health Sector Plan (HSP) Projection

Aside from historical impact and current accomplishments, future impact can also be projected using modeling and estimation. Figure 10 shows three different trajectories of the Philippine HIV epidemic depending on the response the country will take for years to come.

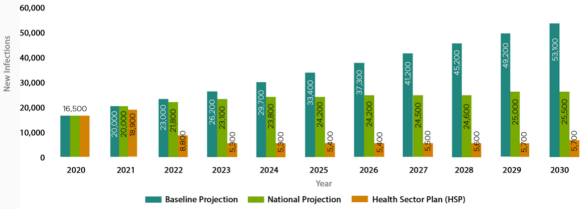


Figure 10. Annual Number of New HIV Infections Among 15 years old and above, 2020-2030

A BRIEFER ON THE PHILIPPINE HIV ESTIMATES

The Baseline projection (blue) shows the trajectory of the country's HIV epidemic in terms of estimated annual new HIV infections if current efforts are simply maintained. It can be seen that if prevention and treatment coverages are not scaled up, estimated annual new infections can reach 23,000 by 2022 and 53,100 by 2030.

On the other hand, the HSP (green) shows how the country can flatten the curve of its estimated annual new HIV infections if the HSP for HIV for 2020-2022 is implemented successfully. This means that by 2022 and onward, prevention coverage among key population, especially MSM, reach 90%, diagnosis coverage among estimated PLHIV reach 95%, and treatment coverage among diagnosed PLHIV reach 95%. Estimated new infections would drop to less than 9,000 by 2022 and remain so until 2030.

However, to get to the HSP scenario, huge leaps in HIV response must be attained. The current national projection (orange) shows that at its current pace, the country can only reduce its annual HIV infections to around 23,000 by 2022 and 25,500 by 2030. If only treatment coverage will improve following the rate the country has done historically (an average of 5% to 6% per year), annual new infections would continue to increase.

These modelling comparisons show that with the successful implementation of the High Impact Prevention, Testing, Treatment and Adherence (HIPTTrea) strategies of the HSP, the Philippines stands a chance at slowing down and controlling one of the fastest growing HIV epidemics in the world.

List of High Burden LGUs (n=119)

NCR	CENTRAL LUZON	CALABARZON	CEBU PROVINCE	OTHER REGIONS
Caloocan	(Pampanga)	(Batangas)	Argao	(CAR)
Las Piñas	Angeles	Batangas	Balamban	Baguio
Makati	Mabalacat	Lipa	Bantayan	
Malabon	San Fernando		Bogo	(MIMAROPA)
Mandaluyong		(Cavite)	Carcar	Puerto Princesa
Manila	(Bulacan)	Bacoor	Cebu	
Marikina	Bulacan	Cavite	Consolacion	(Bicol Region)
Muntinlupa	Malolos	Dasmariñas	Daan Bantayan	Naga
Navotas	Marilao	General Trias	Dalaguete	
Parañaque	Meycauayan	Imus	Danao	(Western Visayas)
Pasay	San Jose Del	Kawit	Lapu-Lapu	Iloilo
Pasig	Monte	Silang	Liloan	Negros Island
Pateros	Santa Maria	Tanza	Mandaue	Bacolod
QC			Minglanilla	
San Juan	(Nueva Ecija)	(Laguna)	Naga	(Eastern Visayas)
Taguig	Cabanatuan	Biñan	Talisay	Tacloban
Valenzuela		Cabuyao	Toledo	
	(Tarlac)	Calamba	Alegria	(Zambangoa
	Tarlac	San Pedro	Alcantara	Peninsula)
		Sta. Rosa	Alcoy	Zamboanga
	(Zambales)		Aloguinsan	
	Olongapo	(Quezon)	Asturias	(Northern
		Lucena	Badian	Mindanao)
			Barili	Cagayan de Oro
		(Rizal)	Boljoon	Iligan
		Antipolo	Borbon	
		Binangonan	Carmen	(Davao Region)
		Cainta	Catmon	Davao
		Rodriguez	Compostela	Tagum
		San Mateo	Cordova	
		Taytay	Dumanjug	(SOCCSKSARGEN)
			Ginatilan	General Santos
			Madridejos	Koronadal
			Malabuyoc	
			Medellin	(Caraga)
			Moalboal	Butuan
			Oslob	
			Pilar	
			Pinamungahan	
			Poro	
			Ronda	
			Samboan	
			San Fernando	
			San Francisco	
			San Remigio	
			Santander	
			Santa Fe	
			Sibonga	
			Sogod	
			Tabogon	
			Tabuelan	
			Tuburan	
			Tudela	

