

RESEARCH DOSSIER: HIV PREVENTION FOR GIRLS AND YOUNG WOMEN PHILIPPINES

This Research Dossier supports the **Report Card on HIV Prevention for Girls and Young Women in the Philippines** produced by the International Planned Parenthood Federation (IPPF), under the umbrella of the Global Coalition on Women and AIDS, and with the support of the United Nations Population Fund (UNFPA) and Young Positives.

The Report Card provides an 'at a glance' summary of the current status of HIV prevention strategies and services for girls and young women aged 15-24 years in the Philippines. It focuses on **five cross-cutting prevention components**:

1. Legal provision
2. Policy context
3. Availability of services
4. Accessibility of services
5. Participation and rights

The Report Card also includes background information about the HIV epidemic and key policy, Programmatic and funding **recommendations** to improve and increase action on this issue in the Philippines.

This Research Report is divided into two sections:

PART 1: DESK RESEARCH: This documents the extensive desk research carried out for the Report Card by IPPF staff and consultants based in the United Kingdom.

PART 2: IN-COUNTRY RESEARCH: This documents the participatory in-country research carried out for the Report Card by a local consultant in the Philippines. This involved:

- o Two **focus group discussions** with a total of 21 girls and young women aged 14-24 years. The participants included girls and young women who are: in school; involved in sex work; living in urban and suburban areas; and working as peer activists.
- o Five **one-to-one interviews** with representatives of organisations providing services and advocacy for HIV prevention for girls and young women. The stakeholders were: Head of Operations at IPPF Member Association; Executive Director of an NGO working on HIV/AIDS advocacy and services; Director of an NGO led by people living with HIV; Trainer/Organizer of an NGO working on HIV/AIDS focusing on migrant workers and HIV positive women, and women and girls in sex work; and Trainer/Organizer at an NGO working on HIV/AIDS with migrant workers and HIV positive women.
- o Additional **fact-finding** to address gaps in the desk research.



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Focus group discussion: 14-24 year olds

One-to-one interview: Head of Operations of the IPPF Member Association

One-to-one interview: Executive Director of a NGO working on HIV/AIDS advocacy and services

One-to-one interview: Director of a NGO led by PLWH

One-to-one interview: Trainer/Organizer of a NGO working on HIV/AIDS with focus on migrant workers, HIV positive women and women and girls in sex work

One-to-one interview: Trainer/Organizer of a NGO working on HIV/AIDS with focus on migrant workers and HIV positive women

One-to-one interview: Officer of an United Nations agency

Abbreviations

ABC	Abstinence, Be Faithful and or use Condoms
AFP	Armed Forces of the Philippines
ARH	Adolescent Reproductive Health
AYHDP	Adolescent and Youth Health and Development Programme
ARVs	Antiretrovirals
ASEAN	Association of Southeast Asian Nations
ASEP	AIDS Surveillance and Education Project
BCC	Behaviour Change Communication
BSS	Behavioural Sentinel Surveillance
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHED	Commission on Higher Education
CIA	Central Intelligence Agency
CRC	Convention on the Rights of the Child
DECS	Department of Education, Culture and Sports
DepED	Department of Education
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FAD	Foundation for Adolescent Development
FHI	Family Health International
FSI	Foreign Service Institute
FLSWs	Freelance Sex Workers
FPOP	Family Planning Association of the Philippines
DOLE	Department of Labour and Employment
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HACTs	HIV/AIDS Core Team
HRGs	High Risk Groups
IDU	Intravenous Drug User
IEC	Information, communication and education
IPPF	International Planned Parenthood Federation
IUD	IntraUterine Device
KRA	Key Result Area
LAC	Local AIDS Council
LGUs	Local Government Units
MCH	Maternal and Child Health
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NCRFW	National Commission on the Role of Filipino Women
NHSSS	National HIV/AIDS Sentinel Surveillance System
NGO	Non-governmental Organisation
OFWs	Overseas Filipino Workers
OWWA	Overseas Workers Welfare Administration
PAFI	Positive Action Foundation, Incorporated
PASE	Population Awareness and Sex Education
PIP	People in Prostitution
PLHA	People living with HIV

PLWHA	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNAC	Philippine National AIDS Committee
PNP	Philippine National Police
POPED	National Population Education Programme
PSI	Population Services International
RFSWs	Registered Female Sex Workers
RITM	Research Institute of Tropical Medicine
RTI	Reproductive Tract Infection
SACCL	STI/AIDS Cooperative Central Laboratory
SHCs	Social Hygiene Clinics
SLH	San Lazaro Hospital
SRH	Sexual and Reproductive Health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TCS	Treatment, Care and Support
TESDA	Technical Education and Skills Development Authority
UNAIDS	United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly
UNHCR	United Nations High Commissioner for Human Rights
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAW	Violence Against Women
VCT	Voluntary, Counselling and Testing
WHO	World Health Organisation
YAFSS	Young Adult Fertility and Sexuality Survey

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PART 1: DESK RESEARCH

COUNTRY PROFILE

- **Size of population:** 89.46 million (July 2006 estimate) (CIA (2006) *The World Factbook – Philippines*, <http://www.odci.gov/cia/publications/factbook/geos/rp.html> (Date accessed 17/05/06))
- **Life expectancy at birth:** Total population: 70.21 years; male: 67.32 years; females: 73.24 years (2006 estimates *The World Factbook – Philippines*, <http://www.odci.gov/cia/publications/factbook/geos/rp.html> (Date accessed 17/05/06))
- **% of population under 15 (ages 0 – 14):** 35% (male 15,961,365/female 15,340,065) (CIA (2006) *The World Factbook – Philippines*, <http://www.odci.gov/cia/publications/factbook/geos/rp.html> (Date accessed 17/05/06))
- **Population below income poverty line of \$1 per day:** 14.6% (from 1990-2003) (UNDP (2005) *Human Development Reports 2005: Philippines*, <http://hdr.undp.org/statistics/data/countries.cfm?c=PHL> (Date accessed 17/05/06))
- **Female youth literacy (ages 15-24)¹:** 95.7% as estimated (2003) (UNDP (2005) *Human Development Reports 2005: Philippines*, <http://hdr.undp.org/statistics/data/countries.cfm?c=PHL> (Date accessed 17/05/06))
- **Youth literacy rate (female rate as % of male rate, ages 15-24):** 101% (Measure DHS website, Country Summary for Philippines, http://www.measuredhs.com/countries/country.cfm?ctry_id=34 (Date accessed 10/07/06))
- **Median age at first marriage for women (ages 25-49 years) old in 2003:** 22 years (HIV/AIDS Indicators Country Report for Philippines (1993-2000), Program Area 9 - Young People's Sexual Behaviour: Philippines National Demographic Survey 1993-2000, http://www.measuredhs.com/hivdata/reports/start.cfm?LoadingDisplay=0&Ctr=34&styp_id=&ShowIndicators=all&Survey_Pop_Based=&char_type=all&char_urban=1&char_age=1&char_ed=1&report_action=view (Date accessed 10/07/06))
- **Median age at first sex among females (ages 15-24)² in 1993:** 22.9 years (HIV/AIDS Indicators Country Report for Philippines (1993-2000), Program Area 9 - Young People's Sexual Behaviour: Philippines National Demographic Survey 1993-2000, http://www.measuredhs.com/hivdata/reports/start.cfm?LoadingDisplay=0&Ctr=34&styp_id=&ShowIndicators=all&Survey_Pop_Based=&char_type=all&char_urban=1&char_age=1&char_ed=1&report_action=view (Date accessed 10/07/06))
- **Median age at first sex among males (ages 15-24) in 1993:** No data available (HIV/AIDS Indicators Country Report for Philippines (1993-2000), Program Area 9 - Young People's Sexual Behaviour: Philippines National Demographic Survey 1993-2000, http://www.measuredhs.com/hivdata/reports/start.cfm?LoadingDisplay=0&Ctr=34&styp_id=&ShowIndicators=all&Survey_Pop_Based=&char_type=all&char_urban=1&char_age=1&char_ed=1&report_action=view (Date accessed 10/07/06))
- **Health expenditure per capita in 2002 (International dollars):** \$153 (UNAIDS (2005) *Country Profile 2005: Philippines*, http://www.unaids.org/en/Regions_Countries/Countries/philippines.asp (Date accessed 17/05/06))
- **Contraceptive prevalence³:** 49% (from 1995-2003) (UNDP (2005) *Human Development Reports 2005: Philippines*, <http://hdr.undp.org/statistics/data/countries.cfm?c=PHL> (Date accessed 17/05/06))
- **Maternal mortality rate:** 200 adjusted ratio per 100,000 live births (for 2000) (UNDP (2005) *Human Development Reports 2005: Philippines*, <http://hdr.undp.org/statistics/data/countries.cfm?c=PHL> (Date accessed 17/05/06))
- **Ethnic groups:** Tagalog 28.1%; Cebuano 13.1%; Ilocano 9%; Bisaya/Binisaya 7.6%; Hiligaynon/Ilonggo 7.5%; Bikolanon 3.4%; other 25.3% (2000 census) (CIA (2006) *The World Factbook – Philippines*, <http://www.odci.gov/cia/publications/factbook/geos/rp.html> (Date accessed 17/05/06))
- **Religions:** Roman Catholic 80.9%; Evangelical 2.8%; Iglesia ni Kristo 2.3%; Aglipayan 2%; other Christian 4.5%; Muslim 1.8%; unspecified 0.6%, none 0.1% (2000 census) (CIA (2006) *The World Factbook – Philippines*, <http://www.odci.gov/cia/publications/factbook/geos/rp.html> (Date accessed 17/05/06))
- **Languages:** Two official languages – Filipino (based on Tagalog) and English; eight major dialects – Tagalog, Ilocano, Hiligaynon or Ilonggo, Bicol, Waray, Pampango, and Pangasinan (CIA (2006) *The World Factbook – Philippines*, <http://www.odci.gov/cia/publications/factbook/geos/rp.html> (Date accessed 17/05/06))
- **Adult (ages 15-49) HIV prevalence rate in 2005:** <0.1% (range <0.2%) (UNAIDS (2006) *2006 Report on the Global AIDS Epidemic*, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf (Date accessed 13/06/06))
- **HIV prevalence rate in females (ages 15-24) in 2005:** No data available (UNAIDS (2006) *2006 Report on the Global AIDS Epidemic*, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf (Date accessed 13/06/06))
- **HIV prevalence rate in males (ages 15-24) in 2005:** No data available (UNAIDS (2006) *2006 Report on the Global AIDS Epidemic*, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf (Date accessed 13/06/06))
- **Number of women (ages 15-49) living with HIV in 2005:** 3,400 (range: 1,800 - 6,000) (UNAIDS (2006) *2006 Report on the Global AIDS Epidemic*, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf (Date accessed 13/06/06))
- **Number of children (ages 0-14) living with HIV in 2005:** No data available⁴
- **Number of deaths due to AIDS in 2005 (adults and children):** <1,000 (range <1,000) (UNAIDS (2006) *2006 Report on the Global AIDS Epidemic*, http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf (Date accessed 13/06/06))
- **Estimated number of orphans (ages 0-17) by AIDS in 2005:** No data available⁵

¹ The percentage of people ages 15-24 who can, with understanding, both read and write a short, simple statement related to their everyday life.

PREVENTION COMPONENT 1: LEGAL PROVISION
(national laws, regulations, etc)

Key questions:

1. What is the minimum legal age for marriage?

- According to the Civil Codes of the Philippines:
Title III. – MARRIAGE, CHAPTER 1, REQUISITES OF MARRIAGE
“Art. 54. Any male of the age of sixteen years or upwards, and any female of the age of fourteen years or upwards, not under any of the impediments mentioned in Articles 80 to 84, may contract marriage.”
(Civil Codes of the Philippines, Requisites of Marriage,
<http://www.chanrobles.com/civilcodeofthephilippinesbook1.htm> (Date accessed 17/05/06))
- From a report titled, “Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes”, “Several indirect policies affect youth, including Republic Act No. 386, which states that the legal age at marriage is 18...” (p. 17)
(Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))
- Eighteen is the legal age for both women and men. The legal basis is Executive Order No. 209, The Family Code of the Philippines, as amended by Executive Order 227 (1988). The correct citation is the Family Code amended. The Civil Code was superseded (specific provisions on family relations/marriage) by the 1988 amendments. (Information provided by in-country consultant)

2. What is the minimum legal age for having an HIV test without parental and partner consent?

- From the “Philippines AIDS Prevention and Control Act of 1998” (Republic Act No. 8504),
- ARTICLE III TESTING, SCREENING AND COUNSELLING”
SECTION 15. *Consent as a requisite for HIV testing.* — No compulsory HIV testing shall be allowed. However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV: *Provided*, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor⁶ or a mentally incapacitated individual. (Minor is defined in the footnote.)
(Republic of the Philippines, Philippine National AIDS Council Manila, *Republic Act No. 8504 Philippines AIDS Prevention and Control Act of 1998*)
<http://www3.who.int/idhl-rils/frame.cfm?language=english> (Date accessed 17/05/06))

3. What is the minimum legal age for accessing SRH services without parental and partner consent?

- From a report titled, “Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes”,
- “The big challenge in the Philippines is addressing the lack of high-level political support for family planning in general, and even more so for family planning information and service delivery to adolescents. There is an urgent need to present and address family planning as a key element of ARH and for ARH to be part of a broader package aimed at development of youth and adolescents.” (p. 1)
- “Philippine Constitution: The 1987 Constitution states that it is the “right and duty” of parents to ensure the welfare of and instil proper moral development in their children. It also stipulates that the State

² The age by which one half of young people ages 15-24 have had penetrative sex (median age).

³ The percentage of married women (including women in union) ages 15-49 who are using, or whose partners are using, any form of contraception, whether modern or traditional.

⁴ This data is unavailable and is not even mentioned in the official government data as one of the indicators ever being monitored. Data / indicators demonstrate a bias and predisposition towards close and almost exclusive surveillance of perceived “at risk” populations like “People in prostitution,” and overseas contract workers. Again, data here is not necessarily sex disaggregated.

⁵ Ibid

⁶ Minor – A person who is below 18 years of age. (Republic of the Philippines, Philippine National AIDS Council Manila, *Policy Implementing Rules and Regulations on STD/HIV/AIDS (Republic Act No.8504)*
<http://www3.who.int/idhl-rils/frame.cfm?language=english> (Date accessed 17/05/06))

an obligation to help parents in this endeavour. Such emphasis has set the tone and focus of much policy Programming surrounding adolescent SRH in the Philippines, which has been described as “indirect and cautious.” The Constitution does not make any reference to youths’ sexual or reproductive rights.” (p. 17) (Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- Arguably, there is no legal minimum for accessing SRH services because there is no law requiring “parental consent” in such cases. However, this question always crops up as an issue both for service providers and young people interested in accessing SRH services.

Conservatives positions cite the Family Code and the Constitution (1987) among others, The following provisions:

Art. 209 (Family Code) Parental Authority

Pursuant to the natural right and duty of parents over the person and property of their unemancipated children, parental authority and responsibility shall include the caring for and rearing them for civic consciousness and efficiency and the development of their moral, mental and physical character and well being.

Sec. 3, Article XV, 1987 Constitution

The Family

The State shall defend: (1) the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood...”

On the other hand, the same provisions, as well as a host of provisions in the Constitution on human rights, religious freedom and health are also cited by pro-RH groups in the context of the CRC principle of the “best interests of the child,” and even the reference to evolving capacities since the Philippines is a member state/has ratified the CRC, as well as other consensus documents like the ICPD and BPFA. (Information provided by in-country consultant)

4. What is the minimum legal age for accessing abortions without parental and partner consent?

- According to the Philippines Revised Penal Code, Art. 256, abortion is illegal in the country.
Art. 256. Intentional abortion. — Any person who shall intentionally cause an abortion shall suffer:
1. The penalty of reclusion temporal, if he shall use any violence upon the person of the pregnant woman.
2. The penalty of prision mayor if, without using violence, he shall act without the consent of the woman.
3. The penalty of prision correccional in its medium and maximum periods, if the woman shall have consented.
Art. 257. Unintentional abortion. — The penalty of prision correccional in its minimum and medium # period shall be imposed upon any person who shall cause an abortion by violence, but unintentionally.
Art. 258. Abortion practiced by the woman herself or by her parents. — The penalty of prision correccional in its medium and maximum periods shall be imposed upon a woman who shall practice abortion upon herself or shall consent that any other person should do so.
Any woman who shall commit this offense to conceal her dishonour, shall suffer the penalty of Prision correccional in its minimum and medium periods.

If this crime be committed by the parents of the pregnant woman or either of them, and they Act with the consent of said woman for the purpose of concealing her dishonour, the offenders shall suffer the penalty of prision correccional in its medium and maximum periods.

Art. 259. Abortion practiced by a physician or midwife and dispensing of abortives. — The penalties provided in Article 256 shall be imposed in its maximum period, respectively, upon any physician or midwife who, taking advantage of their scientific knowledge or skill, shall cause an abortion or assist in causing the same.

⁷ Minor – A person who is below 18 years of age. (Republic of the Philippines, Philippine National AIDS Council Manila, *Policy Implementing Rules and Regulations on STD/HIV/AIDS (Republic Act No.8504)* <http://www3.who.int/idh-rlis/frame.cfm?language=english> (Date accessed 17/05/06))

Any pharmacist who, without the proper prescription from a physician, shall dispense any abortive shall suffer arresto mayor and a fine not exceeding 1,000 pesos.

(WHO Health Legislation. Abortion Laws, Philippines Revised Penal Code, <http://www3.who.int/idhl-rils/frame.cfm?language=english> (Date accessed 17/05/06))

5. Is HIV testing mandatory for any specific groups (e.g. pregnant women, military, migrant workers, and sex workers)?

- o From the "Philippines AIDS Prevention and Control Act of 1998" (Republic Act No. 8504),
 - (b) The State shall extend to every person suspected or known to be infected with HIV/AIDS full protection of his/her human rights and civil liberties. Towards this end:
 - 1) compulsory HIV testing shall be considered unlawful unless otherwise provided in this Act...
 - ARTICLE III TESTING, SCREENING AND COUNSELLING
- SECTION 15. Consent as a requisite for HIV testing. — No compulsory HIV testing shall be allowed. However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV: Provided, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he is of legal age or from the parents or legal guardian in the case of a minor⁷ or a mentally incapacitated individual. Lawful consent to HIV testing of a donated human body, organ, tissue, or blood shall be considered as having been given when:
- (a) a person volunteers or freely agrees to donate his/her blood, organ, or tissue for transfusion, transplantation, or research;
 - (b) a person has executed a legacy in accordance with Section 3 of Republic Act No. 7170, also known as the "Organ Donation Act of 1991";
 - (c) a donation is executed in accordance with Section 4 of Republic Act No. 7170.

SECTION 16. Prohibitions on compulsory HIV testing. — Compulsory HIV testing as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stay in the country, or the right to travel, the provision of medical service or any other kind of service, or the continued enjoyment of said undertakings shall be deemed unlawful.

SECTION 17. Exception to the prohibition on compulsory testing. — Compulsory HIV testing may be allowed only in the following instances:

- a) When a person is charged with any of the crimes punishable under Articles 264 and 266 as amended by Republic Act No. 8353, 335 and 338 of Republic Act No. 3815, otherwise known as the "Revised Penal Code" under Republic Act No. 7659;
- b) When the determination of the HIV status is necessary to resolve the relevant issues under Executive Order No. 309, otherwise known as the "Family Code of the Philippines"; and
- c) When complying with the provisions of Republic Act No. 7170, otherwise known as the "Organ Donation Act" and Republic Act No. 7719, otherwise known as the "National Blood Services Act".

