Country Analysis of AIDS in the Philippines:

Gender and Age Situation and Response

National Economic and Development Authority (NEDA)

With support from
Joint UN Programme on HIV/AIDS (UNAIDS)
United Nations Children's Fund (UNICEF)
United Nations Development Programme (UNDP)

COUNTRY ANALYSIS OF AIDS IN THE PHILIPPINES: GENDER AND AGE SITUATION AND RESPONSE

This report was commissioned by the National Economic and Development Authority (NEDA) to EnGendeRights, supported by the UNAIDS Program Acceleration Fund, executed by UNICEF.

National Economic Development Authority (NEDA)
12 Saint Josemaria Escriva Drive, Ortigas Center, Pasig City 1605 Philippines

United Nations Children's Fund
31st Floor Yuchengco Tower, RCBC Plaza
6819 Ayala Avenue, 1200 Makati City, Philippines

Writers: Gertrudes Libang, Gladys Malayang, Clara Rita Padilla

Designed by: Beetlebugs Communications, Inc.

CONTENTS

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMTP	AIDS Medium-Term Plan
AO	Administrative Order
ARH	adolescent reproductive health
ARV/s	antiretroviral drugs
ART	antiretroviral treatment
BCC	behaviour change communication
CEDAW	Committee on Elimination of Discrimination against Women
CHED	Commission on Higher Education
CHO	City Health Office
CICC	Cebu International Convention Center
CWC	Council for the Welfare of Children
DepEd	Department of Education
DOH	Department of Health
EC	emergency contraception
FGD	focus group discussion
GIPA	Greater Involvement of Persons with AIDS
HACT	HIV/AIDS Core Team
HIV	human immunodeficiency virus
IDU	injecting drug user
IEC	information, education, communication
IHBSS	Integrated HIV Behavioural and Serologic Surveillance
KII	key informant interview
LGBTs	lesbians, gays, bisexuals, transgenders
MARP/MARG	most-at-risk population/group
MARYP	most-at-risk young people
MDG	Millennium Development Goal
MIPA	Meaning Involvement of Persons with AIDS
MSM	men who have sex with men
MTCT	mother-to-child transmission
NASPCP	National AIDS and STD Prevention and Control Programme

NCR	National Capital Region
NEC	National Epidemiology Center
NGO	non-governmental organisation
OFW	overseas Filipino worker
OSY	out-of-school youth
PDOS	Pre-Departure Orientation Seminar
PEP	post-exposure prophylaxis
PGH	Philippine General Hospital
PIP	person in prostitution
PLHIV	person living with HIV
PMTCT	prevention of mother-to-child transmission
PNAC	Philippine National AIDS Council
PNP	Philippine National Police
PWID	person who injects drugs
RAF	Remedios AIDS Foundation
RA	Republic Act
RHWC	Reproductive Health and Wellness Center
RTI	reproductive tract infection
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TESDA	Technical Education and Skills Development Authority
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VAW/VAWC	violence against women/violence against women and children
VCT	voluntary counselling and testing
VSMMC	Vicente Sotto Sr. Memorial Medical Center
WCPC	Women and Children Protection Center
WIP	woman in prostitution

I. INTRODUCTION/BACKGROUND

Addressing gender and age concerns is needed in relation to the Philippines' response to the human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). This paper reviews the country's gender- and age-responsiveness to HIV, takes stock of good practices, and identifies avenues for improvement to aid stakeholders and policymakers in finding ways to address the HIV and AIDS situation in the Philippines. At the end of the paper, strategies and measures are proposed to address the gender and age responses related to HIV and AIDS.

Gender- and age-responsiveness is essential to an effective AIDS response. The inequalities and inequities based on gender and age must be addressed in the implementation of programmes and actions that prevent the spread of HIV and in giving appropriate counselling, care, support and treatment.

GENDER, AGE AND HIV

In reviewing the gender responses to HIV, one needs to examine how discriminatory laws, policies and practices, including discrimination based on one's gender/sexual orientation/gender identity, gender relations and sexual abuse have an impact on vulnerability to HIV and access to information and services regarding prevention, care, treatment and support.

Gender and age concerns affect the social, economic, cultural, legal, and other aspects of a person's life including even civil status, personal well-being, state of health, education and job opportunities. In turn, such impact of gender and age concerns can be related to one's risky sexual behaviour, risks of contracting sexually transmitted infections (STIs) or reproductive tract infections (RTIs), vulnerability to HIV transmission, access to information and services related to STI and HIV prevention, access to voluntary counselling and testing (VCT), access to antiretroviral treatment (ART), negotiating safe sex, practising contraceptive methods, unwanted pregnancies, prevention of mother-to-child transmission (PMTCT), and vulnerability to violence and abuse. Gender and age issues and concerns affect differently the populations of girls and women, boys and men, men who have sex with men (MSMs),[1] transgenders, bisexuals and lesbians. Thus, responses to HIV should consider the different vulnerabilities based on gender and age.

II. ASSESSMENT OBJECTIVES AND METHODOLOGY

A. ASSESSMENT OBJECTIVES

- To conduct a country analysis on the gender- and age-responsiveness of policies, guidelines and key documents
- To develop gender- and age-sensitive AIDS monitoring and evaluation indicators, and
- To prepare a report on the Country Analysis of AIDS in the Philippines – Gender and Age Situation and Response, including policy and programmatic recommendations.