Annex 2: Briefer on the PNAC Roadmap to Address Rights-based Barriers to Accessing HIV and AIDS Services

RA 11166 dictates that the country's HIV response be anchored on the principles of human rights, human dignity and non-discriminatory delivery of HIV services. PNAC developed this Roadmap to guide PNAC in crafting the 7TH AMTP in general and program stakeholders in particular in implementing their respective HIV and AIDS projects and activities. The roadmap will be operationalized under the Strategy Pillar 3: PROTECT of the 7TH AMTP.

To cope with this, a shift of perspective from mere service delivery to a rights-based approach to ending the HIV epidemic was recommended for all stakeholders. The task for PNAC, here, was two-pronged:

1. engage rights holders towards empowering them to demand and access HIV and AIDS services; and
2. engage duty bearers to deliver rights-based HIV and AIDS services

The general categories of barriers are briefly discussed in the context of six focus areas that have been identified by the *Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination*. The six settings are Community, Workplace, Education, Health care, Justice, and Emergency.

Community settings - pertain not only to individuals, but also to their families or households

Workplace settings - refer to all settings where workers work, including informal economies that are traditionally not protected by the State

Education settings - refer to all places where learning occurs, involving both students and educators

Health care settings - refer to public and private settings where service delivery occurs

Justice settings - refer to systems of law enforcement and legal practices

Emergency settings - refer to situations of conflict or crises that cause interruptions in service delivery

UN Joint Programme on HIV/AIDS (UNAIDS), Evidence for eliminating HIV-related stigma and discrimination, 24 April 2020, available at https://www.unaids.org/en/resources/documents/2020/eliminating-discrimination-guidance, accessed 5 December 2020, 10.

Annex 3: Briefer on the National Advocacy Plan 2022 - 2028 (Introduction)

The National Advocacy Plan 2022 - 2028 was developed by the Philippine National AIDS Council (PNAC) to provide for a set of policy priorities to address the country's alarming HIV and AIDS situation. It is also an expression of the PNAC's commitment to concentrate its efforts in addressing key policy gaps within 2022 to 2028.

There is the need to advocate to the Philippine Government and stakeholders at the national and local levels to sustain HIV and AIDS programs. According to the HIV/AIDS & ART Registry of the Philippines, there were a total of 8,945 new reported cases in 2021 alone.

Moreover, the country's HIV epidemic is characterized by a disproportionate shift in key populations affected. In its early years (1984-1990), more than 60% of those diagnosed were females. However, in September 2021, 94% of cases were males (including transgender women—people who were assigned male at birth but identify as women), and 32% of cases were among youth 15-24 years old.
The rising trend is attributable to multiple barriers to accessing HIV and AIDS services: key populations continue to suffer from stigma and discrimination, confidentiality breaches, insufficient information & false beliefs, financial constraints, health system & service-delivery barriers, and legal & policy barriers. These rights-related gaps in the national response, all of which have been exacerbated by the COVID-19 pandemic, have been consistently identified in a broad range of literature.

Thus, there is the need to advocate that the HIV epidemic is not just a health issue, but also a rights-related one. With the passage of the RA 11166, the PNAC is mandated to anchor its response to the country's HIV and AIDS situation on the principles of Human Rights and internationally-recognized HR standards and instruments.