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504 Philippines AIDS Prevention and Control Act of 1998) <http://www3.who.int/idhl-rils/frame.cfm?language=english> (Date accessed 17/05/06))

6. Is there any legislation that specifically addresses gender-based violence?

- o "The Anti-Violence Against Women and Their Children Act was passed in the Philippines in March 2004." (Asia Foundation (2004) *Combating Violence in Women*, p. 3, <http://www.asiafoundation.org/pdf/violenceagainstwomen.pdf> (Date accessed 17/05/06))
- o The Anti-Violence Against Women and their Children Act of 2004 (RA 9262) defines in: "SEC. 3. Definition of Terms. - As used in this Act, (a) "Violence against women and their children" refers to any act or a series of acts committed by any person against a woman who is his wife, former wife, or against a woman with whom the person has or had a sexual or dating relationship, or with whom he has a common child, or against her child whether legitimate or illegitimate, within or without the family abode, which result in or is likely to result in physical, sexual, psychological harm or suffering, or economic abuse including threats of such acts, battery, assault, coercion, harassment or arbitrary deprivation of liberty..." For more information, please refer to the website listed for the full report on this law. (National Commission on the Role of Filipino Women (NCRFW) (2004) Anti-Violence Against Women and Their Children Act of 2004 – Implementing Rules and Regulation 9262), <http://www.ncrfw.gov.ph/insidepages/downloads/ra9262/RA%209262%20and%20IRR%20>

004.pdf#search='The%20Anti%20Violence%20Act%20Against%20Women%20and%20their%20children%20in%20the%20Philippines' (Date accessed 17/05/06))

- "In recent years, sexual harassment has been publicly acknowledged as harmful to women, and countries taking the first steps by adopting legislation prohibiting it. In the last two years, legislation that directly addresses sexual harassment has been passed in Belgium, Belize, Costa Rica, Finland, France, Ireland, Paraguay, the Philippines and Switzerland. Similar legislation has been proposed in Chile, Italy, Jamaica and South Africa." (United Nations Children's Fund (UNICEF) The Progress of Nations 1997, <http://www.unicef.org/pon97/le4to48.htm> (Date accessed 17/05/06))

7. Is there an AIDS Law – or equivalent – that legislates on issues such as confidentiality for testing, diagnosis, treatment, care and support?

- From the "Philippines AIDS Prevention and Control Act of 1998" (Republic Act No. 8504),
- ARTICLE VI CONFIDENTIALITY

SECTION 30. Medical confidentiality. — All health professionals, medical instructors, workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of any medical record data, or test results are directed to strictly observe confidentiality in the handling of all medical information particularly the identity and status of persons with HIV.

SECTION 31. Exceptions to the mandate of confidentiality. — Medical confidentiality shall not be considered breached in the following cases:

(a) when complying with reportorial requirements in conjunction with the AIDSWATCH Programmes provided in Section 27 of this Act;

(b) when informing other health workers directly involved or about to be involved in the treatment or care of a person with HIV/AIDS: Provided, That such treatment or care carry the risk of HIV transmission: Provided, further, That such workers shall be obliged to maintain the shared medical confidentiality;

(c) when responding to a subpoena duces tecum and subpoena ad testificandum issued by a Court with jurisdiction over a legal proceeding where the main issue is the HIV status of an individual: *Provided*, That the confidential medical record shall be properly sealed by its lawful custodian after being double-checked for accuracy by the head of the office or department, hand delivered, and personally opened by the judge: Provided, further, That the judicial proceedings be held in executive session.

SECTION 32. Release of HIV/AIDS test results. — All results of HIV/AIDS testing shall be confidential and shall be released only to the following persons:

(a) the person who submitted himself/herself to such test;

(b) either parent of a minor child who has been tested;

(c) a legal guardian in the case of insane persons or orphans;

(d) a person authorized to receive such results in conjunction with the AIDSWATCH Programme as provided in Section 27 of this Act;

(e) a justice of the Court of Appeals or the Supreme Court, as provided under subsection (c) of this Act and in accordance with the provision of Section 16 hereof.

SECTION 33. Penalties for violations of confidentiality. — Any violation of medical confidentiality as provided in Sections 30 and 32 of this Act shall suffer the penalty of imprisonment for six (6) months to four (4) years, without prejudice to administrative sanctions such as fines and suspension or revocation of the violator's license to practice his/her profession, as well as the cancellation or withdrawal of the license to operate any business entity and the accreditation of hospitals, laboratories or clinics.

SECTION 34. Disclosure to sexual partners. — Any person with HIV is obliged to disclose his/her HIV status and health condition to his/her spouse or sexual partner at the earliest opportune time.

SECTION 18. *Anonymous HIV testing.* — The State shall provide a mechanism for anonymous HIV testing and shall guarantee anonymity and medical confidentiality in the conduct of such tests.

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504 Philippines AIDS Prevention and Control Act of 1998)
<http://www3.who.int/idhl-rils/frame.cfm?language=english>(Date accessed 17/05/06))

8. Is there any legislation that protects people living with HIV/AIDS, particularly girls and young women, from stigma?

and discrimination at home and in the workplace?

- o From the "Philippines AIDS Prevention and Control Act of 1998" (Republic Act No. 8504),
(b) The State shall extend to every person suspected or known to be infected with HIV/AIDS full protection of his/her human rights and civil liberties. Towards this end:
(1) compulsory HIV testing shall be considered unlawful unless otherwise provided in this Act;
(2) the right to privacy of individuals with HIV shall be guaranteed;
(3) discrimination, in all its forms and subtleties, against individuals with HIV or persons perceived or suspected of having HIV shall be considered inimical to individual and national interest; and
(4) provision of basic health and social services for individuals with HIV shall be assured.

ARTICLE VII DISCRIMINATORY ACTS AND POLICIES

SECTION 35. Discrimination in the workplace. — Discrimination in any form from pre-employment to post-employment, including hiring, promotion or assignment, based on the actual, perceived or suspected HIV status of an individual is prohibited. Termination from work on the sole basis of actual, perceived or suspected HIV status is deemed unlawful.

SECTION 36. Discrimination in schools. — No educational institution shall refuse admission or expel, discipline, segregate, deny participation, benefits or services to a student or prospective student on the basis of his/her actual, perceived or suspected HIV status.

SECTION 37. Restrictions on travel and habitation. — The freedom of abode, lodging and travel of a person with HIV shall not be abridged. No person shall be quarantined, placed in isolation, or refused lawful entry into or deported from Philippine territory on account of his/her actual, perceived or suspected HIV status.

SECTION 38. Inhibition from public service. — The right to seek an elective or appointive public office shall not be denied to a person with HIV.

SECTION 39. Exclusion from credit and insurance services. — All credit and loan services, including health, accident and life insurance shall not be denied to a person on the basis of his/her actual, perceived or suspected HIV status: Provided, That the person with HIV has not concealed or misrepresented the fact to the insurance company upon application. Extension and continuation of credit and loan shall likewise not be denied solely on the basis of said health condition.

SECTION 40. Discrimination in hospitals and health institutions. — No person shall be denied health care service or be charged with a higher fee on account of actual, perceived or suspected HIV status.

SECTION 41. Denial of burial services. — A deceased person who had AIDS or who was known, suspected or perceived to be HIV-positive shall not be denied any kind of decent burial services.

SECTION 42. Penalties for discriminatory acts and policies. — All discriminatory acts and policies

referred to in this Act shall be punishable with a penalty of imprisonment for six (6) months to four (4) years and a fine not exceeding Ten thousand pesos (P10,000.00). In addition, licenses/permits of schools, hospitals and other institutions found guilty of committing discriminatory acts and policies described in this Act shall be revoked.

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504 Philippines AIDS Prevention and Control Act of 1998)

<http://www3.who.int/idhrlis/frame.cfm?language=english> (Date accessed 17/05/06))

9. Are sex workers legally permitted to organise themselves, for example in unions or support groups?

- o From a report titled, "Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes", "Several indirect policies affect youth, including Republic Act No. 386, which states that the legal age at marriage is 18, and the illegality of prostitution even if the practice is rampant." (Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Program p. 17,
http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf
(Date accessed 30/05/06))

10. Are harm reduction methods for injecting drug users (such as needle exchange) legal?

- o There is no legal prohibition per se to such Programmes although as a whole, "drug dependence and addiction" is generally approached by the state more as a police problem or one of criminality, and not a health issue at all. Likewise, recent data from the Correctional Institute for Women (women's correctional facility) indicates that a high number of women in prison are serving time for drug related (and other poverty related) crimes. (Information provided by in-country consultant)
- o Background information: Not sure, but according to the Fourth AIDS Medium Term Plan 2005-2010 (AMTP I

"With regards to IDUs, small-scale harm reduction efforts have been initiated in two cities – Cebu and Ger Santos." (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010, p. 11, (AMTP IV))

Discussion questions:

- **Which areas of SRH and HIV/AIDS responses are legislated for?**
- **What are the biggest strengths, weaknesses and gaps in legislation in relation to HIV prevention for girls and y women?**
- **Is action taken if laws are broken (e.g. if a girl is married below the legal age)?**

- From the "Philippines AIDS Prevention and Control Act of 1998" (Republic Act No. 8504), SECTION 33. *Penalties for violations of confidentiality.* — Any violation of medical confidentiality as provided in Sections 30 and 32 of this Act shall suffer the penalty of imprisonment for six (6) months to four (4) years, without prejudice to administrative sanctions such as fines and suspension or revocation of the violator's license to practice his/her profession, as well as the cancellation or withdrawal of the license to operate any business entity and the accreditation of hospitals, laboratories or clinics.

SECTION 42. Penalties for discriminatory acts and policies. — All discriminatory acts and policies referred to in this Act shall be punishable with a penalty of imprisonment for six (6) months to four (4) years and a fine not exceeding Ten thousand pesos (P10,000.00). In addition, licenses/permits of schools, hospitals and other institutions found guilty of committing discriminatory acts and policies described in this Act shall be revoked.

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504
Philippines AIDS Prevention and Control Act of 1998)
<http://www3.who.int/idh-rils/frame.cfm?language=english> (Date accessed 17/05/06))

From the Philippine Abortion Law, Penal Civil Code:

Art. 256. Intentional abortion. — Any person who shall intentionally cause an abortion shall suffer:

1. The penalty of reclusion temporal, if he shall use any violence upon the person of the pregnant woman.
2. The penalty of prision mayor if, without using violence, he shall act without the consent of the woman.
3. The penalty of prision correccional in its medium and maximum periods, if the woman shall have consented.

Art. 257. Unintentional abortion. — The penalty of prision correccional in its minimum and medium period shall be imposed upon any person who shall cause an abortion by violence, but unintentionally.

Art. 258. Abortion practiced by the woman herself or by her parents. — The penalty of prision correccional in its medium and maximum periods shall be imposed upon a woman who shall practice abortion upon herself or shall consent that any other person should do so.

Any woman who shall commit this offense to conceal her dishonor, shall suffer the penalty of prision correccional in its minimum and medium periods.

If this crime be committed by the parents of the pregnant woman or either of them, and they act with the consent of said woman for the purpose of concealing her dishonor, the offenders shall suffer the penalty of prision correccional in its medium and maximum periods.

Art. 259. Abortion practiced by a physician or midwife and dispensing of abortives. — The penalties provided in Article 256 shall be imposed in its maximum period, respectively, upon any physician or midwife who, taking advantage of their scientific knowledge or skill, shall cause an abortion or assist in causing the same.

Any pharmacist who, without the proper prescription from a physician, shall dispense any abortive shall suffer arresto mayor and a fine not exceeding 1,000 pesos.

(WHO Health Legislation. Abortion Laws, Philippines Revised Penal Code,

<http://www3.who.int/idh1-rils/frame.cfm?language=english> (Date accessed 17/05/06))

- **Is there any specific legislation for marginalised and vulnerable groups⁸? If yes, is the legislation supportive or punitive? And what difference does it make to people's behaviours and risk of HIV infection?**
- **To what extent are 'qualitative' issues – such as confidentiality around HIV testing – covered by legislation?**
 - From the "Philippines AIDS Prevention and Control Act of 1998" (Republic Act No. 8504), - ARTICLE VI CONFIDENTIALITY

SECTION 30. *Medical confidentiality.* — All health professionals, medical instructors, workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of any medical record data, or test results are directed to strictly observe confidentiality in the handling of all medical information particularly the identity and status of persons with HIV.

SECTION 31. *Exceptions to the mandate of confidentiality.* — Medical confidentiality shall not be considered breached in the following cases:

- (a) when complying with reportorial requirements in conjunction with the AIDSWATCH Programmes provided in Section 27 of this Act;
- (b) when informing other health workers directly involved or about to be involved in the treatment or care of a person with HIV/AIDS: Provided, That such treatment or care carry the risk of HIV transmission: Provided, further, That such workers shall be obliged to maintain the shared medical confidentiality;
- (c) when responding to a subpoena duces tecum and subpoena ad testificandum issued by a Court with jurisdiction over a legal proceeding where the main issue is the HIV status of an individual: *Provided*, That a confidential medical record shall be properly sealed by its lawful custodian after being double-checked for accuracy by the head of the office or department, hand delivered, and personally opened by the judge *Provided, further*, That the judicial proceedings be held in executive session.

SECTION 32. *Release of HIV/AIDS test results.* — All results of HIV/AIDS testing shall be confidential and shall be released only to the following persons:

- (a) the person who submitted himself/herself to such test;
- (b) either parent of a minor child who has been tested;
- (c) a legal guardian in the case of insane persons or orphans;
- (d) a person authorized to receive such results in conjunction with the AIDSWATCH Programme as provided in Section 27 of this Act;
- (e) a justice of the Court of Appeals or the Supreme Court, as provided under subsection (c) of this Act and in accordance with the provision of Section 16 hereof.

SECTION 33. *Penalties for violations of confidentiality.* — Any violation of medical confidentiality as provided in Sections 30 and 32 of this Act shall suffer the penalty of imprisonment for six (6) months to four (4) years, without prejudice to administrative sanctions such as fines and suspension or revocation of the violator's license to practice his/her profession, as well as the cancellation or withdrawal of the license to operate any business entity and the accreditation of hospitals, laboratories or clinics.

SECTION 34. *Disclosure to sexual partners.* — Any person with HIV is obliged to disclose his/her HIV status and health condition to his/her spouse or sexual partner at the earliest opportune time.

SECTION 18. *Anonymous HIV testing.* — The State shall provide a mechanism for anonymous HIV testing and shall guarantee anonymity and medical confidentiality in the conduct of such tests.

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504 Philippines AIDS Prevention and Control Act of 1998)

<http://www3.who.int/idh1-rils/frame.cfm?language=english>(Date accessed 17/05/06))

- **How much do girls and young women know about relevant legislation and how it relates to them? Are there any initiatives to raise awareness about certain laws?**
 - "The Anti-Violence Against Women and Their Children Act was passed in the Philippines in March 2004. Th

⁸ Examples include: people living with HIV/AIDS, sex workers, injecting drug users, migrant workers, refugees and displaced people, street children, school drop-outs, lesbians and ethnic minorities.

Asia Foundation is supporting the National Commission on the Role of Filipino Women (NCRFW) to conduct information campaign to raise public awareness that violence against women is now a crime. The Asia Foundation will support the NCRFW to disseminate information on the new law in English and Filipino to representatives of government agencies, NGOs, local governments, and the general public during NCRFW organized regional consultations on the implementing rules and regulations of the law." (The Asia Foundation (2004) *Combating Violence in Women*, p. 3, <http://www.asiafoundation.org/pdf/violenceagainstwomen>. (Date accessed 17/05/06))

• **Overall, how is relevant legislation applied in practice? What are the 'real life' experiences of girls and young women? What difference does it make to their vulnerability to HIV infection?**

- A Fact Sheet about Filipino Women published by the National Commission on the Role of Filipino Women reported the following on domestic violence in women:
 - "There are different trends in the number of violence against women (VAW) cases from different government agencies. The number of VAW cases reported to the police increased six-fold, from 1,100 in 1996 to 6,505 in 2005. The highest recorded number of VAW cases in the police department peaked in 2001 at 10,345."
 - "The social welfare department, however, saw a general decline in the number of Women in Especially Difficult Circumstances (WEDC) cases served - from 7,763 in 1999 to 5,608 in 2002 and to 5,389 in 2005."
 - "Both the 2005 police and social welfare records show that physical injuries/battering and rape are the most common types of reported VAW cases. One in every three reported cases to the police were battering / physical injuries while 17.2% accounted for the rape cases. Similarly, the social welfare department served a total of 1,217 cases of physical abuse/battering or 28.8%, while sexual abuse cases accounted for 6.8%."

(National Commission on the Role of Filipino Women, *Philippine Machinery for the Advancement of Women (2006) Fact Sheet on Filipino Women*, <http://www.ncrfw.gov.ph/insidepages/downloads/factsheets/Factsheets%20on%20Fil%20Women.pdf> (Date accessed 17/05/06))

- From a report titled, "Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes", "Age at first marriage is relatively late in Philippine society, although some women marry early. About 10 percent of young women ages 15–19 and 45 percent of young women ages 20–24 were ever-married. Early marriage has been strongly associated with education; by age 24, about 80 percent of elementary educated women are married compared with only 40 percent among those with a college education. Poverty also predisposes women to marry early. Premarital sex and pregnancy, however, tend to initiate or accelerate the process of marriage." (pp. 10-11)

(Policy Project (2003) *Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes*, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- From a report titled, "Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes", "Estimates of induced abortions among adolescents reached 319,000 in 2000 and could approximate 400,000 by 2015. Large numbers of abortions among adolescents occur because of non-use of contraception to prevent unwanted or mistimed pregnancies. In 1998, 32 percent of girls ages 15–19 and 45 percent of those ages 20–24 who were currently married said that they wanted to postpone, space, or limit childbearing but were not using any form of contraception." (p. 14)

(Policy Project (2003) *Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes*, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- According to a report on reproductive health:
 - "Substantial societal changes have improved Filipino women's lives and influenced their family-size goals. Fertility has fallen considerably, and women want even fewer children than they typically had in the past."
 - Almost half of recent births were either not wanted at all or not wanted at the time. At the national level, this situation has not improved over the last decade; in some regions, unplanned childbearing has increased.
 - Non-use of contraception and increasing use of traditional methods contribute to the high level of

unplanned pregnancy. Half of married women do not want a child soon, or want no more children but are not using a modern contraceptive.

- An estimated 400,000 women from all regions and backgrounds have illegal abortions each year; approximately 100,000 are hospitalized for related complications.
- Poor access to modern contraceptives, a reflection of a lack of social and political support, is a major obstacle to wider use. Increased government support and resources are needed at all levels to improve access to family planning services.

(The Allan Guttmacher Institute (2003), *Improving Reproductive Health in the Philippines*,
<http://www.guttmacher.org/pubs/rib/rib1-03.pdf> (Date accessed 3/7/06))

- **How do the effects of legislation vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

PREVENTION COMPONENT 2: POLICY PROVISION (national policies, protocols, guidelines, etc)

Key questions:

11. Does the current National AIDS Plan address the full continuum of HIV/AIDS strategies, including prevention, care, support and treatment?