B. METHODS USED IN THE ASSESSMENT

The assessment was done using secondary data analysis, focus group discussions (FGDs), key informant interviews (KIIs) and workshops. The secondary data analysis looked at existing data, policies and programme intervention reports in terms of gender- and age- sensitive provisions. A listing and analysis of the data available were part of this assessment process. Following are some data sources:

- 2007 Millennium Development Goals Philippine Progress Report
- 2008 AIDS Medium-Term Plan IV Mid-Term Assessment Report

- 2008 United Nations General Assembly Special Session Report
- 2008 Spousal Transmission of HIV in the Philippines
- 2008 Country Gender Assessment
- 2009 Universal Access Country Report
- 2010 UNGASS Report
- 2010 AIDS Summit Proceedings
- 2010 Study on Call Centres and HIV
- AMTP IV Operational Plan for 2009-2010
- Department of Health Administrative Order 2009-0016: Policies and Guidelines on the Prevention of Mother-to-Child Transmission of Human Immunodeficiency Virus
- DOH-AO 2009-0006: Guidelines on Antiretroviral Therapy among Adults and Adolescents with Human Immunodeficiency Virus
- Guidelines in the Conduct of HIV Counselling and Testing at All Levels of Health Care.

FGDs were done amongst those involved in implementing the HIV and AIDS programme intervention, and the recipients of the intervention. FGDs were conducted in three identified areas in the country – National Capital Region (NCR), Metro Cebu and Metro Davao. The FGDs used standard questionnaires for each of the following groups: non-governmental organisations (NGOs) implementing HIV and/or AIDS projects, local AIDS councils, health service providers and most-at-risk populations (MARPs, referring to persons in prostitution (PIPs) and their clients, MSMs, transgenders and persons who inject drugs (PWIDs)). FGDs amongst persons living with HIV (PLHIVs) were also done. The FGDs focused on both gender- and age-sensitive issues arising from the implementation of HIV and AIDS programmes and access to HIV services. Modified participatory FGD processes were done to capture the nuances of gender- and age-related issues in HIV and AIDS. Most-at-risk young people[2] (MARYPs, who are 15-18 years old and who include PIPs, MSMs and PWIDs) were included in the FGDs to ensure the active participation of this age group. Separate follow-up discussions were also done to encourage sharing of additional information. Information on experiences amongst persons younger than 15 years was gathered through retrospective questions.

KIIs were held with the heads of government organisations and offices and other policymakers. These offices include the Philippine National AIDS Council (PNAC), National AIDS and STD Prevention and Control Program (NASPCP), National Epidemiology Center (NEC) and the Joint UN Programme on HIV/AIDS (UNAIDS). Specific areas of in-depth interviews revolved around programme implementation and the extent to which gender- and age-specific issues are included. KIIs were also done with representatives from the PLHIV and PWID populations to extract stories and experiences that provide insights into the behavioural influences of HIV and AIDS.

This assessment reviewed HIV and AIDS programmes, and how they have or have not addressed gender and the empowerment of individuals (i.e., women, girls, men, boys, MSMs, transgenders, bisexuals and lesbians). It also looked at existing age-responsive interventions in light of the increasing number of HIV cases found amongst young people. The assessment examined the following areas in terms of gender and age issues in relation to HIV.

- Risk factors to HIV transmission and increasing the prevention of HIV transmission by addressing gender [3] and age concerns, including promoting the effective and consistent use of female and male condoms, making condoms and lubricants widely accessible, and reasons why individuals engage in risky sexual behaviour

- Effects of HIV infection and AIDS on women, men, MSMs, bisexuals, transgenders and lesbians including children and young people

- Different biological, economic and social vulnerabilities to HIV/AIDS of the populations of girls, women, boys, men, MSMs, transgenders, bisexuals and lesbians

- Knowledge of HIV transmission, prevention, testing, counselling and care amongst the populations of girls, women, boys, men, MSMs, transgenders, bisexuals and lesbians

- Sexual and reproductive rights of women, men, children, young people and lesbians, gays, bisexuals and transgenders (LGBTs) including the right to education relating to sex/sexuality/ sexual orientation and the right to reproductive health information/services and reproductive self-determination

- Extent of trainings and programmes related to gender and age (ex. equality and non-discrimination of women/men/children/young people/LGBTs, rights-based approach to women's/men's/children's/young people's/LGBTs' rights, gender relations, subordination and marginalisation of women, discrimination against women/children/young people/LGBTs, empowerment of women/children/young people/LGBTs)

- Extent of programmes tackling HIV, gender and age issues for the following groups: PIP clients; bisexual men and women and MSMs including those who identify themselves as heterosexuals; partners of MARPs, MARYPs and PLHIVs including children and young people

- Access of women/men/children/young people/LGBTs to (1) rights-based approach training on sexual and reproductive health and rights (SRHR), sexual orientation and gender identity, and (2) SRHR services

- Knowledge and positive behavioural change of women, men, children, young people and LGBTs on (1) SRHR, (2) risky sexual behaviour, (3) the impact of risky sexual behaviour and early sex (ex. early pregnancy, early marriage, STIs/RTIs/HIV, delaying sexual debut), (4) the relation of STIs with HIV, (5) the risks of early pregnancy (ex. risky pregnancies and risky childbirth), and (6) managing their fertility

- Empowerment of women, men, children, young people and LGBTs to say no to sex under circumstances they do not consent to and to negotiate for safe sex

- Knowledge of and access to VCT, ART, PMTCT, post-exposure prophylaxis (PEP) and emergency contraception by addressing gender and age concerns including gender- and children/youth-friendly health services

- Gender relations including disclosure to partners, condom use, intimate partner violence and multiple burdens, and their impact on treatment-seeking behaviour

- Root causes of gender and age discrimination, and eliminating this type of discrimination