The objectives of the NAP are thus aligned with the Human Rights-Based Approach (HRBA) of empowering "rights-holders" to claim their rights and increasing the capacity and accountability of "duty-bearers" to meet their obligations of respecting, protecting and fulfilling human rights. Furthermore, the NAP is guided by the HRBA principles of participation, accountability, non- discrimination, transparency, human dignity, empowerment and rule of law (PANTHER).

The legal basis for this document is Section 5(J), Article I of the RA 11166— it is the mandate of the PNAC to "Advocate for policy reforms to Congress and other government agencies to strengthen the country's response to the HIV and AIDS situation." The NAP will be a guiding document for the PNAC to advocate for policy reforms.

The NAP has a six-point policy area advocacies, namely:

Policy Area 1: Advocate for policies that strengthen localization of HIV response

Policy Area 2: Advocate for policies that enhance the legal and policy environment of key populations

Policy Area 3: Advocate for improved systems of health care and service delivery

Policy Area 4: Advocate for greater domestic funds for HIV prevention, including community-led responses

Policy Area 5: Advocate for increased information, education and communication campaign

Policy Area 6: Advocate for policies to strengthen the capacity of the PNAC to fulfill its mandate

Annex 4: Briefer on Unified HIV Community Agenda: United Towards Meaningful Community and Government Partnerships to End AIDS

The unified HIV community agenda is a collegial effort of four (4) major networks of civil society organizations and community organizations, namely: *Network Plus, Dangal Pilipinas, Lakanbini Advocates Pilipinas,* and *Network to Stop AIDS Philippines (NSAP*).

The Community Agenda has four (4) themes that directly relate to PNAC's mandate. A fifth theme consists of advocacy areas that HIV CSO networks intend to pursue beyond PNAC in order to support the advocacy within the Council that the CSO Caucus will be advancing. Theme 1 outlines key activities that PNAC should focus on to be more effective in fulfilling its legally mandated function. Theme 2 includes recommendations for PNAC's advocacy work directed at strengthening the local HIV response. Theme 3 is focused coordination and the need for PNAC to contribute to strengthening resilient and sustainable systems for health (RSSH). Theme 4 is focused on the community's recommendations in terms of research and the need to generate strategic information needed to support PNAC's advocacy work and ensure that the Council is able to successfully deliver the Themes 1 to 3.

Annex 5: Links to the Legal Basis

a. Global AIDS Strategy 2021–2026
https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026

b. Declaration on HIV and AIDS: Ending Inequalities and Getting On Track to End AIDS by 2030 (June 2021 https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf

c. RA 11166: Philippine HIV and AIDS Policy Act and its Implementing Rules and Regulations
https://www.officialgazette.gov.ph/2018/12/20/republic-act-no-11166/
https://www.officialgazette.gov.ph/downloads/2019/07jul/20190712-IRR-RA-11166-RRD.pdf

d. RA 11223: Universal Health Care Act
https://www.officialgazette.gov.ph/2019/02/20/republic-act-no-11223/

1. RA 7160: Local Government Code of 1991
https://www.officialgazette.gov.ph/downloads/1991/10oct/19911010-RA-7160-CCA.pdf

e. RA 11036: Mental Health Act
https://legacy.senate.gov.ph/republic_acts/ra%2011036.pdf

f. Supreme Court Mandanas-Garcia Ruling
https://sc.judiciary.gov.ph/3726/

g. Universal Declaration of Human Rights 1948
https://www.un.org/en/about-us/universal-declaration-of-human-rights

h. Convention on the Rights of the Child
https://www.coe.int/en/web/compass/convention-on-the-rights-of-the-child#:~:text=The%20Convention%20was%20adopted%20by,the%20age%20of%20eighteen%20years.

i. Beijing Declaration and Platform for Action 1995
https://archive.unescwa.org/our-work/beijing-declaration-and-platform-action

j. Yogyakarta Principles 2007
https://data.unaids.org/pub/manual/2007/070517_yogyakarta_principles_en.pdf