The *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, addresses the following:

- Policy (Policy Guidelines on HIV/AIDS Prevention Control; Policy and Strategies for STD/HIV/AIDS in the Workplace; Integration of HIV/AIDS Education In All Schools Nationwide; Guidelines on the Entry of People with HIV/AIDS in the Philippines; Policy Guidelines on HIV/AIDS Testing Among Children; and Memorandum circular enjoining Local Government Units (LGUs) to implement RA 8504) (p. 10)
- Prevention including the following components:
- Information, Education and Communication (IEC) includes "Integration of HIV/AIDS into the elementary, secondary and vocational curricula is continuously being pursued, with teaching modules being revised to be life-skills based." This also targets employers, labour groups, fish folks, drivers, men and women in uniform, human resource groups, media, legislators, Parent-Teachers Associations and in-school youth. (p. 10)
- Advocacy including a "Media Manual for HIV/AIDS Reporting" and "Popularizing the IRR of RA 8504" in 2001 (p. 10)
- Training of service providers, labour sectors, men and women in uniform, Dept. of Education, Dept. of Social Welfare and Development, peer facilitators, overseas Filipino workers (OFWs), etc. (p. 11)
- Prevention Services to include STI prevention and control, condom promotion, harm reduction and provision of social hygiene services. (p. 11)
- Treatment, Care and Support – "Care and support services have been and are now being provided, although a limited number of PLWHAs. Care and support services have been extended to PLWHAs seeking services from RITM and SLH. Other institutions offering support services include the (a) Pinoy Plus Association, Inc.; (b) Reme AIDS Foundation; (c) Positive Action Foundation Philippines, Inc.; and (d) Bahay Lingap, a halfway home for HIV positive individuals. Other significant work includes the development of HIV/AIDS clinical management guidelines for hospitals, the training and establishment of HACTs (HIV/AIDS Core Team) in 56 DOH (Department of Health) retained hospitals and about 40 provincial hospitals, incorporation of antiretroviral (ARV) drugs into the National Drug Formulary, development of Care and Support Manual for Social Workers, and training of 103 social workers for community-based care and support." (p. 12)
- Local Response – "Local response is present in at least 18 sites of donor-assisted projects (ASEP and The Policy Project of The Futures Group). In these LGUs (Local Government Units), local AIDS ordinances had been enacted for the establishment of LACs (Local AIDS Council) and allocation of budget for an HIV/AIDS Programme. An additional 11 LGUs have started to develop HIV/AIDS prevention Programmes through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) project." (pp. 12-13)
- Surveillance and Research – "The early establishment of the surveillance system, particularly the conduct of prevalence surveys among most-at-risk groups starting in the mid-1980s, the establishment of the HIV/AIDS Registry in 1991, and the NHSSS in 1993 gave decision-makers and Programme planners a better understanding of the common modes of HIV transmission in the country, the age range and sex of people infected and the group most-at-risk to the virus. The NHSSS-BSS introduced in 1997, continues to provide vital information on the knowledge and trend of sexual behaviour of groups most-at-risk. This has been institutionalized in 10 sites where pre-disposing conditions exist for the prevalence of high-risk behaviour." (p. 13)
- Monitoring and Evaluation - "Monitoring and evaluating the thrusts of the national response has been

- inadequate. Efforts have been limited to partial assessments that do not provide the complete picture. No evaluation has been done to ascertain compliance with the provisions of RA 8504. For example, the establishment of an HIV/AIDS Programme in the workplace is not enforced due to inadequate number of personnel in the DOLE (Dept. of Labour and Employment). Furthermore, there is no data on whether curriculum integration in learning institutions at various levels is actually being pursued. There is also no definitive information on whether hospitals are following the protocols for treatment, care and support. An HIV/AIDS monitoring and evaluation (M & E) system has recently been developed by the PNAC (Philippine National AIDS Committee). However, operationalisation of the M and E system requires substantive resources.” (p. 13)

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

12. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of girls and young women

- o In the Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV), there is mention of sex workers or people in prostitution (PIPs).
 - Under the Guiding Principles of the AMTP IV, “7. Efforts should be made to constantly improve HIV-related Programmes and adopt gender-responsive and rights-based approaches.” (p. 17)
 - Under Strategy 4, Operational Strategies: “The AMTP IV will support the continuous conduct of gender and development workshops/training among service providers, policy-makers and the general public. Gender responsiveness of policies, standards and protocols including training modules, IEC materials and advocacy documents will be inherent in their design and dissemination.” (p. 27)
 - In the Annex 4 Indicators and Targets section, under Key Strategies:
 - Strategy 1: Scaling-up and quality improvement of preventive interventions targeted to identified highly vulnerable groups (sex workers and their clients, IDUs, MSMs and OFWs)
 - Indicators/Targets:
 - 1.1 Increase in the proportion of OFWs (overseas Filipino workers), MSMs, IDUs and PIPs with appropriate knowledge on HIV prevention
 - 1.2 increase in the percentage of patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled
 - 1.3 increase in the number of STD clinics where VCT services for HIV are provided and/or referred to other facilities
 - 1.4 increase in the percentage of OFWs tested positive for HIV (p. 51)
 - Under Operational Strategies, Key Result Areas and Major Activities, Key Result Areas:
 - “KRA 2: PIPs are provided with focused STI/HIV/AIDS preventive education, skills and services.” (pp. 19 & 21)

Key Result Area 3: Clients of PIPs are provided with STI/HIV/AIDS preventive information and services.						
Activity	2005	2006	2007	2008	2009	2010
1. expand community outreach (in red light districts and entertainment establishments)						
2. dialogue/advocacy among owners and managers of commercial sex establishments						
3. strengthen partnership and linkage among NGOs, PNP and DSWD at the local level						
4. promote condom use and training on negotiation skills for condom use						

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

13. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of marginalised and vulnerable groups, including people who are living with HIV/AIDS?

- o Yes, the Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV),
 - Under the Guiding Principles section,
 - 3. “Mainstreaming of treatment, care and support services for the infected and affected into existing health and social services should likewise be pursued;”
 - 4. “The dignity and rights of persons infected and affected by HIV/AIDS and that of health care providers must, at all times, be promoted and respected;”
 - 5. “All efforts should be harnessed to ensure the genuine and meaningful involvement of persons infected and affected by HIV/AIDS at all levels of policy-making, project design, implementation, monitoring and evaluation;”
 - 6. “HIV interventions should be voluntary with quality information and guaranteed with utmost

confidentiality;" and,

7. "Efforts should be made to constantly improve HIV-related Programmes and adopt gender-responsive and rights- based approaches." (p. 17)

- Under Policy Directions section,

3. "Priority must be given to the infected and affected as well as to the existing and emergent highly-vulnerable groups, especially those not covered in the AMTP III, which include OFWs, youth, infected and affected child (p. 17)

- Under "OPERATIONAL STRATEGIES, KEY RESULT AREAS & MAJOR ACTIVITIES"

Strategy 1 – "Scaling-up and quality improvement of preventive interventions targeted at population segments with risk behaviours and those identified as highly vulnerable."

- "Epidemiological studies have identified risk behaviours

and vulnerability factors that facilitate the transmission of HIV/AIDS like unprotected sex as frequently practiced by MSMs, sex workers and their clients and the use of infected needles among IDUs.

Specific population groups like OFWs are also identified as vulnerable to infection. These groups are rendered highly vulnerable to HIV infection because of the socio-economic and occupational contexts they are in. Though the country lacks solid data on the number of highly vulnerable populations, studies show an increased prevalence of unprotected sex among them, and some occupational groups are emerging as more vulnerable than others."

"KEY RESULT AREAS (KRA)

KRA 1: All migrant workers are provided with STI/HIV/AIDS preventive information and services.

KRA 2: PIPs are provided with focused STI/HIV/AIDS preventive education, skills and services

KRA 3: Clients of PIPs are provided with STI/HIV/AIDS preventive information and services.

KRA 4: MSMs are provided with focused preventive information, skills and services

KRA 5: IDUs are provided with focused STI/HIV/AIDS preventive education and skills and services."

(p. 19)

- In the Annex 4 Indicators and Targets section, under Key Strategies:

"Strategy 1: Scaling-up and quality improvement of preventive interventions targeted to identified highly vulnerable groups (sex workers and their clients, IDUs, MSMs and OFWs)

Indicators/Targets:

1.1 Increase in the proportion of OFWs (overseas Filipino workers), MSMs, IDUs and PIPs with appropriate knowledge on HIV prevention

1.2 increase in the percentage of patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled

1.3 increase in the number of STD clinics where VCT services for HIV are provided and/or referred to other fac

1.4 increase in the percentage of OFWs tested positive for HIV" (p. 51)

- Under Strategy 3: "Scaling-up and improving the quality of treatment, care and support services targeted at those infected and affected"

- "Access to health services is a basic human right, and empowering citizens to be productive is a basic duty the state. Providing care and support services will enable PLWHAs to lead positive and productive lives.

The country recognizes that TCS (treatment, care and support) services, as articulated in the MDGs (Millennium Development Goals), UNGASS Declaration, and ASEAN Joint Ministerial Statement as well as in RA 8504, are just as necessary as prevention interventions. These are to be given equal priority as integral parts of the national response while placing the HIV positive community at the core of the response. Access, however, to good quality TCS is limited. Only a few tertiary government and private hospitals in major urban centres offer institutional care. While community care and support programmes exist to address the diverse needs of PLWHAs, these are still limited." (p. 25)

OPERATIONAL STRATEGIES

"The AMTP IV will endeavour to make TCS more accessible to the infected and affected. It will continue to support the establishment of three sub-national STI/HIV/AIDS centres in Luzon, Visayas and Mindanao. The procurement scheme for ARV drugs and medicines for opportunistic infections will be reviewed and redefined. Options to be pursued in procurement will be brought to the PNAC leadership. Quality of care, treatment and support being provided by hospital facilities and other institutions will be assessed and further improved. Ways to inculcate respect for PLWHAs and gender sensitivity in serving them will be a continuing effort among service providers. The turn-around time of confirmatory test/results will be reviewed and necessary improvement in protocols will be employed.

Continuous training/retraining of the core hospital teams will be judiciously prioritized. Working with affected families who are also in need of care and support services is essential to engendering a culture of care for PLWHAs. In this regard, capacities of affected families to cope with their situation will be strengthened. Community-based support will be expanded while the network of NGOs, the local government and community volunteers or outreach workers will be mobilized and capacitated to provide quality and timely care. Critical in all these efforts is a well-defined and strengthened referral scheme that would allow HIV positive individuals to seek and avail of necessary care. Advocacy for the involvement of NGOs, church and local governments will be undertaken.

Policies necessary to create a more conducive support environment will be developed and promoted for adoption at the local level. The participation of the PLWHAs will be consciously pursued at every opportunity." (p. 25)

KEY RESULT AREA (KRA)

"KRA 1: High quality diagnostic, treatment and care are provided to HIV infected and affected persons

KRA 2: PLWHAs are provided with support services and referred for further intervention." (p. 25)

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

14. Does the National AIDS Plan emphasise confidentiality within HIV/AIDS services?

- o Yes, the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, Under the Guiding Principles section, 6. "HIV interventions should be voluntary with quality information and guaranteed with utmost confidentiality." (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010, p. 17 (AMTP IV))

15. Does the national policy on VCT address the needs of girls and young women?

- o In the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, there is no specific language around VCT need girls and young women. (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))
- o Young women and girls are not specifically mentioned or even addressed as a separate sector in any existing national policy. The law itself (AIDS law) mentions that women's right to maintain/carry a pregnancy even when HIV positive. (Information provided by in-country consultant)

16. Does the national protocol for antenatal care include an optional HIV test?

- o No. According to Remedios AIDS, ARVs for infants (proper dosage/formulation) are not available in the Philippines. (Information provided by in-country consultant)

17. Does the national protocol for antenatal care include a commitment that any girl or young woman testing HIV positive should automatically be offered PMTCT services?

- o Not applicable. (Information provided by in-country consultant)

18. Is there a national policy that protects the rights and needs - including HIV prevention, SRH services, employment opportunities and education - of young women or girls at risk or affected by early marriage?

- o No. (Information provided by in-country consultant)

19. Is HIV prevention within the official national curriculum for both girls and boys?

- o In the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, Under Strategy 2: "Strengthening institutional and general public preventive interventions"
 - "Prevention interventions apply not only to HRGs (high risk groups) but to everyone since every individual is vulnerable to the infection. Unsafe sexual behaviour, particularly unprotected sex, is reportedly increasing especially among young people. Substance and sexual abuse among children and youth is also on the rise. Majority of HIV recorded infections were among the age groups 20-49, considered the most economically productive segment of the population. Awareness of the correct ways of preventing HIV transmission among the general public remains low. The extent of coverage of STI/HIV/AIDS prevention interventions, given the large population size of target groups, is still limited. Quality of service requires further improvement." (p. 22)

KEY RESULT AREA (KRA)

KRA 1: Children in risky situations are provided with appropriate STI/HIV/AIDS preventive information, life skills and services

KRA 2: Children and young people in school (formal, non-formal, alternative learning systems) are provided with appropriate STI/HIV/AIDS preventive information, life skills and services
 KRA 3: Children and young people out of school provided with appropriate information and services on STI/HIV/AIDS.” (pp. 22-23)

Key Result Area 1: Children in risky situations are provided with appropriate STI/HIV/AIDS preventive information, life skills and services						
Activity	2005	2006	2007	2008	2009	2010
1. develop guidelines in communicating, reporting and monitoring children regarding HIV						
2. build capacity and gender sensitivity of GO-NGO child-focused institutions on provision of STI/HIV/AIDS preventive information/services						
3. develop training and advocacy modules for service providers						
4. capacitate children in risky situations through counseling and life skills training						
5. formulate policy on HIV/AIDS for children						
6. advocate and integrate STI/HIV/AIDS information and services into existing policy and program framework on children						
7. strengthen referral network system for other needs						

Key Result Area 2: Children and young people in school (formal, non-formal, alternative learning systems) are provided with appropriate STI/HIV/AIDS preventive information, life skills and services						
Activity	2005	2006	2007	2008	2009	2010
1. assess quality and scope of intervention coverage for in school and out of school youth						
2. integrate life skills approach in STI/HIV/AIDS modules of DepEd, CHED, TESDA and NGOs with similar activities for children and/or parents						
3. build capacity in STI/HIV/AIDS life skills education of school-based service providers						
4. expand the implementation of school-based HIV/AIDS instruction and information						
5. ensure accessibility of school youths to quality STI counseling and services						

Key Result Area 3: Children and young people out of school provided with appropriate information and services on STI/HIV/AIDS						
Activity	2005	2006	2007	2008	2009	2010
1. develop capacity of civil society organizations and youth organizations (e.g., SK) to provide information and education services						
2. integrate STI/HIV/AIDS information and services into the local government's and existing community-based programs						
3. establish community outreach and peer education programs for out-of-school youth						

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

- o From the “Philippines AIDS Prevention and Control Act of 1998” (Republic Act No. 8504), ARTICLE I EDUCATION AND INFORMATION
 SECTION 4. HIV/AIDS education in schools. — “The Department of Education, Culture and Sports (DECS), the Commission on Higher Education (CHED), and the Technical Education and skills Development Authority (TESDA), utilizing official information provided by the Department of Health, shall integrate instruction on the causes, modes of transmission and ways of preventing HIV/AIDS and other sexually transmitted diseases in subjects taught in public and private schools at intermediate grades, secondary and tertiary levels, including non-formal and indigenous learning systems: Provided, That if the integration of HIV/AIDS education is not appropriate or feasible, the DECS and TESDA shall design special modules on HIV/AIDS prevention and control: Provided, further, That it shall not be used as an excuse to propagate birth control or the sale or distribution of birth control devices: Provided, finally, That it does not utilize sexually explicit materials.

Flexibility in the formulation and adoption of appropriate course content, scope, and methodology in each educational level or group shall be allowed after consultations with Parent-Teachers-

Community Associations, Private School Associations, school officials, and other interest groups. As such, no instruction shall be offered to minors without adequate prior consultation with parents who must agree to the thrust and content of the instruction materials.

All teachers and instructors of said HIV/AIDS courses shall be required to undergo a seminar or training on HIV/AIDS prevention and control to be supervised by DECS, CHED and TESDA, in coordination with the Department of Health (DOH), before they are allowed to teach on the subject.”

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504
Philippines AIDS Prevention and Control Act of 1998)
<http://www3.who.int/idhirls/frame.cfm?language=english>(Date accessed 17/05/06)

20. Is key national data about HIV/AIDS, such as HIV prevalence, routinely disaggregated by age and gender?

Discussion questions:

- **To what extent are relevant bodies – such as the Ministry of Education, NGO networks, religious organisations, – engaged in policy-making around HIV prevention for girls and young women?**
- **To what extent do those bodies work in partnership or in isolation? What areas of HIV prevention responses (e. behaviour change, counselling, treatment, home-based care) have national protocols or guidelines?**
- **To what extent do those protocols address the needs of girls and young women, including those that are marginalised and vulnerable?**
- **What does school-based sex education cover? Does it help to build young people’s confidence and skills, as well as knowledge?**
- **To what extent do policies help to reduce stigma and discrimination? For example, do they encourage people to stop using derogatory language or ‘blaming’ specific groups for HIV/AIDS?**
 - According to the Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV), “Consultations with the sub-national regional and local stakeholders confirmed the increasing number of individuals practising high-risk behaviour, low level of awareness on HIV/AIDS prevention among most-at-risk groups, young people and the general public, and strong discrimination and stigma against people living with HIV/AIDS (PLWHAs).” (p. 9) (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))
 - The Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)
 - Strategy 4 – “Integrate stigma reduction measures in preventive, treatment, care and support services as well as the design and installation of management support systems” (p. 27)
 - “HIV/AIDS stigma is defined as “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV and at individuals, groups, and communities with whom they are associated (1996 Herek, G.M., et. al, 1996). Stigma and the discrimination that accompanies it negate efforts to combat HIV/AIDS. It drives the epidemic by blocking the public’s understanding of its causes and makes it more difficult for men and women, especially those infected and affected, to adopt preventive behaviours such as condom use, and voluntary counselling and testing (VCT). It also affects the quality of care given and the perception of PLWHAs by communities, families and partners. In the health care setting, stigma and discrimination happens because, more often than not, health workers themselves have not been prepared to come to terms with their fears, anxieties and prejudices.” (p. 27)
 - OPERATIONAL STRATEGIES “Reducing stigma is essential in making care, treatment and support more readily accessible to those who are infected and affected. While it may be unrealistic to think that stigma and discrimination can be eliminated, it can be reduced through a mix of interventions that include supportive policies as well as information, education and counselling, among others. The AMTP IV will support the continuous conduct of gender and development workshops/training among service providers, policy-makers and the general public. Gender responsiveness of policies, standards and protocols including training modules, IEC materials and advocacy documents will be inherent in their design and dissemination. Management support systems such as planning, monitoring and evaluation, surveillance and reporting can significantly reduce the stigma against PLWHAs if properly designed and with gender perspective in mind. Having adequate and correct information about HIV transmission is key to understanding PLWHAs and appreciating their conditions and needs. Identifying credible individuals as champions in the cause of the PLWHAs is essential in propagating accepting behaviours and attitudes towards PLWHAs. Engaging PLWHAs

themselves in the campaign and other HIV/AIDS-related work will help demystify and correct misconception about them. Note that the following key result areas and activities are already integrated in the other key strategies and interventions. They are only presented here to emphasize and to highlight that stigma reduction efforts must be relentlessly pursued.” (p. 27)

- KEY RESULT AREA (KRA)

“KRA 1: Supportive non-discriminatory policies, guidelines and systems are developed and enforced at the national, sub-national and local levels.”

“KRA 2: Service providers, key stakeholders and the general public are educated regarding stigma and discrimination.”

“KRA 3: PLWHAs are empowered as effective advocates and educators.” (pp. 27-28)

Key Result Area 1: Supportive non-discriminatory policies, guidelines and systems are developed and enforced at the national, sub-national and local levels.						
Activity	2005	2006	2007	2008	2009	2010
1. review, amend if needed, and enforce compliance with the provisions of RA 8504, and other policies, standards, protocols and guidelines specifically on discrimination						
2. review, revise as needed, and/or develop gender-sensitive and rights-based IEC and advocacy materials that promote accepting attitude towards people with HIV/AIDS						
3. review, revise as needed, and/or develop training manuals and materials that promote gender sensitivity and reduce stigma against the HIV positives and the affected						

Key Result Area 2: Service providers, key stakeholders and the general public are educated regarding stigma and discrimination.						
Activity	2005	2006	2007	2008	2009	2010
1. training/orientation of service providers (schools, hospitals, health facilities, NGOs, communities etc.) on gender sensitive STI/HIV/AIDS response to include the emotive part of coming to terms with their own fears, anxieties, sexuality, prejudices	c/o Strategy 1, 2 and 3					
2. educate policy-makers, program implementers and other influentials re gender-sensitive HIV/AIDS response	c/o Strategy 1, 2 and 3					
3. conduct mass media campaign for the general public emphasizing accepting attitudes toward the STI/HIV/AIDS positives and affected	c/o Strategy 2 KRA 5					

Key Result Area 3: PHAs are empowered as effective advocates and educators						
Activity	2005	2006	2007	2008	2009	2010
1. provide assistance to develop capacities of PHAs as advocates and educators						
2. strengthen capacity of PHAs' network and organizations in providing support to positive members						

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

- **To what extent are different areas of policy provision – such as for HIV/AIDS and antenatal care – integrated or isolated?**
- **What policy measures exist in relation to consent, approval and confidentiality? For example, can girls and young women access services such as VCT without having to notify their parents and/or partner? And are they informed of their right to confidentiality?**
 - Yes, the Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV), Under the Guiding Principles section, 6. “HIV interventions should be voluntary with quality information and guaranteed with utmost confidentiality.” (p. 17) (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))
- **Overall, how are relevant policies applied in practice? What are the ‘real life’ experiences of girls and young women? How much do they know about them and how they relate to them? What difference do these policies make to their vulnerability to HIV infection?**
 - The Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV), in Part1 Situationer, under section B. RISKS & VULNERABILITIES:
 - “While the current epidemiological picture shows a low level of HIV prevalence in the Philippines, the evidence of high-risk situations and practices indicate that an AIDS epidemic may be hidden and growing

PREVALENCE. One indicator of high-risk behaviour is the alarmingly high prevalence of sexually transmitted infections (STI). The 2004 STI/HIV/AIDS Technical Report revealed increasing patterns of STI among selected groups. Syphilis rates among high-risk groups (HRGs) ranged from 1-4%, being highest among the freelance workers (FLSWs) and lowest among the registered female sex workers (RFSWs). The female sex workers, both registered and non-registered, reported signs and symptoms of STI more often than MSMs. A 50 percent increase of IDUs who reported signs and symptoms of STI was noted in 2003 compared to 2002. STI prevalence is also quite high among young females and males compared to the general population, being highest among youth in the 18-24 age group. (2002 RTI/STI Prevalence Survey in Selected Sites in the Country). A 2 study conducted by Family Health International (FHI) in Angeles City provides an alarming picture of STI prevalence in high-risk areas. It showed a prevalence of gonorrhoea and chlamydia ranging from 6.0 to 51 percent during three survey rounds among the various groups studied, and that 35 percent of the respondents cited pain in the lower abdomen and frequent urination as the most common signs and symptoms (2002 Prevalence Study in Angeles City Among Sex Workers)."