- Push factors that cause MARPs, MARYPs and vulnerable groups to become vulnerable to discrimination, abuse and HIV infection;

- Discrimination based on gender and age in relation to HIV and AIDS [4]

- Access to skills/education training for PIPs, including children and young people, to enable them to find alternative sources of income

- Access to outreach programmes that target PIP clients and tackle HIV, gender and age issues

- Issues related to gender-based violence and HIV including (1) access to information and services on emergency contraception (EC), PEP, safe and legal abortion; (2) extent of programmes/ training on intimate partner abuse and sexual abuse; (3) level of knowledge of women, men, children, young people and LGBTs on intimate partner abuse and sexual abuse, and legal recourses for gender-based violence; (4) level of empowerment of women, men, children, young people and LGBTs to break free from their abusive partners

- Extent of programmes/training on abuses/discrimination against LGBTs including children and young LGBTs

- Level of knowledge of women, men, children, young people and LGBTs on rights against discrimination based on PLHIV status; level of knowledge on discriminatory acts that are actionable under Republic Act (RA) 8504, the Philippine AIDS Prevention and Control Act of 1998; extent of training for women/men/children/young people/LGBTs on punishable acts under RA 8504; extent of support services for complaints against the violation of RA 8504 for women/men/children/young people/LGBTs

- Laws and policies related to HIV (including review of RA 8504 and AOs on VCT, ART and PMTCT) and the gender and age issues and concerns of women, men, LGBTs, children and young people (how the policies and programmes either equally benefit or discriminate against them); review of related laws and advocacy towards the improvement of laws and policies on gender, age and HIV

- Access to information and services on safe abortion and post-abortion care

- Use of international human rights standards on gender, age and HIV.

III. LIMITATIONS OF THE ASSESSMENT

A. LIMITATIONS OF THE ASSESSMENT INSTRUMENTS

The assessment instruments used included standard questionnaires for the FGDs and KIIs. A review of the secondary data in the National Response to HIV and AIDS was also done. The collection of available secondary data on gender- and age-responsive interventions was done as extensively as possible within the limited time available. Although a good number of resources were found, the possibility that not all the vital data and information that could contribute to the assessment is recognised. The standard questionnaires were developed with as many inputs from various affected sectors as possible. However, not all circumstances and experiences could be captured by the questions or subsequent follow-up questions.

B. LIMITATIONS OF THE POPULATION SAMPLED

The limitations of the assessment are intrinsic within the methods used to conduct the assessment. FGDs cannot capture the total behavioural and experiential aspects of each group subject. Although the selection of participants to the FGDs was presumed to represent the MARPs, infected and affected persons, policymakers, and implementers, outlier experiences and even common experiences may not be captured.

The FGDs and consultations were dependent on who participated. The responses were limited to the opinions of the participants and sometimes referred only to their knowledge and experiences.

C. TIME LIMITATION

The inherent limitation of the research is the time constraint in conducting the FGDs, consultations and KIIs. Any lack of secondary data can be discussed as future ground for research and analysis. The FGDs provide snapshots of experiences from which an assessment of gender- and age-related interventions can be derived.

IV. DEFINITION OF TERMS

A. GENDER-SENSITIVE AND GENDER-RESPONSIVE

Gender-responsive objectives have been defined as "programme and project objectives that are non-discriminatory, equally benefit women and men, and aim at correcting gender imbalances". [5]

A programme is said to be gender-sensitive if "gender norms, roles and inequalities have been considered, and awareness of these issues have been raised although appropriate actions may not necessarily have been taken. For example, in a gender-sensitive [PMTCT] programme, there is explicit acknowledgement that women may not have the status, rights and decision-making power to practice safer sex and adopt safer infant-feeding practices". [6]

Being gender-responsive includes implementing a comprehensive rights-based approach to universal access to HIV prevention, treatment, care and support for women and other MARPs. With women in prostitution (WIPs), for example, this includes addressing the economic, social and gender-based reasons for entry into prostitution, extending health and social services to WIPs, and giving opportunities to find alternatives to prostitution for those who choose to do so. [7] Efforts to support female overseas Filipino workers (OFWs) and spouses of OFWS must be strengthened, especially those OFWs that may be highly vulnerable (such as domestic or entertainment workers). OFWs should receive detailed information about HIV before they travel and, if required to do so, understand what an HIV test involves and what its consequences might be. [8]

A programme becomes gender-responsive if gender norms, roles and inequalities have not only been considered, but measures have been taken to actively address them. [9] Such programmes go beyond raising sensitivity and awareness, and actually respond to gender inequalities. For example, a gender-responsive PMTCT programme is one where women's lack of decision-making is addressed by reaching out to men and the male partners of women, with the women's permission, to promote joint decision-making regarding safer sex and infant feeding.[10] Or the programme can be gender-transformative with the aim to "re-define women and men's gender roles and relations by transforming unequal gender relations to promote shared power, control of resources, decision-making, and support for women's [/girls'/boys'/men's/MSMs'/bisexuals'/transgenders'/lesbians'] empowerment". [11]

Under the Harmonized Gender and Development Guidelines, gender-sensitive means the programme has passed the gender and development test, [12] whilst gender-responsive means it is being commended. [13]

For purposes of this assessment report, the term gender covers risks and vulnerabilities of both sexes as related to sexual orientation and gender identity, thereby covering concerns related to girls and women; boys and men; and MSM, transgender, bisexual and lesbian populations, including those who are out, closeted, undecided or curious.

With gender-responsive programmes, access to information and services related to HIV and AIDS will increase, and beneficiaries will be empowered to seek and demand access to information and services related to HIV and AIDS, to break free from abusive relationships and situations that make them vulnerable to abuses and discrimination.