- "CONDOM USE. Consistent condom use was generally low (<30%) among the HRG in 2003. Results of the 2003 Behavioural Sentinel Surveillance (BSS) showed that:

- only MSM posted improvement from 2002 to 2003
- condom use by female sex workers with their non-regular partners was higher compared to condom use with their regular-paying and regular non-paying partners
- MSM practiced anal sex more with their regular non-paying partners while they practiced oral sex more with their non-regular partners and regular paying partners.

- "Based on the 2000 FHI STI Prevalence Survey in Angeles City, only 36 percent of the respondents said they used condom every time they had sex. Among women, the proportion that consistently used condoms was highest among registered sex workers and lowest among Guest Relations Officers. Condom use among young people had also remained low even while the percentage of the youth population engaging in premarital sex has increased by 5 percent from its 1994 level. Based on the 2002 Young Adult Fertility and Sexuality Survey (YAFSS), 26 percent reportedly use condoms, but not consistently.

- Number of Sexual Partners. The number of sex partners of female sex workers varies from one to 80 per week based on the BSS conducted from 1997-2003. However, the median was two per week for RFSW and four per week for FLSW. Some MSM reported as many as 55 sex partners per month but the norm was two per month. Since 1998, the median number of sex partners per 9 months for the IDU was one. (2004 STI/HIV/AIDS Technical Report)."

- "Young People's Sexuality. Vulnerability of young people is also a major concern. Based on the 2002 YAFSS, the proportion of young people engaging in premarital sex increased from 17.8 percent in 1994 to 23.1 percent in 2002. Among those sexually active in the 15-27 age groups, 34 percent reported having multiple sex partners. The percentage of young men and women engaging in unprotected sex was 70 percent and 68 percent, respectively. The percentage of young people who believe that there is no chance for them to contract HIV/AIDS was 60 percent. Among the general population, the 2003 National Demographic and Health Survey revealed widespread lack of knowledge on HIV/AIDS. While almost all men and women have heard about AIDS, only about half know the two major methods for preventing transmission of HIV (using condoms and limiting sex to one uninfected partner). Among HRGs, the 1997 to 2003 BSS revealed that most study participants knew of at least three correct ways of preventing HIV transmission. However, the aggregate results showed no HRG posting significant improvement in knowledge over time and no HRG attained the targets of the AIDS Surveillance and Education Project (ASEP) for this variable.

- "Sharing of Needles. The 2004 Technical Report of the National HIV/AIDS Sentinel Surveillance System (NHSSS) showed that most surveillance sites reported use of prohibited drugs by HRG, but few are cases of injecting drug use. Although the proportion of IDUs sharing injecting equipment has been decreasing, the use of bleach and water in cleansing these equipments has also been decreasing since 2002."

- "Consultations with the sub-national or regional and local stakeholders confirmed the increasing number of individuals practising high-risk behaviour; low level of awareness on HIV/AIDS prevention among most-at-risk groups, young people and the general public, and strong discrimination and stigma against people living with HIV/AIDS (PLWHAs)." (pp. 8-9)

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

- o From a report titled, "Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes" under the Operational Barriers to ARH,
 - "Policy barriers to adolescent sexual and reproductive well being: Many operational barriers to SRH care

supplies exist for Filipino adolescents, including cultural stigma against (unmarried) youth using contraceptives, negative attitudes on the part of health service providers, pressure from the Church, and lack of adequate supplies at the local health system level.”

- “Limited awareness of pertinent policies: While the AYHP Administrative order was issued in 2000, few key informants knew of its existence. In fact, many key informants said that no ARH policy existed at the time they were interviewed.”

- “Perceived lack of local authority to address adolescent health problems: Many key informants stated that a great obstacle to implementation is the incomplete decentralization of health services. Although decision-making power is in theory devolved to local government level, bureaucrats still do not feel this system has legitimacy and still want/wait for central government approval for action. This was particularly evident in 1 regional interviews, during which informants noted that local government unit (LGU)-level officials do not want to implement Programmes that would actually improve adolescents’ access to information and services because they want confirmation from central/head offices in Manila. This is despite the fact that with decentralization, they technically have the authority to put various health Programmes in place.”

- “Moral or erroneous interpretations of policies affecting adolescent access: Key informants stated that health care providers’ make “moral judgments” on whether their adolescent patients should receive reproductive health treatment and/or supplies. While guidelines such as those stipulated by the government for the AYI (Adolescent and Youth Health) Policy and the AYHDP (Adolescent and Youth Health and Development Programme) or by an NGO (FPOP (Family Planning Association of the Philippines) guidelines), in theory guarantee access to services, in practice young people face many operational barriers to SRH services. They include lack of clear guidelines on how to deal with youth.” (pp. 21-22)

(Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- **How do the effects of policies vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

PREVENTION COMPONENT 3: AVAILABILITY OF SERVICES⁹ (number of Programmes, scale, range, etc)

Key questions:

21. Is there a national database or directory of SRH and HIV/AIDS services for young people?

- The directories/databases existing are initiatives of NGOs. RAF has been providing this since 2000/ revised in 2003 and updated on their website: www.remedios.com.ph (Information provided by in-country consultant)

22. How many SRH clinics or outlets are there in the country?

- There is no government data to indicate the exact number of government run facilities or even private or NGO run services service about 1% of the total demand for SRH services (according to the IPPF MA). Like SRH per se is not always available at the level of primary health care because of the current administrative policy against RH. Local governments run health care Programmes depending on their own will and position on RH. Manila bans family planning and reproductive health services, specifically, contraceptives in their health clinics. (Information provided by in-country consultant)

23. At how many service points is VCT available, including for young women and girls?

- From the Philippines Comprehensive HIV/AIDS Indicator Report located on the HIV In Site website: Clients receiving VCT services in 2003 were 18,169 and VCT sites available in 2003 were 500. (HIV In Site, Philippines Comprehensive HIV/AIDS Indicator Report, sourced from WHO Health Services, 2004 <http://hivinsite.ucsf.edu/global?page=cr08-rp-00&post=19&cid=RP> (Date accessed 30/05/06))

⁹ (Refers to the full range of SRH and HIV/AIDS services relevant to girls and young women. These include antenatal care, STI information and treatment, HIV prevention, condoms, VCT and other counselling, positive prevention, treatment of opportunistic infections, care and support, treatment (including ARVs), skills building, economic development, etc).

- According to RAF, there are less than 10 doctors qualified/confident in practicing medicine in the area of treatment. RAF is the only NGO, which offers screening. Most are private/public hospitals/clinics. But only Lazaro Hospital (a public hospital) has facilities to do confirmation (2nd test) at the DOH central laboratory (Information provided by in-country consultant)

24. Are male and female condoms available in the country?

- From the Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV), "Condom use promotion has been done aggressively through the ASEP and Programme initiatives of NGOs in partnership with DKT International. Selected LGUs (local government units) also piloted the 100% Condom Use Programme (CUP) initiated by WHO in 2000. The 100% CUP seeks to reduce the spread of HIV infection by increasing condom use among PIPs (people in prostitution). Programme interventions have consisted of providing PIPs with information and condom supplies." (p. 11) (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))
- Female condoms are not available. While male condoms are available, there has been a dramatic decrease of supplies since the USAID phase out began in 2000 and the current administration has refused to allocate budget for any FP supplies. (Information provided by in-country consultant)

25. Is a free HIV test available to all pregnant girls and young women who wish to have one?

- From the "Philippines AIDS Prevention and Control Act of 1998" (Republic Act No. 8504),

"SECTION 20. Pre-test and post-test counselling. — All testing centres, clinics, or laboratories which perform HIV test shall be required to provide and conduct free pre-test counselling and post-test counselling for persons who avail of their HIV/AIDS testing services. However, such counselling services must be provided by persons who meet the standards set by the DOH."

(Republic of the Philippines, Philippine National AIDS Council Manila, Republic Act No. 8504 Philippines AIDS Prevention and Control Act of 1998) <http://www3.who.int/idh/rils/frame.cfm?language=english> (Date accessed 17/05/06)

- No. The lowest cost for screening (only the 1st part of the test) is around 1,000 Philippine pesos (user's fee) in most public and private clinics. (Information provided by in-country consultant)

26. At how many service points are PMTCT services (such as nevirapine) available for pregnant girls or young women who are HIV positive?

- From the Philippines Comprehensive HIV/AIDS Indicator Report located on the HIV In Site website: Number of sites offering PMTCT were 56 and Percentage of HIV positive pregnant women who received ARV prophylaxis was reported at 0%. (HIV In Site, Philippines Comprehensive HIV/AIDS Indicator Report, sourced from WHO Health Services, 2004 <http://hivinsite.ucsf.edu/global?page=cr08-rp-00&post=19&cid=RP> (Date accessed 30/05/06))

27. At how many service points are harm reduction services for injecting drug users available?

- According to the Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV), "With regards to IDUs, small-scale harm reduction efforts have been initiated in two cities – Cebu and General Santos." (p. 11) (Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

28. Are there any specific national projects (such as camps, conferences, and training courses) for boys/girls and young people living with HIV/AIDS?

- There have been projects such as camps, conferences and trainings both for young people and HIV positive people; this has been done through the NGOs. (Information provided by in-country consultant)

29. At how many service points are ARVs available to people living with HIV/AIDS?

- According to the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, "Current financing relies primarily on donations and personal expense of PLWHAs themselves. Aside from the prohibitive cost of ARV drugs, the inaccessibility of basic drugs like pain relievers and medicines for opportunistic infections. It is also possible that the low coverage of drug treatment is caused by the reluctance of PLWHAs to seek services due to fear of stigma and discrimination." (p. 12) (Philippine National AIDS Council, *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*)
- From the Philippines Comprehensive HIV/AIDS Indicator Report located on the HIV In Site website: Estimated

coverage of ART in 2005 is 5% and estimated number of people receiving ART in 2005 is under 200. (HIV In Philippines Comprehensive HIV/AIDS Indicator Report, sourced from WHO 3X5 Progress Report 2006, 2004 <http://hivinsite.ucsf.edu/global?page=cr08-rp-00&post=19&cid=RP> (Date accessed 30/05/06))

- ARVs are available through the DOH, at San Lazaro Hospital and through private clinics and hospitals through a referral system. (Information provided by in-country consultant)
- Remedios AIDS Foundation estimates that ARVs are available now for a minimum of around 2-3,000 pesos month (that is roughly around 50 dollars a month, down from originally in 1992 which was at 25,000-30,000 pesos) because of the generic drugs from India. However, they also discovered these are sold on the black market (DOH available supply) for as high as 5,000 pesos (double the price). (Information provided by in-country consultant)

30. Are there specific positive prevention services, including support groups, for young women and girls living with HIV/AIDS?

- Support services by HIV/AIDS NGOs and government hospitals are available to both women/men girls and boys in "general," and rarely just to young girls/women. Most of the services targeting women are those geared towards education for women migrant workers (either departing or returning abroad) and women prostitution (bars, brothels and street walkers). Most if not all of these services target ADULT women. (Information provided by in-country consultant)

Discussion questions:

- **What scale and range of HIV prevention services is available for girls and young women? For example, do Programmes go beyond 'ABC' strategies? Do Programmes cover social issues (e.g. early marriage)?**
- **To what extent are SRH, HIV/AIDS and broader community services integrated and able/willing to provide referrals to each other? For example, could most SRH clinics refer a girl testing HIV positive to a support group for people living with HIV/AIDS?**
 - From a report titled, "Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies Programmes", under ARH Programmes:
 - National HIV/AIDS Prevention and Control Programme: Put in place through a series of republic acts and Philippines AIDS Prevention and Control Act of 1998, this Programme addresses several targets, including HIV/AIDS education in schools (all levels: primary, secondary, tertiary, and technical institutions) organized DECS, CHED, and the Technical Education and Skills Development Authority (TESDA); provision of HIV/AIDS education as part of health service delivery; HIV/AIDS education as part of human resource development in government and private offices; and protection of human rights such as medical confidentiality and access to schooling for HIV sero-positive students.
 - DECS Population Education Programme: The National Population Education Programme (POPED) tackle four basic components: (1) reproductive rights and health, (2) family life and responsible parenthood, (3) gender and development, and (4) population resources and environment. There is no direct policy forbid pregnant adolescents to attend (secondary) school. A university researcher, however, expressed concern about whether schoolteachers are prepared to deal with ARH: *Even teachers do not have the proper information and resources to give the right facts to young people. Teachers are very clinical in their approach. They talk about reproductive organs whereas youth want a more human approach. But even teachers do not feel at ease in this role...*
 - Population Awareness and Sex Education (PASE): PASE, authorized by Administrative Order No. 950, is a population and sexuality education Programme specifically targeted at out-of-school youth. The Programme is administered by the Bureau of Youth Welfare of the Department of Social Welfare.
 - An NGO family planning and reproductive health Programme: The guidelines of the Family Planning Association of the Philippines (FPOP) stipulate that all individuals of reproductive age (specified as ages 15–44) have the right to information, counselling, physical examinations, and contraceptive supplies, specifically condoms or contraceptive pills. Use of emergency contraception is limited to cases of rape or incest.
 - The POPCOM ARH Programme: One of the five programmatic areas of POPCOM is adolescence. The Adolescent Fertility Programme addresses the fertility and sexuality-related needs of adolescents, with the main aim of reducing incidence of early marriage and teenage pregnancy.
 - Foundation for Adolescent Development (FAD): With few exceptions, nongovernmental adolescent SRH initiatives, such as university campus-based Programmes, include only IEC and referrals to government clinics if youth are in need of contraceptives. FAD's founder noted that

when the university-based Programme was first founded, it included SRH services but dropped this component due to pressure from religious members of the organization's board, which considered service provision inappropriate.

- Drug and pharmaceutical regulations: Many medications (including hormonal contraception and antibiotics) can be obtained over the counter (without a prescription) and, for the most part, relatively cheaply. Fake prescriptions can be obtained fairly easily for those medications that require a script. Many of those interviewed noted that given the barriers posed in the formal health care system, self-medication through pharmacies is adolescents' preferred mode to gain access to contraceptives as well as to obtain treatment for STIs. Describing the results of a recent study among adolescents in the Visayas, an anthropologist at San Carlos University noted, "Most of the time they (youth) self-medicate. This is a problem because it leads to improper use of medicines. We have had this in our recommendations (the dangers of self-medication) from our studies since 1997, because almost all of our groups report self medication." (pp. 19-20)

(Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- **To what extent are HIV prevention services available through 'non-traditional' outlets (e.g. religious organisati youth clubs)?**
- **Are there community Programmes on gender awareness/dialogue for girls/boys and young women/men? Do they explore power differences and social 'norms' for sexual behaviour? Is there mentoring, peer support and economic development that targets females?**
- **How available is prevention information and support for girls and young women living with HIV/AIDS?**
- **How available are HIV prevention 'commodities' (e.g. condoms)? How are they distributed?**
- **How much do girls and young women know about the availability of services, such as where to get condoms ARVs?**
- **Overall, what does the availability of HIV prevention services mean in practice? What are the 'real life' experiences of girls and young women? What difference do these services make to their vulnerability to HIV infection?**
 - The Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV),
Under Prevention:
 - "Information, Education & Communication (IEC). Through the ASEP (1993-2003), various IEC initiatives of n government organizations (NGOs) proved effective in reaching groups most at risk of HIV infection. Utilizin Behaviour Change Communication (BCC) as an overarching framework, these strategies employed one-one risk reduction counselling, community outreach and peer education complemented with IEC materi and mass media campaigns. Integration of HIV/AIDS into the elementary, secondary and vocational curr is continuously being pursued, with teaching modules being revised to be life-skills based. Breakthroughs h been achieved in targeting the workforce. The tripartite partnership of the DOLE (Dept. of Labour and Education), employers and labour groups is an effective strategy in the promotion and adoption of HIV/A Programmes in the workplace. Seminars among fisher folks, drivers, men and women in uniform and humc resource groups have also been done. Media, legislators, Parents-Teachers Associations and in-school yo were also provided with STI/HIV/AIDS orientation. The current response has been adequate in Programmc scope, but inadequate in terms of coverage. This is especially true with IEC. A national communication pl exists but this has not been utilized such that there remain many missed opportunities in improving their ov cost effectiveness. A number of IEC initiatives have been undertaken but evaluating the effectiveness of i initiatives to help in further sharpening key messages and identifying the most cost effective media mix hc been consistently pursued. There is also the absence of an inventory and clearinghouse of STI/HIV/AIDS materials to facilitate adaptation across areas." (p. 10)
 - "Advocacy. Since the first prominent case (Dolzura Cortez) in 1992, more HIV infected Filipinos have come into the open and volunteered personal testimonies about their condition. These efforts put a human face the disease and made advocacy work gain momentum. For its part, PNAC has done internal advocacy, resulting in the adoption and institutionalization of HIV/AIDS related Programmes by some of its member-agencies. Advocacy efforts aimed at the media were significant, with training/orientation given to memt of various associations of media practitioners, resulting in more sensitive and responsible reporting of HIV// cases. A "Media Manual for HIV/AIDS Reporting" and "Popularizing the IRR of RA 8504" was developed in

to help bring about a clearer understanding of the disease among media practitioners and make them effective partners in HIV/AIDS prevention. However, advocacy activities aimed at mobilizing support from various agencies and sectors have not been creatively sustained at the national, sub-national and local levels. The participation of the private sector in HIV/AIDS efforts also remains minimal. The religious sector (CARITAS, Salvation Army), which has a strategic value for care and support, have not been optimally tapped even as opportunities exist for their participation. Best practices have not been fully documented and disseminated.” (pp. 10-11)

- “Training. Capability building efforts had been strengthened over the years as the necessity for prevention efforts became increasingly felt. For service providers that also include the HIV/AIDS Core Teams (HACTs), training on comprehensive and syndromic STI management had been conducted. For the labor sector, this is Occupational Safety and Health Training (AIDS 101) for key regional implementers that include DOLE and TUCP trainers. There were also efforts to promote HIV/AIDS prevention among specific occupational groups considered exposed to higher levels of risks (e.g., tattoo artists and embalmers). Initial efforts targeting men and women in uniform were pioneered in 1999 and again in 2002, building the capacities on HIV/AIDS prevention among enlisted personnel in the Armed Forces of the Philippines (AFP) and Philippine National Police (PNP). For the education sector, the Department of Education (DepEd) is scaling-up the reach of its School-based AIDS Education Programme (SAEP) through curriculum integration and training of Subject Area Supervisors at the district and division (provincial or city) levels. For those working with families and communities, the Department of Social Welfare and Development (DSWD) produced and disseminated, through capability-building workshops for social workers, a user friendly guidebook for community volunteers and leaders on HIV/AIDS which covers both prevention and care and support. It also has a peer-counseling project that trains peer facilitators on HIV/AIDS prevention information and counselling. More effective means of mainstreaming HIV/AIDS into the counselling and pre-departure services are being enhanced. For OFW training module on HIV/AIDS and migration has been developed and administered to an initial batch of trainees which include Foreign Service Institute (FSI) personnel deployed abroad, and representatives from other agencies like the Overseas Workers Welfare Administration (OWWA), the Philippine Overseas Employment Administration (POEA), DSWD and DOH. Owing to limited financial resources, the reach of the training initiatives has been likewise limited. Manuals have not been produced in adequate quantities and dissemination through training has been selective.” (p. 11)
- “Prevention Services. The implementation of the STI Prevention and Control Programme has been intensified. Social marketing on STI treatment and care using the syndromic management approach was piloted in 10 sites with very promising results. In most cities, the capacity to provide services, such as diagnosis and treatment of STI, counselling and referral system exists. Parallel efforts were also undertaken to develop the capacity of the San Lazaro Hospital’s (SLH) STI/AIDS Cooperative Central Laboratory (SACCL) and Research Institute for Tropical Medicine (RITM) in conducting HIV testing. Condom use promotion has been done aggressively through the ASEP and Programme initiatives of NGOs in partnership with DKT International. Selected LGUs also piloted the 100% Condom Use Programme (CUP) initiated by the WHO in 2000. The 100% CUP seeks to reduce the spread of HIV infection by increasing condom use among PIPs. Programme interventions have consisted of providing PIPs with information and condom supplies. With regards to IDUs small-scale harm reduction efforts have been initiated in two cities - Cebu and General Santos. However, efforts like condom use promotion, harm reduction and provision of social hygiene services, which are aimed directly at preventing transmission of the virus among HRGs have produced unclear results, implying inadequacies in both the quantity and quality of interventions. Services from most social hygiene clinics (SHCs) are lacking in quality due to lack of adequately trained personnel and insufficient logistics like reagents. Also, the location and layout of many SHCs negate stigma reduction and discourage health-seeking behavior (pp. 11-12)

Under Treatment, Care and Support (TCS):

- “Care and support services have been and are now being provided, although to a limited number of PLWHAs. Care and support services have been extended to PLWHAs seeking services from RITM and SLH. Other institutions offering support services include the (a) Pinoy Plus Association, Inc.; (b) Remedios AIDS Foundation; (c) Positive Action Foundation Philippines, Inc.; and (d) Bahay Lingap, a halfway home for HIV positive individuals. Other significant work include the development of HIV/AIDS clinical management guidelines for hospitals, the training and establishment of HACTs (HIV/AIDS Core Team) in 56 DOH-retained hospitals and about 40 provincial hospitals, incorporation of antiretroviral (ARV) drugs into the National Drug Formulary, development of Care and Support Manual for Social Workers, and training of 103 social workers on community-based care and support. The establishment of HACTs in public hospitals has not resulted to clear improvements in the quality of care given to PLWHAs. Based on a study, majority of the complaints about insensitive and discriminatory care of PLWHAs were directed at health service providers themselves. LGUs reported that several hospitals do not have TCS systems in place. While members of the HACTs have undergone training in support systems, they seldom function as such. Although a manual on care and

treatment of HIV/AIDS has been developed, this has not been thoroughly disseminated. There is also no assurance that these protocols are adhered to, due to lack of monitoring. The capability of private hospitals to manage PLWHAs is also inadequate since training has been confined mainly to public hospitals. Community support systems have been initiated by NGOs and the DSWD, but limited resources (e.g., trained social workers, limited funds for training and monitoring) impinge on their capacity to strengthen and expand. There is also no care and support Programme focusing on children.” (p. 12)

(Philippine National AIDS Council, Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV))

- From a report titled, “Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes” under the Operational Barriers to ARH,
 - “Marital status used as basis for providing reproductive health services: Because of the sensitive nature of issues in general in the Philippines, marital status instead of age has generally been the major factor determining how SRH Programmes are organized and provided. As the head of a prominent NGO working with youth and adolescents explained, a married adolescent would not be treated as a teenager but as an adult; access to SRH services is considered appropriate for married women. “*Politically, age is not really the issue in this country. It is always marital status. Even if you are 17 and married, they (health care workers) would say ‘Fine, you need family planning? That’s okay.’ Premarital sex is the issue, not age itself...*” However, despite resistance, there is clamour to focus attention on younger adolescents and to adopt the exact WHO definition of adolescence, which extends between the ages of 10 and 19.” (p. 21)
 - “Barriers to pregnant adolescents attending school: While no policy exists on teenage pregnancy, young unmarried mothers face social and institutional pressures to discontinue schooling during pregnancy or at delivery. This may involve a principal asking her to leave school, parents’ fear of stigma surrounding their (unmarried) daughter’s pregnancy, or her own embarrassment once her condition becomes physically evident. A DECS official stated, however, that about one-half of pregnant teens do return to school. The actual ability to return to school depends on multiple factors. The same official described the following scenario”:

“Most likely a (pregnant school girl) would stay in school until five or six months, when she starts to show. But she would be made to feel very uncomfortable. The pressure is such that she would eventually drop out. She would be able to come back as long as no one saw that she was pregnant, as long as it was kept very hush. (The school) cannot deprive her of her right to go back to school and finish, but if the principal knew (why she dropped out)...The stigma of her condition would pressure against this...” (p. 22)

(Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- **How do the effects of availability vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**
 - Positive Action Foundation, Incorporated: Out of the total number of recorded HIV positive persons in the Philippines at the moment, 38% are overseas workers. 33% in turn from this group are sea farers (men). PAF estimates that only half of departing overseas workers get HIV education that is 10 out of every 20. (Information provided by in-country consultant)

PREVENTION COMPONENT 4: ACCESSIBILITY OF SERVICES (location, user-friendliness, affordability, etc)

Key questions:

31. Are all government HIV prevention and SRH services equally open to married and unmarried girls and young women?

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- From the “The Adolescent and Youth Health and Development Programme Framework” :
 6. Services Offered to Adolescents Under Each RH Element “To better appreciate the importance of the RH Overview as the beginning module in this Training Programme, the set of services that are integrated under the various RH elements are listed below. These services are to be offered and made available to the adolescent at the public health facilities, RHUs and hospitals.” (p. 10)

Box 8: Services to be Offered to Adolescents Under Each RH Element

RH Elements	Services
1. Family Planning	History taking, Fertility Awareness, methods and FP benefits
2. Maternal and Child Health	Prenatal Care; Counselling on Sexual relationships, Tetanus toxoid immunization; Family Planning, Nutrition; Also includes labor and delivery and post-partum care
3. Prevention and Treatment of RTIs including STDs/AIDS	History Taking, counselling and treatment and IEC services
4. Prevention and Management of Abortion and Its Complications	Identification of early signs and symptoms; immediate referral; and post-abortion counselling
5. Adolescent Reproductive Health	well adolescent services; IEC services; FP benefits; MCH services; RTI prevention; prevention of abortion; mental health; and VAW services and counselling
6. VAWC	Early recognition of VAW; First Aid Intervention, support services, referrals and counselling
7. Men's RH	Gender sensitive IEC services, FP services, prevention and management of RTIs, Referrals and counselling on Male involvement
8. Prevention and Management of Breast and reproductive Tract Cancers	Early detection; counselling; referral services, breast exam.

C.1 Coverage of the AYHDP (Adolescent Youth and Health and Development Programme)

It has been recognized that adolescence is a crucial stage in the life cycle of the individuals given their cor and diverse needs. The AYHDP however shall mainly focus on addressing the following health concerns c adolescents regardless of their sex, race and socioeconomic background. The other concerns and needs c adolescents which cannot be directly addressed by the DOH will be closely coordinated with the agency; offices duly mandated to do so. Most of these health concerns stipulated in the AYHDP are actually covere this Training Programme on Adolescent Health except for the communicable diseases and intentional unintentional injuries. These are summarized as follows:

- growth and development
- reproductive health
- communicable diseases
- mental health
- substance use
- injuries and disabilities

(Philippine Department of Health in Collaboration with WHO and UNFPA (2002) *Training Programmeme on Adole; and Youth Health and Development For Health and Non-Health Service Providers*, Volume I-C: Facilitators' Guide Module 2: The Adolescent and Youth Health and Development Programme Framework, <http://www.doh.gov.ph/ayhd/tp/Volume%201-D%20Module%2002/Module%202%20AYHDP%20Frmwk%20-Handc Fac%20guide.pdf> (Date accessed 30/05/06))

32. Are all government HIV prevention and SRH services equally open to girls and young women who are HIV positive or untested?

- o From the "The Adolescent and Youth Health and Development Programme Framework":
 6. Services Offered to Adolescents Under Each RH Element "To better appreciate the importance of the RH Overview as the beginning module in this Training Programme, the set of services that are integrated under the various RH elements are listed below. These services are to be offered and made available to the adolescents by the public health facilities, RHUs and hospitals." (p. 10)

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- growth and development
- reproductive health

- communicable diseases
- mental health
- substance use
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33. Are VCT services free for girls and young women?

- No (Information provided by the in-country consultant)

34. Are approximately equal numbers of females and males accessing VCT services?

- No (Information provided by the in-country consultant)

35. Are STI treatment and counselling services free for all girls and young women?

- No (Information provided by the in-country consultant)

36. Are condoms free for girls and young women within government SRH services?

- No. (After 2000, condoms were no longer distributed for free). In some cases, it is even banned in government run facilities (Manila clinics and city funded hospitals) (Information provided by the in-country consultant)
- According to this newspaper editorial titled, "Natural family planning can free couples from costs", - "THE decision of USAID to "veer away from contraceptive procurement assistance" has elicited various responses from our countrymen, particularly those engaged in procreative health services and those involved in demographic concerns.

This development tends to give rise to questions such as, "What can the country do to be self-reliant in securing its own contraceptives?" To properly respond to this situation, we must see the total picture, lest we be confused or misled by the more conspicuous issues.

The restructuring of USAID involvement in our country's family planning initiatives necessitates a response from the affected sectors and entities. But can we automatically conclude that such a response is directly connected with the need to be self-reliant in contraceptives?

The discontinuance of USAID's supply of contraceptives to government does not mean the total collapse of the country's family planning efforts.

It means that people who wish to use contraceptives just have to find other sources of free supply, or buy their own supply in drugstores. Actually, many people do buy their own contraceptives, and USAID-supplied inventories in government facilities are often underutilized.

Affordability

Of course, the affordability of these products is crucial. The high cost of contraceptives is among the major concerns of poor families when deciding on what family planning method to adopt. When properly understood and lived out, natural family planning relieves Filipinos of having to pay for contraceptives and expenses that may be incurred in case of side effects, illnesses and complications arising from their use.

In fact, the expenses a couple needs to worry about when practicing natural family planning are just the paper and pens needed to chart their fertility, and the thermometer if they choose to apply the basal body temperature, or the sympto-thermal method.

Thus, the issue of "self-reliance" raised in relation to the restructured USAID support causes us to face the greater issue of empowerment, not only of our country's public health system, but also of each concerned family.

While certain institutions may have no qualms about being wholly dependent on the decisions of foreign powers, can we justly subject our Filipino families to such bondage?

Liberation

Informing families that they may no longer avail themselves of free contraceptives from government facilities need not be interpreted as abandonment. It can, in fact, be viewed as liberation.

Married couples are now prompted to be aware of their own fertility and to behave accordingly so they can practice responsible parenthood without high costs, anxiety, fear of side effects, and the many other social and interpersonal difficulties that plague married couples who resort to contraception or sterilization to protect their families. This is how natural family planning becomes liberating.

The question we should ask, therefore, is "What can Filipino families do, now that the pipeline for free contraceptives is being cut?"

Seeking other sources for contraceptives is only one of the answers. Practicing responsible parenthood through natural family planning is another." *Manuel M. Dayrit, M.D., Health Secretary*

(*Dayrit, Manuel M. (October 2003) Natural family planning can free couples from costs*
http://www.inq7.net/opi/2003/oct/27/text/letter_4-1-p.htm (Date accessed 30/05/06))

- o From a newspaper editorial, "Contraceptives: Who should foot the bill?":
"AN OFFICIAL of the United Nations Population Fund (UNFP) has warned of unwanted pregnancies, illegal abortions and rise in maternal deaths in the country after she accused the Macapagal administration of diverting P70 million for contraceptives to natural family planning.

Florence Tayzon, assistant UNPF representative in Manila, claims that the money was allocated for contraceptives under President Joseph Estrada, but his successor, President Macapagal-Arroyo, diverted it to natural family planning.

This comes as no surprise because Ms Macapagal has announced that her administration's reproductive health services will focus on natural family planning, an approach favoured by the Catholic Church.

She highlighted this position when she met Pope John Paul II in Vatican last month. The President said her administration's public policies remained in "accordance with important doctrines of the Church."

Ms Macapagal's position on family planning has the support of United States President George W. Bush whose administration is reducing assistance for artificial means of family planning, while increasing military aid to the Philippines.

The last shipment of condoms donated by the US Agency for International Development (USAID) arrived in the country in March. Pill donations will be phased out in 2007, and injectables the year after. IUD will be phased out later.

This means that couples, mostly the poor, can no longer avail themselves of free contraceptives from government centres—a formula for more Filipino babies being born yearly." *Juan V. Sarmiento, Jr., EDITOR*

(*Sarmiento, Juan V. Jr. (October 2003) Contraceptives: Who should foot the bill?*,
http://www.inq7.net/opi/2003/oct/27/text/letter_1-1-p.htm (Date accessed 30/05/06))

37. Are ARVs free for all girls and young women living with HIV/AIDS?

- o According to the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, "Current financing relies primarily on donations and personal expense of PLWHAs themselves. Aside from the prohibitive cost of ARV drugs, the also the inaccessibility of basic drugs like pain relievers and medicines for opportunistic infections. It is also possible that the low coverage of drug treatment is caused by the reluctance of PLWHAs to seek services fear of stigma and discrimination." (p. 12)

(Philippine National AIDS Council, *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*)

38. Are issues relating to HIV/AIDS stigma and discrimination included in the training curriculum of key health car

workers at SRH clinics?

- o According to the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*,
 - Strategy 4 – “Integrate stigma reduction measures in preventive, treatment, care and support services as the design and installation of management support systems” (p. 27)
 - “HIV/AIDS stigma is defined as “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV and at individuals, groups, and communities with whom they are associated (1996 Herek, G.M., et. al, 1996). Stigma and the discrimination that accompanies it negate efforts to combat HIV/AIDS. It drives the epidemic by blocking the public’s understanding of its causes and makes it more difficult for men and women, especially those infected and affected, to adopt preventive behaviours such as condom use, and voluntary counselling and testing (VCT). It also affects the quality of care given and the perception of PLWHAs by communities, families and partners. In the health care setting, stigma and discrimination happens because, more often than not, health workers themselves have not been prepared to come to terms with their fears, anxieties and prejudices.” (p. 27)
 - OPERATIONAL STRATEGIES “Reducing stigma is essential in making care, treatment and support more readily accessible to those who are infected and affected. While it may be unrealistic to think that stigma and discrimination can be eliminated, it can be reduced through a mix of interventions that include supportive policies as well as information, education and counselling, among others. The AMTP IV will support the continuous conduct of gender and development workshops/training among service providers, policy-makers and the general public. Gender responsiveness of policies, standards and protocols including training modules, IEC materials and advocacy documents will be inherent in their design and dissemination. Management support systems such as planning, monitoring and evaluation, surveillance and reporting can significantly reduce the stigma against PLWHAs if properly designed and with gender perspective in mind. Having adequate and correct information about HIV transmission is key to understanding PLWHAs and appreciating their conditions and needs. Identifying credible individuals as champions in the cause of the PLWHAs is essential in propagating accepting behaviours and attitudes towards PLWHAs. Engaging PLWHAs themselves in the campaign and other HIV/AIDS-related work will help demystify and correct misconceptions about them. Note that the following key result areas and activities are already integrated in the other key strategies and interventions. They are only presented here to emphasize and to highlight that stigma reduction efforts must be relentlessly pursued.” (p. 27)
 - KEY RESULT AREA (KRA)
 - “KRA 1: Supportive non-discriminatory policies, guidelines and systems are developed and enforced at the national, sub-national and local levels.”
 - “KRA 2: Service providers, key stakeholders and the general public are educated regarding stigma and discrimination.”
 - “KRA 3: PLWHAs are empowered as effective advocates and educators.” (pp. 27-28)

Major Activities

Key Result Area 1: Supportive non-discriminatory policies, guidelines and systems are developed and enforced at the national, sub-national and local levels.						
Activity	2005	2006	2007	2008	2009	2010
1. review, amend if needed, and enforce compliance with the provisions of RA 8504, and other policies, standards, protocols and guidelines specifically on discrimination						
2. review, revise as needed, and/or develop gender-sensitive and rights-based IEC and advocacy materials that promote accepting attitude towards people with HIV/AIDS						
3. review, revise as needed, and/or develop training manuals and materials that promote gender sensitivity and reduce stigma against the HIV positives and the affected						

Key Result Area 2: Service providers, key stakeholders and the general public are educated regarding stigma and discrimination.						
Activity	2005	2006	2007	2008	2009	2010
1. training/orientation of service providers (schools, hospitals, health facilities, NGOs, communities etc.) on gender sensitive STI/HIV/AIDS response to include the emotive part of coming to terms with their own fears, anxieties, sexuality, prejudices	c/o Strategy 1, 2 and 3					
2. educate policy-makers, program implementers and other influentials re gender-sensitive HIV/AIDS response	c/o Strategy 1, 2 and 3					
3. conduct mass media campaign for the general public emphasizing accepting attitudes toward the STI/HIV/AIDS positives and affected	c/o Strategy 2 KRA 5					

Key Result Area 3: PHAs are empowered as effective advocates and educators						
Activity	2005	2006	2007	2008	2009	2010
1. provide assistance to develop capacities of PHAs as advocates and educators						
2. strengthen capacity of PHAs' network and organizations in providing support to positive members						

(Philippine National AIDS Council, *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*)

39. Are issues relating to young people included in the training curriculum of key health care workers at SRH clinic

- o From the "The Adolescent and Youth Health and Development Programme Framework
- " E. What Can Service Providers Do When Working With and For Adolescents?": "The Training Programme provides many examples of what service providers can do when working with and for adolescents. In this module, some keys to success in your overall working relationships with adolescents are provided. This involves making adolescents central to whatever work you do with them. More detail will be found in each of the respective modules." (p. 19)

Box 6: Keys to Success in Working with and For Adolescents

How Should Service Providers Work with the Adolescents

- understand the specific needs of each individual adolescent
- treat the adolescent as an individual, not just as a case of this or that health problem
- Acknowledge - and heed to - the viewpoints and perspectives of the adolescent
- prevent personal beliefs and attitudes, preferences and biases from influencing one's professional assessments and actions
- respect the rights of the adolescent (as laid out in the Convention on the Rights of the Child), while at the same time taking into account the rights and responsibilities of parents
- take into primary consideration, the best interests of the adolescent, when making decisions – or taking actions – that affect him/her
- is what I propose to do: legal?; ethical?; in the best interests of the adolescent?

Could my actions lead to a conflict between the rights of the adolescent, and the rights of others? If so, how can I resolve this conflict?

(Philippine Department of Health in Collaboration with WHO and UNFPA (2002) *Training Programme on Adolescent and Youth Health and Development For Health and Non-Health Service Providers*, Volume I-C: Facilitators' Guide Module 2: The Adolescent and Youth Health and Development Programme Framework, <http://www.doh.gov.ph/ayhd/tp/Volume%201-D%20Module%202/Module%202%20AYHDP%20Frmwk%20-HandcFac%20guide.pdf> (Date accessed 30/05/06))

40. Are there any government media campaigns (e.g. television commercials and newspaper advertisements) a

HIV/AIDS that specifically address prevention among girls and young women?