B. AGE-RESPONSIVE

Age-responsive objectives refer to policies, strategies or programme objectives that are non-discriminatory to age and that equally benefit children and adults. Age-responsive programmes also refer to increased access to information and education, including peer and youth-specific HIV education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.[14]

Ensuring young people's [15] access to services includes having clear, national guidance and active facilitation of their access to health facilities that cannot opt out of providing contraceptives, where parental consent is not a prerequisite for using services and health workers receive appropriate training to put youth-friendly, non-judgemental and non-stigmatizing services into practice.[16] Age-responsiveness includes ensuring children's rights to participate in decisions affecting their lives.

Models of HIV prevention must be promoted, going beyond abstinence-only; expanding young peoples' access to a wider range of information and commodities, including male and female condoms; targeting girls/young women, boys/young men, young MSMs, transgenders and bisexuals; focusing on gender relations, including promoting positive models of sexuality; and building understanding of one's sexual and reproductive health, and one's role in supporting HIV prevention. [17]

V. FINDINGS: SECONDARY DATA/REVIEW OF LITERATURE RESULTS

A. BACKGROUND

The status of HIV and AIDS in the Philippines is considered a "latent epidemic",[18] "low prevalence and concentrated epidemic", [19] or in the words of Dr. Austere Panadero, Undersecretary of the Department of Interior and Local Government and Co-Chairman of the PNAC, "low prevalence with accelerated spread amongst men having sex with men and people who inject drugs". [20]

Although the HIV and AIDS prevalence in the Philippines is low, affecting less than 1 per cent of the population,[21] the HIV incidence is growing steadily. As early as 2007, local experts have acknowledged the possibility that from the "low and slow" description from the 1990s until 2004, the HIV status in the country has become "hidden and growing", given the PNAC reports that HIV infection has been picking up pace since 2000. [22] Just last April 2011, former Health Secretary Dr. Esperanza Cabral characterised it as "expanding and growing".[23]

According to the National AIDS Registry data (passive surveillance), the number of reported HIV-positive cases have surged yearly since 2007 – 54 per cent increase in 2008 over 2007 and 58 per cent increase from 2008 to 2009.[24] At the start of 2010, four new cases were being reported every day compared with two new cases reported daily in 2009.[25] According to NEC projections, by December 2010, an additional 1,500 Filipinos would be newly infected by HIV. By 2011, the newly infected would number 4,000-7,000. [26]

Of the total 4,424 reported HIV cases, 90 per cent were infected through sexual contact, 1 per cent (49) through mother-to-child transmission (MTCT) and 0.18 per cent (8) through needle sharing amongst PWIDs.[27] The PNAC UNGASS 2010 Country Report cites sexual transmission as the most common mode of HIV transmission (96 per cent of reported infections in 2009). Of these sexual transmissions, 41.73 per cent were through homosexual contact, 31.34 per cent through bisexual contact and 26.87 per cent through heterosexual contact.[28]

From 1984 to 1990, there were more HIV-infected women than men. But from 1984 to March 2010, 74 per cent of HIV cases were men, with a ratio of 3.5 infected men for every woman.[29]

The 2009 Integrated HIV Behavioural and Serologic Surveillance (IHBSS) [30] showed a rise in HIV prevalence amongst MARPs from 0.08 per cent in 2007 to 0.47 per cent in 2009 (70 individuals amongst 14,976 MARPs).[31] The breakdown of incidence is as follows: MSM at 0.30 per cent (45 individuals), WIPs at 0.15 per cent (23 individuals, with 0.39 per cent incidence amongst all freelance WIPs compared with 0.13 per cent incidence amongst all registered WIPs) and PWIDs at 0.01 per cent (two individuals).[32] In 2009, the MSMs [33] and PWIDs showed a dramatic rise in prevalence which could be explained by the previous IHBSS report showing low prevention coverage, low knowledge amongst MARPs and low condom use specifically amongst MSMs [34] and PWIDs.[35] The 2009 IHBSS showed some improvement in the reach of prevention programmes amongst MARPs especially WIPs. However, increase in knowledge of HIV did not result in a jump in condom use amongst WIPs and MSMs [36] from the previous report. [37]

A steady number of OFWs also contract HIV outside the country and then infect their spouses or partners when they return home. In 2009, 164 returning OFWs were HIV-infected. [38] An alarming 35 per cent of OFWs with HIV are seafarers; a corresponding increase was seen in the number of seafarers' wives infected with HIV. [39]

As early as 2007, more and more young people were being infected with HIV. [40] The number of HIV-infected women and men aged 15-24 rose from 110 (males=102, females=8) in 2008 to 218 in 2009 (males=201, females=17). [41]

The UNGASS 2010 Report shows a mere 5 per cent of HIV-positive pregnant women (six out of 130 in the last 12 months) received antiretroviral medicines to reduce the risk of MTCT. [42]

Results of the Young Adult Fertility Surveys of 1994 and 2002 give warning that more and more youths could become infected.

1. More than twice as many adolescents were misinformed about AIDS in 2002 than in the previous decade. In 1994, 12 to 13 per cent of adolescents thought AIDS was curable. This figure more than doubled to 26 per cent for females and 30 per cent for males by 2002. The proportion of young men who thought they had no chance of contracting AIDS also rose from 67 per cent in 1994 to 72 per cent in 2002.