- No (Information provided by the in-country consultant)

Discussion questions:

- **Are HIV prevention services truly accessible to girls and young women, including those that are marginalised and vulnerable? For example, are they: safe? affordable? reachable by public transport? in appropriate language? non-stigmatising? open at convenient times?**
- **What are the cultural norms around prioritizing females and males for health care?**
- **To what extent are informed and supportive SRH services accessible for girls or young women living with HIV/AIDS?**
- **What are the client/service provider ratios in different types of HIV prevention services? What is the gender ratio of staff in those services?**
- **Do services make proactive efforts to attract girls and young women? For example, do SRH clinics have separate rooms for young women so that they do not risk seeing family members or familiar adults?**
- **What are the attitudes of service providers to girls and young women, including those who are marginalised and vulnerable? Are they kind, non-judgemental and realistic (for example about young people's sexual pressure and desires)? Can they encourage girls/boys to assess their risks of HIV infection and change their behaviour? Are attitudes generally getting better or worse?**
- **Do HIV prevention information campaigns, etc, target girls and young women? For example, are they culturally and linguistically appropriate? Are materials distributed through appropriate media and outlets?**
- **Is there a national monitoring and evaluation framework? Does it encourage data to be disaggregated (according to gender and age) – to help assess the extent to which girls and young women are accessing programmes and services?**
 - According to the *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*, "Monitoring and evaluating the progress of the national response has been inadequate. Efforts have been limited to partial assessments that do not provide the complete picture. No evaluation has been done to ascertain compliance with the provisions of RA 8504. For example, the establishment of an HIV/AIDS Programme in the workplace is not enforced due to an inadequate number of personnel in the DOLE (Dept. of Labour and Education). Furthermore, there is no data on whether curriculum integration in learning institutions at various levels is actually being pursued. There is also no definitive information on whether hospitals are following the protocols for treatment, care and support for HIV/AIDS. A national monitoring and evaluation (M & E) system has recently been developed by the PNAC (Philippine National AIDS Council). However, operationalisation of the M and E system requires substantive resources." (13)

(Philippine National AIDS Council, *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*)

- **Are referrals and follow-up provided during HIV/AIDS, SRH and antenatal care services for young women and girls?**
- **Overall, what difference does accessibility to services mean in practice? What are the 'real life' experiences of girls and young women? What difference is made to their vulnerability to HIV infection?**
 - From a report titled, "Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes",
"Overall, ever-use of contraception among sexually active adolescents was low at 20 percent. Non-desire for pregnancy and high awareness of contraceptive methods were not enough for the young to use contraception. Among those who do use contraception, the more popular methods are the condom, withdrawal, and rhythm. However, the following quote illustrates multiple factors that converge to make contraception inaccessible for Filipino youth:

For the longest time contraception was only made available to married couples of reproductive age. And there was a denial of young people being sexually active. Then, post-Cairo there was the politically correct stance that we have to make contraceptive services available to young people.

So the government suddenly says, "Okay, it is now available for young people." But the milieu simply does not allow it. The policy says you can go but... Even if you can provide supplies to all, it is a major task for a 16 year-old (to go to a clinic). The environment does not allow them to...The culture says you are not supposed to be asking for it...

Condom use was one key topic during the interviews. Informants stressed that condoms are viewed with suspicion as these are often connected with HIV/AIDS infection and prevention, not contraception. As in many parts of the world, there are also (largely negative) gender-specific connotations of condom use and being associated with it. As one individual described, "Condoms are traditionally seen as an object of illicit sexual behaviour. Only sex workers use it." Another noted that condom use among youth is negligible—1 or 2 percent at most. Moreover, there are many sexual negotiation issues surrounding condom use that makes it unpopular, as described in two separate interviews in Davao City. A teenage volunteer peer educator at a Davao NGO said,

Condom use here (in Davao, but elsewhere as well) is still seen primarily as an HIV protection method, not family planning. Its contraceptive aspects are really secondary in terms of how people see it. There are also problems with what condoms mean in a social sense, which keeps people from using them. If you are a teenage girl and are found to have a condom in your purse, for example, you are promiscuous, bad, and evil. And of course youth won't want to be seen like that. Because you are a woman you shouldn't be having condoms with you. The answer (to why people don't use condoms in the Philippines) is cultural. As a woman you shouldn't be doing this...There is a stigma attached to condom use. Men are more likely allowed to this. Condom use is more acceptable for men. But it also has something to do with who is making the decision regarding the use of a condom. As a woman, you don't impose the decision or your preference on your partner. The male should be the one to suggest it. So there is a power relations aspect of condom use too. Condoms are taboo here in our community (suburb of Davao City). Because of our parents... They don't like to see us having anything to do with condoms. I wouldn't keep one in my wallet. What if my mother looked and found it! I just don't know if we would be able to discuss it openly...

Many respondents said that most young people do not discuss or use condoms. One aspect of condom use that makes them unpopular with youth involves their social inaccessibility. The need to buy them in a public place—the other side of the counter in most pharmacies—seemed to make condoms out of young people's reach. Interviewees also said that young people do not seem to know enough about condoms to consider using them. There is also a perceived negative association with condoms; they are seen as "dirty, so people do not like to be seen using them." Beliefs and misconceptions about the side-effects of contraceptive use create barriers to access. For example, one researcher stated, "People see contraception as potentially sterility-inducing. There is a belief that pills accumulate in the uterus and then become cancerous." (pp. 12-13)

(Policy Project (2003) Adolescent and Youth Reproductive Health in the Philippines – Status, Issues, Policies and Programmes, http://www.policyproject.com/pubs/countryreports/ARH_Philippines.pdf (Date accessed 30/05/06))

- From the Fourth AIDS Medium Term Plan, "Treatment, care and support (TCS) are also geographically inaccessible as these services are available only in DOH medical centres (SLH, RITM and other government retained hospitals) and the Philippine General Hospital (PGH). The travel time and the additional transportation costs make it difficult for a number of PLWHAs to access them. The quality of laboratory ser in some facilities is also deteriorating due to old equipment, fast turnover of personnel and limited reagen and other supplies." (p. 12)

(Philippine National AIDS Council, *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*)

- In an article from the Inter Press Service News Agency website titled, POPULATION-PHILIPPINES: Gov't Hanc Tied by Conservatives:
" MANILA, Jan 27 (IPS) - Filipinos are becoming sexually active at a younger age, but the Philippine government feels its hands are tied by conservative groups, including the Catholic Church, that resist more active state involvement in population Programmes and the use of artificial means of birth control.

Twenty-three percent of young people aged 15 to 24 are sexually active in a country where

Catholic mores frown on premarital sex, says the 2003 State of the Philippine Population Report.

The report used much of the fresh data of the 2002 Young Adult Fertility and Sexuality Survey, a national study by the University of the Philippines Population Institute that interviewed nearly 30,000 youth across the country.

In the 1982 and 1994 surveys, the University of the Philippines established the average age of sexual initiation at 18. In 2002, the age of initial sexual activity changed slightly to 17.5. The study also found out that young people who had sex before age 15 has increased eightfold from less than two percent in 1994 to 16 percent in 2002.

For many, the first sexual encounter was a spontaneous event; 55 percent said it was something they did not plan to happen at that time, but went along with it anyway; 43 percent said it was something they wanted to happen at that time. But 40 percent of those who had their first sexual encounter said they did not have any means of protection.

The population report, published by the Commission on Population and the United Nations Population Fund, listed sex as something that happens often at the end of the occurrence and intermingling of risky behaviour such as smoking, drinking and drug use.

But amid this backdrop, Tomas Osias, executive director of the Commission on Population, says the government is treading on fragile ground, wanting to respond to young people's needs but also aware of the sensitivity of the matter.

"There is no clear policy if government would provide services to unmarried sexually active young persons," he said.

Health centres run by the state in localities, he says, offer free health services but these are not ready for services appropriate for the young.

"To the conservatives, we are seen as promoting promiscuity and are allowing unmarried youth to have premarital sex every time we attempt to provide information and services on reproductive health, especially about sex education or the proper use of contraceptives," he said.

But the fact is that "the more we withhold information from the youth, the more problems it would create," said Cecille Villa, executive director of the Foundation for Adolescent Youth, which has peer education Programmes for the youth.

The Catholic Church frowns on any artificial means of contraception, including the use of condoms, and sees their provision as encouraging premarital or casual sex, or sex outside marriage.

This stance has had a lot of influence in a political environment where politicians and governments are often wary of offending the Church, given that more than 80 percent of people in this country of 84 million people are Catholics.

Yet according to the population report, it is time the government heeded the trends of a population that is becoming sexually active earlier and need the right information to avoid risks. Already, it says, "Risk behaviour, both sexual and non-sexual, are multiple and simultaneous. They are interrelated and may be mutually reinforcing".

For instance, it noted the high incidence of smoking cigarettes and drinking alcohol among the young, and how these often lead to drug use and sexual intercourse. "They are not usually done in isolation with each other, but rather, they are interlinked - those who smoke, drink and use drugs are more likely to have sex," the report says.

Although pregnancy and parenthood are not the stuff young people are expected to busy themselves with, reality bites.

The number of teenagers who have begun childbearing is also increasing -- from nine percent reported in the 1993 National Demographic and Health Survey to 11 percent in the 1998 version of

the same report.

One-third of young women in the ages 20 to 24 had already given birth to their first child before reaching their 21st birthday. Young pregnancies account for 30 percent of all births in the Philippines; six percent of spontaneous abortions and three out of four maternal deaths.

The agency estimates that half of the 84 million Filipinos are 21 years old and under. Childbearing among the youth is the largest source of population growth in the Philippines. Of some 1.7 million babies born every year, around 30 percent come from young women.

But Osias said that although the fact that 23 percent of those in the age group 15 to 24, estimated to be around more than 16 million, are sexually active alarms parents, adults and institutions, he said the government pins its hopes on the 77 percent who are not.

"We want the youth to have the ability to say 'no' to sex," he says. "We want them to have many options in life. We want to tell them not to have sex unless they are prepared for the consequences. We want them to be mature first in case they want to get married and have families."

"I have a teenage daughter," Osias says. "As a parent, there is this difficulty to discuss sexuality," he told journalists. "But if I were a father and I know that my children are engaging in sex, I am for a more positive approach - sexually active youth must be given services on reproductive health and responsible sexual behaviour."

Like Osias, Villa is a parent - she has three adolescent and young adult children. Adults may find it difficult to grasp what is going on with adolescents, teenagers and young adults, she adds, but "it pays to be aware".

Because of the influence of media, the Internet, and Hollywood on Western-influenced youth, "sex is more openly discussed among the young", she says.

Villa explains that the young handle their relationships like adults, but often have a slower and immature understanding of the impact of their urges and emotions. "Not all youth who go to bed are in love; not all youth who are in love go to bed," she points out." (END/2004)

(Mendoza, Diana (January 2004) *POPULATION-PHILIPPINES: Gov't Hands Tied by Conservatives* <http://www.ipsnews.net/africa/interna.asp?idnews=22110> (Date accessed 30/05/06))

- **How do the effects of accessibility vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

PREVENTION COMPONENT 5: PARTICIPATION AND RIGHTS **(human rights, representation, advocacy, participation in decision-making, etc)**

Key questions:

41. Has the country signed the Convention on the Rights of the Child (CRC)?

- CRC signed on January 26, 1990 and ratified on August 21, 1990. (Office of United Nations High Commission on Human Rights (UNHCR) (May 2006) *Convention on the Rights of the Child* New York, 20 November 1989 <http://www.ohchr.org/english/countries/ratification/11.htm> (Date accessed 30/05/06))

42. Has the country signed the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages (CCM)?

- CEDAW signed on July 15, 1980 and ratified on August 5, 1981. (United Nations Division for the Advancement of Women, Department of Economic and Social Affairs (May 2006) *Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) State Parties*, <http://www.un.org/womenwatch/daw/cedaw/states.htm> (Date accessed 30/05/06))

43. In the National AIDS Council (or equivalent), is there an individual or organisation that represents the interests girls and young women?

- o No (Information provided by the in-country consultant)

44. In the National AIDS Council, is there an individual or organisation that represents the interests of people living HIV/AIDS?

- o Yes. (Positive Action Foundation, Inc.) (Information provided by the in-country consultant)

45. Was the current National AIDS Plan developed through a participatory process, including input from girls and young women?

- o From the Fourth AIDS Medium Term Plan, "The Fourth AIDS Medium Term Plan is a product of the collective efforts of partners and stakeholders who contribute to the National Response to HIV/AIDS. The Philippine National AIDS Council would like to acknowledge the following:
 - Dr. Manuel M. Dayrit, former Secretary of Health and Chair of the Philippine National AIDS Council, for the leadership he has provided to PNAC;
 - Local government units, for participating in the consultations and providing field level perspectives on HIV/AIDS;
 - Civil society organizations, for valuable inputs on strategies and activities in the areas of prevention, care and support, and stigma reduction;
 - People living with HIV/AIDS, for whom HIV/AIDS is a reality that they deal with every day. Their inputs, gained life experiences, are most valuable;
 - Centres for Health Development of the Department of Health, for providing comments on the strategies and activities;
 - PNAC Secretariat, for mobilizing resources and over-seeing the development of the AMTP IV;
 - Eireen Villa for facilitating the process by which the AMTP IV was developed and Pedrito de la Cruz for consolidating inputs from various sectors;
 - AIDS Society of the Philippines for the logistical support and coordination; and
 - UNAIDS and the members of the United Nations Theme Group on HIV/AIDS, for their technical inputs and financial support (Acknowledgement section)

(Philippine National AIDS Council, *Fourth AIDS Medium Term Plan 2005-2010 (AMTP IV)*)

46. Is there any type of group/coalition actively promoting the HIV prevention and SRH needs and rights of girls and young women?

- o Notably, there is no organization with this specific focus. Majority of the NGOs working around HIV/AIDS do not have an orientation or frame on gender/women/girl children's rights. The closest organization, ACHIEVE, is not a women's organization or a feminist organization per se. Many of its founders however are feminist and even staff have previous working experience in women's groups. It currently supports the first ever coalition of HIV positive women (BABAE plus). (Information provided by in-country consultant)

47. Is there any type of national group/coalition advocating for HIV prevention (including positive prevention) for girls and young women?

- o The closest as mentioned is BABAE Plus but as of now it is just a support group run by women HIV positive. (Information provided by in-country consultant)

48. Is the membership of the main network(s) for people living with HIV/AIDS open to young people, including girls and young women?

- o Yes, as a rule these are all open however, given the background of HIV advocacy in the country, women are now just beginning to be approached as a specifically vulnerable group. (Information provided by in-country consultant)

49. Are there any Programmes to build the capacity of people living with HIV/AIDS (e.g. in networking, advocacy etc)?

- o From the "Directory of Associations of People Living with HIV/AIDS",
 - "PINOY PLUS Association – PINOY PLUS is a sole organization of PLWHA in Philippines. PINOY is a colloquial term for Filipino...The prime motive is to organize PLWHA, and to have one voice and access to available services. We have transformed and developed gradually, from being beneficiaries of services to proactive participants in information, education, and communication campaigns; advocacy; fundraising; networking; and providing care and support services to peers. We provide PLWHA the opportunity to share experience and resources and strengthen each other through planned activities." (p. 94)
 - "Positive Action Foundation Philippines, Inc. – Capability/skills-building; community health education; training;

the workplace; advocacy campaign: Positive Lives Caravan 2003; photo exhibit of PLWHA.” (p. 94)

(United States Agency for International Development (USAID), Global Network of People Living with HIV/AIDS (GNP+) and International Coalition of Women (ICW) (2004) *Directory of Associations of People Living with HIV/AIDS*, http://www.usaid.gov/our_work/global_health/aids/Publications/docs/hivaidsdirectory.pdf (Date accessed 30/05/06))

50. Are there any girls or young women living with HIV/AIDS who speak openly about their HIV status (e.g. on television or at conferences)?

- Yes. A number of them are network members of the BABAE Plus, and other networks of HIV positive persons. This is as far as conferences/trainings go. However, the most public personality who has come out on TV remains to date, Sarah Jane. (Information provided by in-country consultant)

Discussion questions:

- How are international commitments (e.g. CRC, CEDAW, and CCM) applied within the country?
- Is the national response to HIV/AIDS rights-based? For example, does it recognise the SRH rights of women living with HIV/AIDS?
- Do key decision-making bodies (e.g. the Country Coordinating Mechanism of the Global Fund to Fight AIDS, Malaria, and Tuberculosis) have a set number of seats for civil society? Are any of them specifically for representatives of girls and young women or people living with HIV/AIDS?
- Are HIV prevention programmes generally developed ‘for’ or ‘with’ girls and young women, including those who are marginalised and vulnerable? Are girls and young women seen as ‘implementers’ as well as ‘receivers of services’?
- To what extent are girls and young women aware of decision-making processes? Are they encouraged to have a voice? Are they seen as an important constituency within committees, management groups, etc?
- How high are issues relating to HIV prevention for girls and young women (e.g. early marriage and stigma) on the agendas of local leaders and decision-making groups (e.g. district AIDS committees)? To what extent do girls and young women participate in those types of bodies?
- To what extent are people living with HIV/AIDS organised, for example in networks? Are girls and young women involved in those bodies?
- How are issues of participation affected by stigma? For example, is it safe for people living with HIV to speak openly about their HIV status?
- Overall, how are participation and rights applied in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?
- How do the effects of participation and rights vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

PART 2: IN-COUNTRY RESEARCH

Focus group discussion: 16-23 year olds

Age group: 16-23 years

Number of participants: 9

Profile of participants: High school and college students/graduates; out-of-school; trained peer educators/activists; urban areas

Place: Manila

Prevention component 1: Legal provision

What do you know about laws in the Philippines that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? prevent girls from using services unless they have the consent of their parents?

(Note: The discussion here was very enlightening. Young people are generally less concerned with LEGAL provisions, even "minority" (or age) in terms of access to services and information, than adults usually are)

- "We have encountered that the information they give out in school is all wrong; even in the seminars they require sometimes prior to employment --- this is why it is important to reach young people, no matter what age."
- "The FPOP representative shared how within the organization, the issue of parental consent/minority was such a serious matter that the governing body took several steps to discuss its legal implications." (Note: Many reacted in the group that age shouldn't matter and that parents themselves should be subjected to education.)
- "We have had efforts of reaching out to parents. We don't do so as a matter of course or require it before educating young people but we have tried. We have had good experiences where parents recognized the importance of the sexuality education we do."

Prevention component 2: Policy provision:

What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

- None in school; inaccurate; very bio-medical approach, none about relationships which young people are always interested in.

(Note: All of the participants either said there was no school programme on sex ed, let alone AIDS or some said there was some token programme with very inaccurate information; the peer educators shared what they had in terms of their NGO programmes.)

- "In peer educator programmes, we invite speakers from other groups like the PAFI (Positive action foundation, Inc.); we speak about everything from abstinence to safe sex using condoms; masturbation and how to be sensitive when doing education since we wouldn't want to offend others who are not as informed when they get exposed to information about sex."
- "We have a game where we try to single out words (names of sex organs) and level off on using them to get past the taboo."

What could the government of the Philippines do to fight fear about AIDS in your community?

- To have a positive view about sex, to recognize our rights as young persons, we have rights but we also know we have responsibilities

Prevention component 3: Availability of service

What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? condoms? treatment for a sexually transmitted infection (STIs)? an HIV test?

- No available services in the community; no available information; only stuff heard about AIDS is the media.
- Information is available through programmes of ZOTO, youth focused programmes which give information about STDs.
- Services are available outside the community. *"It is banned in Manila (ARH) so we refer them to other NGOs and clinics."*
- Most services are for prevention; one participant had the opportunity to attend training (work related) in Australia (on study tour).
- Programmes train peer educators who in turn do community advocacy and education.

(All of the services and Programmes mentioned are private/NGO led)

How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

- *"Initially girls find it harder to speak out than boys when it is about sexuality; Boys seem to know more than girls but later girls actually take on leadership roles as peer educators."*
- *"Many girls act old fashioned or keep quiet; boys tend to be open-minded about these things."*
- *"More boys stay on than girls in peer educator Programmes on sexuality."*

(Note: This observation was shared by both sets of peer educators including the NGO (FPOP) youth representative. Some speculated it's because girls tend to be more serious than boys about finishing their schooling ---thus not having time for extra curricular work; others observed it may be more difficult so I followed up the question with a query about cases of girls being pressured into sexual favours because they speak openly about sex – One participant acknowledged that YES, she has experienced it and often finds it difficult to handle boys and audiences who expect them to be ready to jump into sexual relationships because of what they know/how much they know)

- *"It depends on the group. Sometimes girls are outspoken but boys tend to react; either compete or become quiet."*
- *"Outspoken girls encourage other girls to speak."*
- *"Young people usually boast about how many sexual positions they know about."*

What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

- For all services to be available at the community level, from information to treatment
- A "tambayan" or a teen centre where young people can meet, express themselves, combination of RH information with values education
- Treatment care and support that is available specifically to young women and girls

Prevention component 4: Accessibility of services

What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

- *"We have met HIV positive people in the course of our trainings with ZOTO but have never encountered a case in our community."*
- *"We have encountered a HEP B positive case but had to refer to other organizations; we have no services within the community."*

What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? unfriendly?

- *"The most difficult would be the stigma. Who would even bother to come forward if one suspects they have AIDS?"*
- *"People will immediately jump to conclusions, if you are a girl, "anong klaseng babae ka?" (Literally: what kind of woman/girl are you? ---This question often asked in relation to chastity)*
- *"Cost would be an issue, of course".*

In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

- Given these types of programmes, people usually expect the married women to access them, not young girls.