2. The likelihood of Filipino adolescents to engage in risky sexual behaviour is increasing. The proportion of young men who had premarital sex increased from 26 percent in 1994 to 31 percent in 2002; for young women, the corresponding increase was from 10 to 16 per cent. Young men who were likely to be less knowledgeable about HIV and AIDS were also twice more likely than young women to participate in risky sexual behaviour. About 31 per cent of young men were engaged in early sex in 2002 compared with 16 per cent of young women. Moreover, about half of the young men and one in ten young women who had early sex also reported having multiple sexual partners. Young men were also more likely to pay for sex

and be paid for sex. The increasing likelihood towards high-risk sexual behaviour is likewise suggested in the greater proportion of young people experiencing serious reproductive health problems (ex. painful urination and abnormal genital discharge) from 19 per cent in 1994 to 23 per cent in 2003 for young women and from 23 per cent to 26 per cent for young men.[43]

B. AIDS MEDIUM-TERM PLAN IV

The goal of the AMTP IV is to prevent the further spread of HIV infection and reduce the impact of AIDS on individuals, families and communities.[44] AMTP is the blueprint for action on the country's response to HIV, AIDS and other STIs. AMTP IV covers the six-year period of 2005 to 2010.

In the 2008 Mid-Term Assessment Report of PNAC, AMTP IV is said to have "managed to maintain the low prevalence of the epidemic".[45] However, the responses under AMTP IV must be assessed amidst the hike in the number of new cases and the results of the 2008 Mid-Term Report, which showed only 19 per cent coverage of HIV intervention for MARPs.[46]

At the same time, AMTP IV points to the need "to focus on enhancing and improving the quality of programmes on the ground, enhancing the speed of direction and policymaking, as well as institutional strengthening, both local and national, in order to make the necessary impact".[47]

C. YOUTH DIMENSION OF THE HIV AND AIDS RESPONSE

At the policy level, the Philippine response to HIV infection has a youth dimension with provisions that are supposed to be sensitive and responsive to the needs of the youth vis-à-vis HIV infection.

AIDS education for youth was legislated in Section 4 of RA 8504 which deputises the Department of Education, Culture and Sports (now the Department of Education or DepEd), the Commission on Higher Education (CHED) and the Technical Education and Skills Development Authority (TESDA) to use official information provided by the DOH and integrate these "in the 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".[48]

Even before RA 8504 was passed, policy statements had already been made on the integration of AIDS education in existing school curricula. The first of these was AO 7-C series of 1995, followed by Memorandum Order No. 495 s 1996 or Integrating HIV and AIDS education in all schools nationwide by the Department of Education, Culture and Sports.[49] In 1992, Executive Order No. 39 created the PNAC as a national policy and advisory body in the prevention and control of HIV infection and AIDS in the Philippines, specifically tasking the HIV and AIDS education in elementary and secondary schools to the DepEd, HIV and AIDS education in tertiary schools to CHED, and HIV and AIDS education in trade and technical schools to TESDA, covering both public and private students.[50] In 2000, CHED Memorandum Order 16 was passed for the Integration of HIV and AIDS Education in the Tertiary Education Curriculum. This specified that HIV/AIDS education be integrated in the following subjects: Natural/Biological Sciences, General Psychology, and General Sociology, effective School Year 2000-2001. PNAC developed a Faculty Handbook on HIV/AIDS Prevention Education which was to be used by tertiary-level educators as per CHED Memorandum Order 37 s 2001.[51]

Also mentioned in Memorandum Order 37 s 2001 is the availability of the Resource Book on AIDS Prevention Education for Tertiary Education Institutions, developed and adopted in 1992 by the Department of Education, Culture and Sports.

The PNAC uses eight monitoring and evaluation indicators on youth.

1. Percentage of young women and men aged 15–24 who are HIV-infected
2. Percentage of out-of-school youth (OSY) reached by HIV prevention programme
3. Percentage of street children reached by HIV prevention programme
4. Percentage of primary schools providing life skills-based HIV education within the last academic year
5. Percentage of secondary schools providing life skills-based HIV education within the last academic year
6. Percentage of young women and men aged 15–24 who had more than one sexual partner in the past 12 months and who reported using a condom during their last intercourse
7. Percentage of street children who are positive for syphilis
8. Percentage of OSY who are positive for syphilis.[53]

Indicators 1, 4, 5 and 6 are generalised indicators or indicators for the general public. The rest are specific indicators targeting OSY (indicators 2 and 8) and street children (indicator 7). The focus on the age group 15-24 years is based on the need to identify recent trends. However, actual data on these indicators are lacking. For indicator 1, the data available pertain only to the number of young women and men aged 15-24 who are HIV-infected and not the percentage. For indicator 6, the data available from the National Demographic Health Survey 2008 covered only women.[54] For indicators 2-5 and 7-8, either the data are lacking or there are no disaggregated data pertaining to the 15-24 age bracket.[55]

Under the 6th Country Programme of the United Nations Population Fund (UNFPA), 877 elementary and 646 high school teachers were trained on adolescent reproductive health (ARH). In addition, 270 peer educators from school- and community-based teen centres were trained to enhance their knowledge on ARH and life skills-based teaching methodology. The project has served 24,851 elementary pupils and 39,742 secondary students in School Years 2008-2009 and 2009-2010.[56] Under the UNICEF Power of You programme, 30 pilot schools underwent training on life skills education.

These programmes involved only certain pilot schools. No data are available on the percentage of schools providing life skills-based education in academic year 2009-2010.[57] In fact, HIV and AIDS education in schools is still very limited, as the number of teachers trained in life skills education on HIV and AIDS is limited.[58] These data relate to youth indicators 4 and 5.

A comprehensive review of ARH education for the rest of public and private schools was unavailable despite the clear requirement to provide HIV education to children and youth. The proposed Reproductive Health Bill, which mandates ARH education, still has not been passed into law despite the lapse of more than eight years since it was first filed in 2001.

The 2009-2010 ATMP IV Operational Plan aims to focus on the youth, as shown by its clear target of servicing 5,220,000 OSY, 33,648 street children and 19.8 million in-school youth.[59]

Children and youth in difficult circumstances, like street children and OSY, were identified as amongst the vulnerable groups given particular attention in the prevention thrust of AMTP IV.[60] The Operational Plan expands the target of the prevention strategy to cover employed young people who have been considered a "potential hub of the infection" and makes a conscious move towards "invigorating HIV prevention initiatives amongst people in the workplace and in-school youth".[61]

Section 32 of RA 8504 provides that the results of HIV/AIDS testing shall be released only to the person who submitted himself/herself to the test or either parent of a minor child who got tested. This would pose a problem for children who subject themselves to VCT without the knowledge and consent of their parents since some service providers tend to require them to ask their parents to get their results for them, and would discourage them from getting such results.

D. GENDER AND THE NATIONAL RESPONSE TO HIV AND AIDS IN THE PHILIPPINES

The HIV programme response is focused amongst the MARPs and vulnerable populations.[62] The interventions, however, are general and do not cater to the gender and age differences of the different target groups. Information is lacking on the assessment of gender issues amongst MSMs, bisexual men and transgenders.

The gender dimension of the Philippine national response to HIV and AIDS is in Section 2 sub-paragraph d of RA 8504 which states, "The State shall positively address and seek to eradicate conditions that aggravate the spread of HIV infection, including but not limited to, poverty, gender inequality, prostitution, marginalisation, drug abuse and ignorance".[63] Although RA 8504 guarantees access to complete HIV and AIDS information at tourist points of entry, local communities, schools, health facilities, offices and seminars for OFWs before they leave the country,[64] the Act also specifies that HIV and AIDS education in schools should not be used "as an excuse to propagate birth control or the sale or distribution of birth control devices" and should not use "sexually explicit materials".[65] A gender-responsive law/programme should ensure that complete and accurate information on sexual and reproductive health including fertility management is disseminated. For information, education and communication (IEC) materials on STIs to be effective as a prevention strategy, graphic photographs of sexual organs with STIs need to be shown.

RA 8504 does not specifically mention PMTCT or gender-based violence in relation to HIV. It mentions prophylaxis, but this is not practised for rape and sexual assault victims, and no specific guidelines or protocols exist on the use of PEP for rape or sexual assault victims. Based on the UNGASS 2010 Country Report, the country's policy on PEP, as of now, covers only occupational exposure such as needle stick injuries in healthcare settings in tertiary-level reference hospitals.[66]

The prevention programme of the 2009-2010 AMTP IV Operational Plan has sub-grouped OFWs in recognition of the "differences in the situations and conditions obtained in their places of work". OFWs, specifically female seafarers who number 6,436, were segregated from their male counterparts. Amongst their identified need is the enactment of gender-based policies on board ships to "protect them from certain vulnerabilities to HIV and other R[eproductive] H[ealth] problems". Also worth noting is the inclusion as a separate sub-group of male seafarers' spouses, who are estimated at 11,150. This is in recognition of the sexually risky behaviour of their partners. But the spouses of non-seafarer OFWs who might also be at risk though they have sex with only one partner, are not mentioned as a target of the prevention programme.[67]

The pronouncement in RA 8504 that the State shall "positively address and seek to eradicate conditions that aggravate the spread of HIV including…gender inequality" is not obvious in AMTP IV or in the whole country's response to HIV infection for the following reasons:

1. Of the 26 PNAC members, no agency is specifically in charge of the gender response to HIV infection.

2. No indicators in the monitoring and evaluation system of AMTP IV are concerned with gender, although the National Registry can sex-disaggregate the data on infections.

3. The MDG Philippine Progress Report 2007 says, "AIDS prevention and STI management is getting support from the donor community. These include the reproductive health component of the 6th Country Programme with assistance from the UNFPA, the German-assisted Reproductive Health Project, the World Bank's Second Women's Health and Safe Motherhood Project and the United States Agency for International Development Program on Health and Population. There is also the Joint UN Program on HIV and Migration, the UNICEF support on the national AIDS response [68] and the new proposal for Global Fund Round 5." How these projects contributed to the HIV and AIDS response is not manifested in AMTP IV.

4. Though OFW-female seafarers and the spouses of male seafarers are part of the 2009-2010 Operational Plan of AMTP IV, AMTP IV does not mention the need for gender-specific education materials on HIV and AIDS. Thus, during the 2010 AIDS Summit, a recommendation was added, calling for "better application of gender perspective".[69]

Gender inequality will affect the character of HIV infection in the years to come. Though the ratio of HIV-positive men and women in the Philippines is 3.5 men to one woman, this could change.[70] Evidence shows that women are more likely than men to receive the infection from their HIV-infected partners.[71] Even the PNAC recognised this in the AMTP IV Operational Plan 2009-2010 when it said, "[c]urrent data indicates that young adults, men who have sex with men (MSMs), people in prostitution (PIPs), injecting drug users (IDUs), overseas Filipino workers (OFWs) and the partners of all these groups are particularly vulnerable to HIV infection".[72]

Amongst low-risk populations, HIV prevalence is highest amongst the female partners of MSMs at 422 per 100,000 population,[73] followed by partners of PWIDs at 167 per 100,000 population, female partners of male clients of sex workers at 107 per 100,000 population and partners of OFWs at 42 per 100,000 population. HIV prevalence amongst partners of MSMs and PWIDs is higher than the estimated HIV prevalence rate amongst WIPs, male clients of PIPs and OFWs.[74]