Service providers are surprised when a woman is not married, more so if she is somebody young

- *"When it comes to condoms, if it's a girl talking about it, giving it out, the smiles we get, it shows their surprise."*
- *"Many grown-ups are baffled often by peer educators and why they know so much about sex."*
- *"I encountered boys who said that when a girl is outspoken about sex, they get embarrassed."*

(Note at this point I followed up with a question about what has been the most extreme reaction they ever got from audiences as peer and community educators in RH---

"A parent approached us and asked why we were teaching their children lewdness/scandalous things.")

- *"My mother was shocked when she found a condom in my bag!"*

Prevention component 5: Participation and rights

Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

- Peer educators' training with continuous capacity building by Zoto took over a year with several trainings
- None in Sta Monica
- In Pandacan Manila, we started with posters in health centres

What would encourage you to get more involved in HIV prevention in your community?

- School based and community based programmes
- Media

Summary

What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in the Philippines to protect themselves from HIV?

"Talk about issues we can relate to, sex itself, RH care for girls and women, love and relationships, courtship, rights."

Focus group discussion: 14-24 year olds

Age group: 14-24 years

Number of participants: 12

Profile of participants: Young women and girls engaged in sex work

Place: Cebu City

Prevention component 1: Legal provision

What do you know about laws in The Philippines that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? prevent girls from using services unless they have the consent of their parents?

(Note: Much of our discussion around law, focused on their direct hand experience in vagrancy law violations and arrests.)

- "When you get caught, its not just the money, the police make use of us." (Note: rape, or sexual abuse is often termed; "ginamit;" or literally "used")
- "We run, we hide, but they know where to get us."
- "Once I started running and got caught, he (the police) grabbed me and hit me."
- "It is so hard to undergo detention. They make us work, they ask us to do their housework and other things."
- "Young girls get taken to the DSWD (social work) not detention but sometimes they get detained too."

Prevention component 2: Policy provision:

What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

What could the government of the Philippines do to fight fear about AIDS in your community?

"Provide more information other than scaring us with the cases of HIV AIDS. All we know is the condom but we can't really insist all the time."

"Nobody helps us when we need legal assistance. The NGOs we hear about help women who are battered by their husbands."

(Note: it is also a common assumption by the women/girls that they are both at risk and that they ARE to BLAME for HIV AIDS getting spread around, this despite the data which shows it is the heterosexual men who go back to their wives/partners who transmit the virus.)

Prevention component 3: Availability of service

What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? condoms? treatment for a sexually transmitted infection (STIs)? an HIV test?

- "The Social Hygiene clinic run by City health gives us most of the information we have."
- "We get tested for STDs and screened once every week; otherwise we cannot work without those cards." (Note: stamped pink slips indicating a woman has gotten tested)
- "We took an HIV test once, we waited 1 month for the results because they sent them to Manila."

(Note: The women noted they get tested every Tuesday and services were free all this time except that over a month ago, the city health started charging a fee of 30 pesos a week for the tests)

How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

- "Customers don't seem informed. Filipinos do not like using condoms."
- "Foreigners use condoms almost always."
- "We know that the way to prevent HIV AIDS is the condom but not all customers like using it."

(Note at this point I asked about which clients are hardest to negotiate with on condom use, expecting the answer to be the police or military but surprisingly they said that ALL Filipino men and BOYS are hard to negotiate with as far as condom use is concerned. One even disclosed that seminarians and priests are also hard headed when it comes to condom use)

What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

(Note: I was taken aback by the answer here because women/girls in prostitution were not even coming from a position of demanding anything from government or thinking it owed them something. Neither were they thinking from a perspective of rights to "services".)

- "The only help we need is someone to help us choose who to do business with, negotiate the price and for them to agree to use a condom." (One woman said this and all of them nodded and agreed.)
- "City health hygiene clinic is ok. We know that helps us."

Prevention component 4: Accessibility of services

What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

{Note again there was difficulty getting the women to be even the least bit critical about the services they got from City health because they also need to be in good terms with these health officials otherwise they cannot work.}

- "City health is ok; they help us a lot."
- "We do not mind the fee, it only started this month."
- "It is a bit expensive having to deal with it now (the fee)."

What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? unfriendly?

- "Vagrancy law, getting arrested all the time, losing what you earned in a night."
- "It is a way of life. Of course, we get arrested. What we do is illegal".
- "Sometimes the pink card matters, sometimes, it does not. Police arrest us whenever they feel like making a few bucks."
- "Judges are in on it too; so are prosecutors, they get our money."
- "We get charged 300 pesos, we don't know if it's a fine, we don't get a receipt."
- "What we get is a release form from detention, we get charged 1,000 sometimes." (Note this cases are usually when the woman charged is caught more than once within a period or classified under law as a recidivist)

In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

- City health here does not discriminate.
- All working girls get access to testing.
- Minors aren't asked questions when they are in this line of work.

(Note this is the 1st time I encountered such an arrangement with a hygiene clinic looking the other way when it is minors, which may on one hand be a good development rather than a denial of access for young people so common in many parts of Manila.)

Prevention component 5: Participation and rights

Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

Most Programmes here that have been given are on prevention such as how to use a condom; Sarah Jane's case.

What would encourage you to get more involved in HIV prevention in your community?

- *"We would welcome most anything if it helped us."*
- *"We want to use condoms but when the men refuse, what do we do?"*
- *"I refuse them, no condom, no deal2."*

(Note: At this point noting how some of them said they know about condom use and its importance in HIV prevention, I asked them whether they also demanded condom use with their partners; i.e. husbands or boyfriends; it turns out they find it even harder to do so because of the nature of expectations and the relationship)

- They say *"it's not pleasurable!"*

Summary

What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in the Philippines to protect themselves from HIV?

(Note: again it was very difficult to cull out answers for these types of questions because they tended to express gratitude for community health's hygiene clinic even with the user's fees)

One-to-one interview: Head of Operations (male) of the IPPF Member Association

General

What is your impression about the general situation of HIV prevention for girls and young women in the Philippines? Are things getting better or worse ... and why?

Our situation used to be considered or described as low and slow, that is according to documented cases of HIV and AIDS, now it has been called hidden and growing. I would suppose it is not as worse as the situation of our Asian neighbours, like Thailand, but the fact that there is an increase would mean it is worsening. Because of women's and girl's vulnerability, its also getting worse, even for all young persons in general.

Prevention component 1: Legal provision

In your opinion, what laws in the Philippines are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as: Whether girls can get married at an early age? Whether sex work is legal? Whether girls or young women can have abortions? Whether girls and young women can use sexual and reproductive health services without their parents' consent?

The Laws are making it worse.

Laws like the penal prohibition on prostitution, alongside a system of "hygiene clinics," which actually issue "permits," for bar girls and streetwalkers are complicating the problem. *"Hygiene clinics don't really exist for the women because prostitution is illegal and they land in prison when they don't get tested and don't have permits."*

As far as girls and young women are concerned, service delivery guidelines are supposed to be "neutral" or "blind," to the status of the person vis-a-vis the issue of access but in reality, issues such as marital status and parental consent (especially minors) still pose access issues for women and girls. *"Among service providers, legal protection is a big concern,"* due to core beliefs around who has the authority to decide in matters of family planning, right down to condom use.

Even the 1998 law on HIV AIDS for all its merits, reflects this same biases, *"In the law, it says while we can talk about the condom in the context of HIV education, we cannot mention family planning!"*

How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are: In/out of school? Married/unmarried? In rural/urban areas? Living with HIV? From marginalised groups (such as sex workers, migrants or orphans)?

What the Philippines has in terms of policies, (the 1998 HIV AIDS Act, a handful of administrative policy pronouncements on adolescent reproductive health) are mere paper; local provinces have yet to organize their local councils (approximately 10 provinces (of 37) have organized theirs with support from UNFPA); ideally the local governments can play a huge role in Programmes.

The existence of local government representation for young persons in the form of the Sangguniang Kabataan (SK) (Youth Council), which is composed of openly elected youth representatives does not by itself, mean anything in terms of actually representing the interests of young people; the SK is so underutilized when in fact it could influence governance within its frame and mandate.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Abolish the penal provision on prostitution (which penalizes women in prostitution), re-orient the hygiene clinics to end the inconsistency in policy.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in the Philippines better or worse?

“While the DOH adopts most of WHO eligibility criteria on medical services, there is a real need for a re-orientation among service providers.”

“Apart from technical assistance, providers need to be trained, and re-oriented on ethics in service-delivery, why even in the medical profession and in medical education, there is a need to raise these issues.”

It doesn't follow that just because service delivery guidelines are neutral or supposedly inclusive, that young women and girls necessarily have equal access to services and information. In fact, discrimination on the Programme level is common simply because government services in health do not recognize “sexual health needs” for girls who aren't supposed to be having sex yet anyway.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

Knows of UNFPA supported initiatives with the Department of Education to develop modules on sexuality education; this is new since the old one was never implemented but hasn't seen actual modules. Cites organization's own experience engaging the schools.

In attempting to work with school administrators to be able to provide young people with access to information and services in reproductive health, came face to face with conservative attitudes around the way our society treats young people, especially when it comes to sexual matters.

“In a forum where young people had the actual opportunity to ask questions, and get answers from qualified professionals and resource persons on sexuality, we discovered that they were actually “fed,” which questions to raise!”

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

“We have to veer away from what has been a tendency to a purely bio-medical approach to HIV/AIDs issues and start recognizing it as the social, cultural, political and economic problem that it is.”

We already have a lot in terms of written policy, the next step is to go beyond written law and implement law; linking up at the local levels, getting local governments involved is a good strategy alongside other partners (NGOs) and the departments of education, health and social welfare.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in the Philippines? For example, to what extent is it possible for them to get: Male and female condoms? Information and treatment for sexually transmitted infections (STIs)? Voluntary counselling and testing? Antiretroviral drugs (for children and adults)?

With regard to HIV/AIDS prevention services and Programmes for girls and young women, *“Don't expect any from government, wala (there is none).”*

The male condom is not available; voluntary counselling and testing is available through NGOs, and in private clinics this is not free; there is only 1 hospital which does confirmatory testing; ARVs for women in prostitution or children in prostitution is virtually impossible.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

Programmes don't appear to be especially focused on any group except that in the past women and prostitution and migrant workers were singled out, but even then it is usually dependent on the policy of the host country (if the host country requires testing, they have to get tested).

"Recently, cases of HIV+ have been monogamous wives and partners of male sea farers. Now when you explore the issues of HIV prevention in those cases, it is not unlikely you will find out that the same core issues and attitudes and beliefs regarding condoms, and condom use will crop up, i.e. its not something a married couple would resort to either because they listen to conservative Catholic views on birth-control, women are menopausal, their husband had a vasectomy or simply that wives don't get to decide on condom use."

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

The Government doesn't target young people. NGOs are taking it up within sexuality and STI discussions and modules.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Connect prevention/education initiatives to tackling of the core issues around sexuality, morality, spirituality; veer away from bio-medical model of discussing sex education.

It is time we acknowledged that even within the Catholic church, there is an ongoing debate about condom use.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in the Philippines? For example, is it: The cost of the services? The location of the services? The lack of privacy at the services? The hours that the services are open? The language that the services use? The attitudes of the staff that run the services? Fear that confidentiality will be breached by the services? The attitudes of parents or friends? Cultural norms, for example that prioritise the health of boys over the health of girls?

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in the Philippines?

It is all policy on paper.

To what extent is the national response to AIDS 'rights-based'? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

There is a big gap in how HIV/AIDS and RH are engaged as issues. The effort to address them together is recent. Apart from turfing, even the integration of gender into HIV or RH is fairly recent. Not all of those who "do RH advocacy" or "HIV AIDS" advocacy do so with a framework on gender but inclusion of "rights" has so far been common among the NGOs.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in: Developing the National AIDS Plan? Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

We are not active in the AIDS council but we know of NGOs who are active and do consult the communities of HIV positives.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

One mechanism used could be the Sangguniang Kabataan (Youth Council).

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in The Philippines?

One-to-one interview: Executive Director (male) of a NGO working on HIV AIDS advocacy and services

General

What is your impression about the general situation of HIV prevention for girls and young women in the Philippines? Are things getting better or worse ... and why?

"Relative to others, particularly our Southeast Asian neighbours, the phenomenon of a low incidence of HIV AIDS tends to be used as an excuse for government agencies not to do anything."

Prevention component 1: Legal provision

In your opinion, what laws in the Philippines are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as: Whether girls can get married at an early age? Whether sex work is legal? Whether girls or young women can have abortions? Whether girls and young women can use sexual and reproductive health services without their parents' consent?

Laws like the illegal status of sex work, parental consent issues raised by service providers.

How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are: In/out of school? Married/unmarried? In rural/urban areas? Living with HIV? From marginalised groups (such as sex workers, migrants or orphans)?

Testing is virtually unheard of, an in-existent, in far flung areas - plus the only place where confirmatory testing is done is San Lazaro hospital in Manila. Apart from availability though is the health seeking behaviour which remains low and problematic. For instance, part of the reason detection is high among Overseas Filipino Workers is because the destination countries require it before arrival or before renewal of a contract of work. "Those who do get tested are tested because it is required of them," (Migrant workers) but even then, they usually get information not at a point of being able to prevent HIV but only after getting infected."

Among women in prostitution, there are social hygiene clinics which can do screening but not all areas have hygiene clinics.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

The DOH should be clear on its policy regarding adolescent reproductive health.

"In one study which advocated a peer approach through the establishment of youth centres at the local government level, it was a disappointment that they only encouraged a system of referral from the youth centre to private or NGO clinics."

Again the issue of government not taking a position of funding local programmes for young people as well as providing access to services was identified as a big challenge. In several instances, apart from encountering provider bias in reproductive health or sexuality information and services for young people, some local government units have actually gone to the extent of banning young people from local health clinics when they seek information and services on matters regarding sex. *"This is because the national government (DOH) policy on adolescent reproductive health is not clear. There is almost nobody (apart from NGOs) who cater to young people."*

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in the Philippines better or worse?

Most initiatives (NGO and GO) have been focused on out-of-school youth. *"Attempts to include sexuality education in Public schools generally fare better than in private schools (majority of which are Catholic schools) but the Department of Education has been slow in working on the issue."*¹⁰

"Even in a context where some information is available, young women and girls may not have the skills to ask for it and even find out where to get them."

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

There are a number of UNFPA and UNICEF supported projects but so far no word yet whether they have been published.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

"Instead of making services available through a network of local AIDS councils, the national body has degenerated into a body that allocates sub-grants instead of facilitating policy direction. In a highly politicized setting such as the current administration with its biases against matters of reproductive health, it is the Secretary (of Health) who decides, it is no longer the council."

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in the Philippines? For example, to what extent is it possible for them to get: Male and female condoms? Information and treatment for sexually transmitted infections (STIs)? Voluntary counselling and testing? Antiretroviral drugs (for children and adults)?

Most services are provided by NGOs. There is counselling and IEC; condoms, which are no longer widely available for free; female condoms are not available, likewise given low acceptance of male condom among Filipino men, this is unlikely to take off. There is testing but even among NGOs there are only a handful of accredited; confirmatory testing is only at San Lazaro Hospital (a DOH run hospital) so results normally take 2 weeks and more if the request is from the provinces.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

Very few programmes focus solely on women although in the past women in prostitution have been singled out and migrants. There have been programmes to integrate HIV AIDS education in the pre departure seminars for migrant workers although not all OFWs are able to get such education/orientation.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

"Young men, or boys generally have more access to information and even services usually by sheer reason of less stigma on their part." From our own experience of maintaining youth volunteers and peer educators, boys stay on longer in the programme.

"Our protective attitudes with girls often serve as a barrier to their participation in matters regarding their sexual health."

Overall, what type of services are most urgently need to be increased to improve HIV prevention for girls and young women?

When dealing with young people, it has always been more effective to take up matters of sex and sexuality using the entry point of "life skills" development. Alongside, peer led education and services,

¹⁰ The Officer in Charge of the Department of Education has recently clashed with the Catholic Bishops Conference over the renewed attempts by the DepEd to again develop sexuality education in the public school curriculum. The current OIC's dissenting view comes in as a first of such a position in many years where past Secretaries have all but succumbed to CBCP pressure and abandoned Programmes (some UNFPA- supported) once controversy erupted with the Bishops.

the models in youth participation put up by FPOP are ideal where young people actually have a say in Programme development and aren't token representatives.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in the Philippines? For example, is it: The cost of the services? The location of the services? The lack of privacy at the services? The hours that the services are open? The language that the services use? The attitudes of the staff that run the services? Fear that confidentiality will be breached by the services? The attitudes of parents or friends? Cultural norms, for example that prioritise the health of boys over the health of girls?

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in the Philippines?

Government monitors, reviews but that is all we hear.

To what extent is the national response to AIDS 'rights-based'? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?
It is mentioned in the law that women with HIV shall not be prevented from bearing children but that is all, the law doesn't really focus on women/girls.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in: Developing the National AIDS Plan? Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

Our organization has been active in the AIDS council since 1998. The Council is no longer acting like the policy making body that it is supposed to be. In terms of representation, there has never been any direct involvement, only through the NGOs.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

Even with the attempts to put in a "rights-based" frame (or even women's reproductive health and rights) into written national policy at the level of the DOH, it just looks good on paper without anything actually being done in terms of action.

The efforts to integrate issues of rights and gender came later even within the HIV AIDS advocacy community. *"There has been a tendency to compartmentalize many of these issues despite the clear links between issues of reproductive health and HIV AIDS. The link is of course, sex and sexuality and our attitudes about these things."*

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in the Philippines?

One-to-one interview: Director (male) of a NGO founded and led by PLWH

General

What is your impression about the general situation of HIV prevention for girls and young women in the Philippines? Are things getting better or worse ... and why?

Given the cultural barriers that exist, things could be improved as far as women/girls are concerned.

Prevention component 1: Legal provision

In your opinion, what laws in The Philippines are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as: Whether girls can get married at an early age? Whether sex work is legal? Whether girls or young women can have abortions? Whether girls and young women can use sexual and reproductive health services without their parents' consent?

We lack laws which support rights and alleviate poverty. This increases people's vulnerability to HIV AIDS.

How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are: In/out of school? Married/unmarried? In rural/urban areas? Living with HIV? From marginalised groups (such as sex workers, migrants or orphans)?

We have more migrant workers who are women, and women's situation in our society in terms of becoming victims of sexual crimes also makes them more vulnerable.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

The AIDS law needs to be applied locally. It is there but not well known even to the politicians. Even the 20 million in funds (allocation) has not translated into programmes. (Note: sources say the annual appropriations for the implementation of the AIDS law has gone down from 13 million to 6 million as of the last budget)

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in the Philippines better or worse?

The cost of treatment is a big issue. In terms of availability, there is only one public hospital equipped to deal with HIV AIDS (San Lazaro). Many cannot handle paying user fees, however minimal, couple that with the health seeking behaviour of Filipinos, very few seek even information.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

"No. This is nonexistent. Many programmes are with out-of-school youth. In one area (Iloilo) where we had such a programme, we were surprised that the local Catholic schools blamed us for the absences in their classes, suspecting youth attended our training but it wasn't true. Our programme was for out-of-school youths. We received attacks from them and they sent out text messages telling people we were turning young people into "sex-robots," and that we were "anti-Catholics."
(interviewee showed me the actual text messages they received going around)

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in The Philippines? For example, to what extent is it possible for them to get: Male and female condoms? Information and treatment for sexually transmitted infections (STIs)? Voluntary counselling and testing? Antiretroviral drugs (for children and adults)?

Female condoms are not available. We have a big problem with condoms in the country. In our experience the whole issue is an ideological one. We should get over this hang-up because even if it is available, men don't use it.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

Services are available in general to everybody. We do not discriminate. However many, many migrant workers are not being reached. Say from a group of 20 departing OFWs, only 10 will get information on HIV/AIDS.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

(Initially interviewee also answered services and information are equally available so I asked him about their experience with peer educators, noting the answer of one earlier interviewee.) We also encounter resistance from the parents, maybe its also because girls are not expected to talk about sex. We have more boys staying as peer educators too than girls.

Overall, what type of services are most urgently need to be increased to improve HIV prevention for girls and young women?

We have to engage both women and men, for instance, as a couple, we cannot just educate the woman or the man, it has to be both.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in The Philippines? For example, is it: The cost of the services? The location of the services? The lack of privacy at the services? The hours that the services are open? The language that the services use? The attitudes of the staff that run the services? Fear that confidentiality will be breached by the services? The attitudes of parents or friends? Cultural norms, for example that prioritise the health of boys over the health of girls?