E. DEPARTMENT OF HEALTH POLICIES

The DOH recently approved the following guidelines:

1. DOH-AO 2009 – 0016: Policies and Guidelines on the Prevention of Mother-to-Child Transmission of Human Immunodeficiency Virus

2. DOH-AO 2009 – 0006: Guidelines on Antiretroviral Therapy amongst Adults and Adolescents with Human Immunodeficiency Virus

3. Guidelines in the Conduct of HIV Counselling and Testing at All Levels of Health Care

4. Guideline on Post-Exposure Prophylaxis.

E.1. ADMINISTRATIVE ORDER ON PMTCT

The framework of the AO on PMTCT adopts a four-element strategy to prevent HIV amongst infants and young children. The elements are (1) primary prevention of HIV amongst women of childbearing age, (2) preventing unintended pregnancies amongst women living with HIV, (3) preventing HIV transmission from a woman living with HIV to her infant, and (4) providing appropriate treatment, care and support to women living with HIV, their children and their families.

The AO outlines a comprehensive list of services on PMTCT, including the referral and admission to the nearest treatment hub of HIV-infected pregnant women who are about to deliver.

The AO also requires service providers to extend family planning services. The AO is subject to interpretation: the service provider might not give the full range of effective temporary and permanent modern contraceptive methods.

E.2. ADMINISTRATIVE ORDER ON VCT

The AO on VCT is comprehensive in scope and covers all service providers, outpatient care, community-based interventions and outreach programmes. The AO on VCT set guidelines for provider-initiated HIV testing and counselling (PICT), where healthcare providers recommend HIV testing and counselling to persons attending healthcare facilities as a standard component of medical care.

The AO adapted the 2004 World Health Organisation-SEARO VCT Trainors' Manual, where VCT is linked to the continuum of HIV prevention, treatment and care, and where services such as access to FP, access to condoms, STI prevention, screening and treatment, maternity services for PLHIV, promotion and facilitation of behaviour change (sexual, safe injecting), amongst others, should be provided. The AO provides that in the event of an HIV-positive test result, there should be encouragement of disclosure to other persons who may be at risk of exposure to HIV.

E.3. GUIDELINE ON POST-EXPOSURE PROPHYLAXIS

The UNGASS 2010 Country Report mentioned an existing guideline for PEP provision for needle stick prick in tertiary hospitals, but this guideline does not require it for rape victims.

VI. SITUATIONER BASED ON FINDINGS FROM THE FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

This section discusses the findings according to specific behaviours and groups such as the youth, PIPs and their clients, PWIDs and PLHIVs.

The FGDs, KIIs and consultations looked into different vulnerabilities based on gender and age. The important factors that increase vulnerability to HIV based on gender and age are engaging in risky sexual behaviour and risky behaviour. In preventing HIV transmission, it is important to look at the push factors and root causes of why people engage in risky sexual behaviour and risky behaviour, and why people continue to it despite knowledge of STI/HIV risks and the protective use of condoms. General issues concerning the impact of HIV on individuals, depending on their gender and age, can discriminate an individual further based on other intersectionalities of discrimination.

Because of gender and age, the vulnerability of girls, boys, gays, bisexuals and transgenders to HIV is compounded by a host of reasons such as sexual and physical abuse, early sex, risky sexual behaviour, early pregnancy, prostitution, drug use and discrimination, amongst others.

The discussion below tackles the responses of participants to the FGDs, consultations and KIIs particularly their experiences and situation in relation to gender, age and HIV. The experiences of the participants and the stories of their beneficiaries set examples of problems that beset individuals and led to their vulnerability to HIV based especially on their gender and age, and give insights into how present and future HIV interventions can be improved by addressing gender and age concerns.

A. BEHAVIOURS

1. General Observations on Risky Sexual Behaviour

The results of the FGDs, consultations and KIIs show that many engage in risky sexual behaviour with a happy-go-lucky attitude, thinking that the possibility that they will get infected with HIV is remote. Many have multiple sex partners and do not use condoms. The participants express regret when they find out later that they are HIV-positive.

2. Gender Issues and Condom Use

The following responses show the gender issues related to condom use. Many women stated that even if they negotiated for or demanded condom use, the men would refuse to wear condoms. One OFW woman said that, at times, her husband does not want to use condoms, and this becomes a cause for a fight.[75] For other women, girls, men, boys, MSMs and transgenders, they opt not to use condoms when the partner is their loved one, when they are attracted to the other person or when s/he looks clean. The PLHIVs who keep their positive status a secret usually do not insist on using condoms for fear that their status will be disclosed.

B. SPECIFIC GROUPS

1. Vulnerabilities of Children and Young People

Children and young people become vulnerable to HIV for various reasons, including incidence of runaways and prolonged stay outside of the home and school, early sex, risky sexual behaviour, drug use, gang membership, peer pressure, sexual and physical abuse, low condom use, misconception about STIs, HIV and AIDS, and prevalence of social networking sites.

a. Incidence of Runaways and Prolonged Stay Outside of the Home and School

Runaways refer to children and young people (also called stokwa, short for stowaway) who leave their homes or stay out of their homes for prolonged lengths of time due to issues with their mothers/fathers/stepfathers, broken communication lines with their parents and family members, abuses they suffer from incidence of incest/rape/domestic violence, amongst others. These children and young people are usually out-of-school.[76]

b. Early Sex, Risky Sexual Behaviour, Early Pregnancies and Drug Use

The activities of the children and young people include engaging in drugs and/or risky sexual behaviour. [77]

i. **Girl-children and young women and the impact of early sex, risky sexual behaviour and early pregnancy**