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in The Philippines?

These international commitments are nothing without local action, we need to localize efforts around these, including UNGASS.

To what extent is the national response to AIDS 'rights-based'? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

(Note: unlike most of the interviewees, this interviewee was insistent that HIV/AIDS be kept separate from RH)

The HIV AIDS community is certainly linked with the RH community but it is different. HIV/AIDS should remain a separate tack unto itself and not be reduced as a mere element (the local draft policies on reproductive health cites HIV/AIDS as one of 10 elements)

Unlike the way RH advocacy has developed, HIV/AIDS is immediately associated with a human face. RH here has been quite elitist and tends to be too technical when taken up by the women's groups.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in: Developing the National AIDS Plan? Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

The GF now is a good development because we are seeing more projects which allows a focus; it also mandates impact assessment which is good and otherwise not found in Programmes before.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

Government should sustain and support Programmes, local politicians need to get educated and donors should continue support our Programmes. Community leaders should be given technical support and we should revisit our methods.

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in The Philippines?

One-to-one interview: Trainer/Organizer (female) of a NGO working on HIV/AIDS with focus on migrant workers and network of HIV positive women

General

What is your impression about the general situation of HIV prevention for girls and young women in the Philippines? Are things getting better or worse ... and why?

Women's access to information and services on HIV and AIDS is still very much affected by the same old issues and conservative norms that relate to sex as far as Philippine society is concerned.

Prevention component 1: Legal provision

In your opinion, what laws in the Philippines are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as: Whether girls can get married at an early age? Whether sex work is legal? Whether girls or young women can have abortions? Whether girls and young women can use sexual and reproductive health services without their parents' consent?

The penal law on vagrancy (prostitution); the lack of a policy and programmes on reproductive health.

How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are: In/out of school? Married/unmarried? In rural/urban areas? Living with HIV? From marginalised groups (such as sex workers, migrants or orphans)?

It isn't the law per se but attitudes around a woman's status. *"Less stigma seems to be carried by the so-called "legitimate victims," or aggrieved wives of seafarers who got their infection via monogamous marital sex."*

When working with women who are HIV positive, the same old assignments of blame and stigma are still more pronounced when women, both young or old, get infected outside of prescribed marital sex.

"There is an "othering" process even among women testing positive for HIV and often it is surprising for us to encounter married women being more accepting of their "fate."

"Many women we encountered rely on their husband to make these decisions and waited for the husband to get tested."

"There was one woman who found out her husband was HIV positive about five days before he died. When she got tested she was HIV positive as well and all those years she never even thought about condoms or HIV tests, how could she? She was a wife and her husband, a Pastor."

"Even in treatment among spouses who test positive, it is notable how men are prioritized for treatment over women, and in turn, women don't find anything significant change in their condition after finding out they have a life-threatening disease. They still do all of the housework."

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Abolish penal law on prostitution (vagrancy law); amend the AIDS law to take away bias against family planning, make it more rights based, pass reproductive health law and policy; ensure there are Programmes and services.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in the Philippines better or worse?

The HIV AIDS movement has predominantly been adopting a “generic” or “neutral” stance as far as Programmes are concerned. *“It has been interesting to note that over 92% of those who tested HIV positive in the country in fact cite heterosexual sex as the primary mode of transmission and yet programmes and approaches have hardly considered the how sexual power relations figure in all these things.”*

In fact in the past, women in prostitution (and gay men) were singled out in our local programmes, not really with the sole agenda of protecting them but because generally they were thought of as the culprits, the carriers. Studies have proven this wrong because it is the customer, usually the men who go back to their spouse or have other sexual relationships where they increase the risk of transmission. Recent data shows many of those testing positive are even monogamous women, infected by their husbands/partners.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

There is no institutionalized sex education Programme by the department of education, at least nothing uniformly implemented across schools. There have been many programmes for out-of-school youth through the years. Content is usually bio-medical, and even then, hardly comprehensive.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in the Philippines? For example, to what extent is it possible for them to get: Male and female condoms? Information and treatment for sexually transmitted infections (STIs)? Voluntary counselling and testing? Antiretroviral drugs (for children and adults)?

There are no services to speak of in terms of programmes focusing on young women/girls. Many programmes by NGOs claim not to discriminate, claim that services are available to all but in the end, given the unequal power relations between women/men; girls/boys, women/girls face greater risks.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

We focus on migrant women workers and have also come to include spouses and partners of male migrant workers because they are at risk. In terms of scale, it is not that huge. Most services and even protocols of counselling/testing are offered by the NGOs. The most well known government services are at San Lazaro hospital which is in Manila.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Boys certainly get more access to information because it is generally more acceptable to be pro-active as far as sex is concerned, when it is the boy looking for it. It is different for girls.

In the context of peer education and involving young people, it is a challenge to go beyond training them to be capable of dishing out information, but they are not capable of addressing “sexual inequality” issues among themselves. *“In some cases, it has happened. Young boys and girls entering relationships when they meet and work together and sometimes in the context of the work they do (sex education), it even becomes an expectation. Maybe she is more liberal, is an assumption certainly even boys will make when a girl speaks frankly about sex.”*

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Time and again, condoms have been the topic of debates (usually with Catholic Bishops against condom use and who equate it with promiscuity). Instead of challenging “male privilege,” and tackling the issue of the male defined concept of “sexual pleasure,” many advocates in the past just did what the Bishops expected of them and that was to defend “liberal positions on sex.”

"While there is nothing wrong with having multiple partners or even casual (non-marital sex) per se in the context of consenting and capable and responsible people, the problem is that we haven't really hit upon the problem of why Filipino men aren't using condoms in the first place¹¹ and why women (even sex workers) are in no position to even negotiate condom-use!"

Women have commonly referred to "sex" as "pag-gamit" (Literally: using; being used by the male partner) and it is so telling of how the sexual power imbalance precludes concepts around women and even girls deciding about their bodies, their sexual pleasure and ultimately, their protection against HIV AIDS.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in the Philippines? For example, is it: The cost of the services? The location of the services? The lack of privacy at the services? The hours that the services are open? The language that the services use? The attitudes of the staff that run the services? Fear that confidentiality will be breached by the services? The attitudes of parents or friends? Cultural norms, for example that prioritise the health of boys over the health of girls?

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in The Philippines?

We know compliance is monitored by government every so often, they submit reports but that is as far as it goes. In the area of AIDS, even the local groups do not generally come with a background on women's rights.

To what extent is the national response to AIDS 'rights-based'? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

There is no service or treatment programme specific for women so apart from whatever written AIDS policy, this is hard to answer. There isn't any programme or policy on reproductive health in the first place. The administration is against it.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in: Developing the National AIDS Plan? Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

I have no idea. I have never seen women represented there even if Sarah Jane got a lot of press back in the late 90s.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

¹¹ Remedios AIDS Foundation (Dr. Sescon) noted that in their phone counselling services alone, condom use always figured below 10% in terms of acceptability and the issue of "male pleasure" was cited as the barrier/attitude against it.

Programmes supportive of groups led by women who are HIV positive (like Babae plus) is a worthy start.

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in The Philippines?

One-to-one interview: Trainer/Organizer (female) of a NGO working on HIV/AIDS focused on migrant workers and HIV positive women

General

What is your impression about the general situation of HIV prevention for girls and young women in the Philippines? Are things getting better or worse ... and why?

HIV prevention among girls and young women is still emerging in the Philippines. Traditionally, prevention strategies in HIV/AIDS in the Philippines were focused on so-called most at risk populations (sex workers, men who have sex with men and injecting drug users). These efforts did not have a conscious perspective of taking on the more specific vulnerabilities faced by young women and girls.

Prevention component 1: Legal provision

In your opinion, what laws in The Philippines are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as: Whether girls can get married at an early age? Whether sex work is legal? Whether girls or young women can have abortions? Whether girls and young women can use sexual and reproductive health services without their parents' consent?

HIV/AIDS prevention as enshrined in RA8504 covers HIV prevention for everyone. But certainly, the fact that young women cannot access RH services without parents' consent hinders the effectiveness of prevention campaigns. This is particularly challenging since majority of women infected with HIV, according to the National Registry, are those ages 15 to 24. But an over-arching issue is the fact that even if there is an HIV/AIDS Law, the public is not aware about it.

How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are: In/out of school? Married/unmarried? In rural/urban areas? Living with HIV? From marginalised groups (such as sex workers, migrants or orphans)?

- In/out of school?

The AIDS Law provides for integrating HIV/AIDS education in the curriculum but because it is not being implemented, young women in school are not given information. Lack of knowledge on HIV/AIDS increases their vulnerability. Also, because sex education is very limited to certain schools and the coverage of topics is mainly on preventing pregnancy, it does not make young women aware of their vulnerability to HIV/AIDS.

- Married/unmarried?

More than legislation, it is the cultural norms that make married women vulnerable to HIV/AIDS. For instance, women are expected to have sex with their husbands; women are unable to negotiate or assert safer sex practices with their husbands - that's what makes them vulnerable. Marital rape, though covered under the rape law is still largely unreported.

- From marginalised groups (such as sex workers, migrants or orphans)?

The AIDS provides specific provision for the orientation of OFWs on HIV/AIDS before leaving the country for overseas work. Ideally, having the PDOS that includes HIV/AIDS education should help prevent HIV transmission among migrants. Unfortunately, the PDOS is not very effective because it is conducted too late in the migrant's application process and it is lumped together with all other topics in the PDOS. HIV/AIDS only take up around 45 minutes of the one-day orientation. Even migrants say that they don't listen during the PDOS.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

A comprehensive law on reproductive health should be enacted that could more power on women in general to decide over RH matters that affect them. This law should include the specific needs of young women and girls. Laws that criminalize women in prostitution (Article 202) should be abolished

because prevention interventions among women in prostitution are much more difficult when having condoms is used against them as proof that they are prostitutes.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in the Philippines better or worse?

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

According to anecdotal accounts, there is sex education in some schools. Content includes physiological changes in the body during puberty, anatomy, body functions related to the reproductive organ, menstruation, ovulation in young girls, natural family planning methods; some introduce condoms and other contraceptives. But this does not seem to be official in the sense that it is a DepEd-approved curriculum.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Integrate RH, responsible sexuality and HIV/AIDS in the curriculum of elementary, high school and even collegiate levels.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in the Philippines? For example, to what extent is it possible for them to get: Male and female condoms? Information and treatment for sexually transmitted infections (STIs)? Voluntary counselling and testing? Antiretroviral drugs (for children and adults)?

- Male and female condoms?

Female condoms are not readily available in the country. Male condoms are available commercially. However, I have not seen a study yet that looks into whether young women access these commodities commercially. According to accounts of organized youth (heard in conferences) they are not able to access these commodities from public healthcare establishments.

- Information and treatment for sexually transmitted infections (STIs)?

Access to these services is generally very limited for women and worse among young women and girls. Unless they belong to specific groups (sex workers or migrants who go through PDOS at the Women in Development Foundation), they might not easily come across these information.

- Voluntary counselling and testing?

The issue here is whether people, especially young women, know that voluntary counselling and testing is available. Chances are, they are not aware. On the other hand, this is voluntary so the choice of utilizing this service lies in the person. Generally, Filipinos do not voluntarily submit themselves even to routine medical check ups. The stigma on HIV/AIDS is added reason why people, much less young women, will not seek testing.

- Antiretroviral drugs (for infants, children and adults)?

Affordable antiretroviral drugs are very limited in the Philippines. The limited supply of generic ARVs is sourced through NGOs or the DOH (in the case of the ARVs procured under the Global Fund for AIDS, TB and Malaria project. There is a clinical criteria for those who should take ARV. Unfortunately the bigger barrier to access is the cost even with generics being much cheaper. I am not very knowledgeable on the availability of ARVs for children. But according to members of the Pinoy Plus Association, ARVs for children are even more inaccessible in the Philippines. Note: Ask UNICEF about their project of procuring ARVs for children here.

- Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive mother to her children?

Sorry, not very knowledgeable here.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

- Unmarried?

This category would fall under the general population unless they fit other categories like OSYs, sex workers, migrants, etc.

- Out of school?

There are NGOs that work with out-of-school youth on adolescent RH. This is not focused on just the young women. Some services include awareness-raising, organizing, life skills development, developing theatre groups for advocacy.

- Involved in sex work?

There are NGOs that raise the awareness of women in sex work on their vulnerabilities, on HIV/AIDS and RH issues. There are NGOs that have RH clinics that provide RH services for women, young and adults; and centres where counselling is available and RH commodities are also being distributed either free of charge or at discounted prices.

- Injecting drug users?

This group is still the most difficult to reach by prevention efforts and harm-reduction strategies mainly because they are criminalized.

- Migrants?

Government conducts the PDOS which includes basic HIV education. There are NGOs and CBOs/Pos that conduct community-based education on HIV/AIDS and migration issues for migrants and their families.

- HIV positive?

The association of positives and some NGOs provide a range of services for PLWHAs on issues of RH of positives and counselling to promote better lifestyles.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

The information available to the general public is just the basic HIV/AIDS information, what it is, how it's transmitted. This is also just the information given to the most at-risk populations. Achieve includes gender and sexuality in its education sessions but we only reach migrants.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

This refers to 'positive prevention' – meaning HIV prevention among people living with HIV to both prevent them becoming re-infected and to prevent them transmitting the virus to others. Examples of ways to encourage positive prevention include: health promotion among individuals living with HIV; scaling up general AIDS and sexual and reproductive health services; and carrying out relevant advocacy and policy work).

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in the Philippines? For example, is it: The cost of the services? The location of the services? The lack of privacy at the services? The hours that the services are open? The language that the services use? The attitudes of the staff that run the services? Fear that confidentiality will be breached by the services? The attitudes of parents or friends? Cultural norms, for example that prioritise the health of boys over the health of girls?

I am not very sure about this. I would however agree that cultural norms pose a barrier, particularly to accessing HIV services primarily because of the stigma. Nobody wants to be associated with HIV so most of the general public will not actively seek information or services related to it. Another barrier is even more basic: Young women are not aware of their vulnerability and so they do not have the interest to access prevention services. Or they may not know that there are services available.

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

- Married or unmarried?

Harder for unmarried if they go to government health centres.

- In school or out of school?

Harder for out-of-school unless they belong to communities where NGOs are conducting interventions.

- HIV positive?

Services on prevention are available among NGOs and their doctors. Compliance is the problem.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

First, their awareness needs to be raised on gender and sexuality issues. The problem is cultural and so there needs to be a reshaping of their notion of being a boy or a young man. Their attitudes about their sexuality need to be changed and be oriented to be more respecting of girls and women's rights.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in the Philippines?

To what extent is the national response to AIDS 'rights-based'? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

The AIDS Law protects the rights of all people living with HIV/AIDS. It does have some specific provisions for women - like the right to bear children should not be taken away from a woman living with HIV - although support needs to be provided to the woman to prevent transmission to the child.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in: Developing the National AIDS Plan? Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

Although there is representation among people living with HIV and although there are women's and children's organizations sitting in the PNAC, it does not necessarily mean that young women's voices are heard in the development of policies. As to the actual processes involved or conducted by these organizations to solicit the opinions of young women, I'm not very familiar.

Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria? The creation of the CCM for the Global fund was not participatory from the beginning.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

Support the newly organized support group of women living with HIV/AIDS. RH organizations and women's organizations should become more conscious and pro-active in integrating HIV/AIDS in their issues because women, especially younger women are definitely more vulnerable to HIV infection than their male counterparts.

One-to-one interview: Officer of a United Nations agency

General

What is your impression about the general situation of HIV prevention for girls and young women in the Philippines? Are things getting better or worse ... and why?

While there have always been HIV/AIDS prevention programs, on the whole, they have been "general" programmes and none have focused specifically on girls or even women, except specific groups of women (i.e. prostitution and migrant workers).

Prevention component 1: Legal provision

In your opinion, what laws in the Philippines are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as: Whether girls can get married at an early age? Whether sex work is legal? Whether girls or young women can have abortions? Whether girls and young women can use sexual and reproductive health services without their parents' consent?

The lack of a law ensuring RH services is aggravating the dearth of HIV/AIDS prevention programmes.

How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are: In/out of school? Married/unmarried? In rural/urban areas? Living with HIV? From marginalised groups (such as sex workers, migrants or orphans)?

(Note: The UNFPA supported SEX EDUCATION programme being led/developed by the Department of Education has recently come under fire from the Catholic Bishops' Conference (CBCP); news reports say that the Dep. ED has again acceded to the Catholic Bishops' demands.)

The program on SEX ED would have included HIV/AIDS for all curricula in high school. Right now, the CBCP is demanding that they be allowed to "input" into the modules as well as demanding schools to leave such instruction to the parents. The problem is that parents aren't always equipped or in a position to educate children. Many also probably never had sex education in school.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Overall, we do already have a lot of laws in place which can help women fare better but we really lack full implementation of many policies.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in the Philippines better or worse?

The UNFPA in the Philippines supports projects that do have collaborations with government agencies, but for the most part are led and implemented by the NGO partners who have more experience in terms of community-based strategies and community mobilization. Many of the strategies we support are preventive in nature.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

(Note: The UNFPA supported SEX EDUCATION programme being led /developed by the Department of Education has recently come under fire from the Catholic Bishops' Conference (CBCP); news reports say that the Dep. ED has again acceded to the Catholic Bishops' demands.)

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to leave such instruction to the parents. The problem is, parents aren't always equipped or in a position to educate children. Many also probably never had sex education in school.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Collaborative approaches where we can proceed from highlighting our common ground can probably lead to more success. Confrontational strategies tend to make such approaches impossible. For instance, recently, even the Catholic organization, Caritas acknowledged that there is ongoing debate within the church regarding their position on condom use in cases of HIV/AIDS. This has led to an ongoing dialogue between Catholic organizations and UNAIDS as well as the AIDS council in the Philippines. Even as these groups have huge differences in their approaches and positions on condom use, Caritas gives palliative care to HIV positives.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in the Philippines? For example, to what extent is it possible for them to get: Male and female condoms? Information and treatment for sexually transmitted infections (STIs)? Voluntary counselling and testing? Antiretroviral drugs (for children and adults)?

So far the ARVs in proper dosage for infants and children is unavailable. Practitioners make do with lessening the dosages. Available ARVs which are subsidized are available now through DOH hospitals all over the Philippines. (Cebu, Davao, Northern Luzon)

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

Most programmes in the past concentrated on specific groups of women like those in prostitution and migrant workers. For migrant workers, a big concentration of the programmes we supported to integrate HIV/AIDS education in the pre-departure seminars are in northern Luzon, notably because of the huge number of migrant workers originating from northern Luzon (Cordilleras).

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Information and services are usually accessible through ARH programmes, generally available to both boys and girls. (Note: NGO programs)

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

More attention needs to be given to the barriers as far as women and young girls are concerned. Even the mothers of children we encountered, testing HIV positive are often unable to even take their children in for testing. We encountered cases of this where parents who tested positive are not even preparing their children to undergo testing or even making the disclosure! The children are growing up and some of the already in their teens!

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in the Philippines? For example, is it: The cost of the services? The location of the services? The lack of privacy at the services? The hours that the services are open? The language that the services use? The attitudes of the staff that run the services? Fear that confidentiality will be breached by the services? The attitudes of parents or friends? Cultural norms, for example that prioritise the health of boys over the health of girls?

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in the Philippines?

The UN documents and instruments have been very useful in a sense that they give us the opportunity to articulate government mandates, country programs etc. But again, there is a big difference between laying down policy and implementation.

To what extent is the national response to AIDS 'rights-based'? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

Everything we support needs to be within the rights-based framework. We also specifically include gender as a running thematic concern so that partners need to integrate gender analysis in their programs/projects; i.e. data has to always be de-segregated.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in: Developing the National AIDS Plan? Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

There are two organizations which represent the HIV positives, Positive Action Foundation (PAFI) and Pinoy Plus. Both participate directly in the AIDS council. The BABAE plus (Women plus) network is a new/recent development from ACHIEVE.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

UNFPA is currently studying the possibility of youth advisory panels that will somehow include direct participation of young people in program creation/design on a host of issues, not the least of which includes HIV/AIDS. The youth groups which participated in a recently held national conference on RH (in May) even mentioned this in their manifesto. They acknowledged and realized that HIV/AIDS affects them and is an issue which involves them.