Many girl-children and young women, including OSY, engage in early sex with their boyfriends and/or gang mates without protection, thus, the high incidence of early pregnancies.[78]

A 20-year old peer educator who handles the women's desk at a barangay says that they have lots of cases of early pregnancy, ex. pregnant 13-year-olds who start living with their partners and end up having more children. They tried teaching them about family planning last year, but the children were not open, even if everything was free.[79]

ii. **Many of the girl-children and young women were driven away from their homes when their mothers found out they were already sexually active and/or pregnant.**[80]

c. Gang Membership and Peer Pressure

The activities of the children and young people include late-night jaunts or plain tambay (staying out with friends or gangs doing nothing specific).[81]

The beneficiaries of Tambayan, an NGO catering to OSY, shared their accounts in the gangs where male gang members ask their female neophytes to choose between hirap (hardship) or sarap (pleasure). If the neophyte girl-children choose sarap, then their initiation rites would be having sex with the gang members.[82] This could mean having sex with all the male gang members. More girls would rather choose sarap in order to avoid the pain of whipping, representing hirap, thus making them vulnerable to sexual abuse, infection and early pregnancy. This practice clearly manifests machismo and women's oppression.

i. The actors (term used for the boys) initiate group sex with the actresses (term used for the girls). The actors talk about how they will have sex with the actress/es. Some actors want to impregnate the actresses. Although the girls do not want to become pregnant, many eventually do get pregnant. [83]

ii. In one night, they can have several rounds of sex. One girl can have sex with several boys. They do it sometimes at the grabahan in Matina. The girls would have vices like drinking or taking drugs and rugby. Sometimes the boys slip vetsin in the girls' drinks to make the girls dizzy. [84]

iii. Sometimes the girls would ride motorcycles with men and have sex with them. The girls would get cigarettes in exchange. The girls would start roaming at 6:00 pm and return home at 4:00 am. [85]

d. Sexual and Physical Abuse

A peer educator found out through their women's desk and the SK training on counselling on abuse of children that many of the children were raped by their grandfathers or by someone older than they.[86]

e. Low Condom Use

A peer educator observed that many girls do not use condoms because they are in love, and they let their hearts rule. That is why they become pregnant early.

i. A participant from KAUGMAON, an NGO catering to in-school and out-of-school youth, noted that men/young boys ask their partners to have sex with them by using the word love. A boy tells his girlfriend that if she loves him, then they should not use condoms. At the same time, men (and most women also) carry the notion that the woman is responsible for exerting effort to prevent unplanned pregnancy and that the woman is at fault when unplanned pregnancy happens.

ii. Some peer educators in Davao estimated that about 20 per cent of children and young people amongst their beneficiaries use condoms.

f. Misconception about STIs, HIV and AIDS

ii. A 16-year-old officer of a youth organisation thought there are medicines that can cure AIDS.

iii. A peer educator thought guest relations officers take a vaccine every month to prevent STIs.

g. Prevalence of Social Networking Sites

The prevalence of social networking sites makes it easy for MSMs, bisexuals, transgenders, lesbians, adult women and men to find sexual partners.[90]

2. Vulnerabilities of People in Prostitution and their Clients

The vulnerabilities of PIPs (ex. women, gays, bisexuals, transgenders, young people, freelance people), clients of PIPs and their partners are discussed below.

a. Women in Prostitution

Women are pushed into prostitution by various reasons such as growing up in large families, poverty, need to survive, early pregnancy, multiple early pregnancies, low level of education and concurrent lack of employment opportunities. WIPs are vulnerable to HIV infection due to low condom use, low practice of modern contraceptive methods and lack of knowledge on VCT, amongst others. Other issues involving WIPs are the harassment, arrests, abuses and discrimination to which they are subjected, their abusive partners, unwanted pregnancies, multiple abortions, and PLHIV women who continue to engage in prostitution.

i. Push Factors

- **Belonging to a Large Family, Poverty and Need to Survive**

  - A 25-year-old, HIV-positive woman admitted she still engages in prostitution. Being the eldest in the family, she does it to support her parents and three siblings.[91]

- The peer educators mentioned that some people engage in prostitution with payment of as low as 20 pesos just to get something to eat.[92]

- One former woman in prostitution admitted that if she did not love the person with whom she was having sex, then she disliked the act.[93]

- **Early Pregnancy, Multiple Early Pregnancies, Low Level of Education and Concurrent Lack of Employment Opportunities**

  - By age 18, one woman had already borne three children. Because of her pressing need to care for the children, she started as a dancer and then eventually got paid for sex. She became part of the outreach trainings of Lawig Bubai [94] and Talikala,[95] but stopped engaging in prostitution only when Talikala employed her.[96]

  - One woman bore her first child at age 19. To support her child, she engaged in prostitution for eight years. She became part of the outreach trainings of Lawig Bubai and Talikala, but she decided to leave prostitution only after the third incident of physical abuse she suffered at the hands of a client who beat her when she demanded the use of a condom. She stopped when Talikala employed her.[97]

ii. Vulnerability to HIV Infection

- **Low Condom Use**

  - Participants said many customers do not want to use condoms and will pay higher if condoms are not used. Because WIPs need the money, they end up not using condoms.[98] Furthermore, customers will pay less if they know a condom is used.

  - A Lawig Bubai member said her organisation has helped her learn about protecting oneself. Nonetheless, she also has to earn money, and if the customer does not want to use a condom, then she can do nothing.

  - The WIPs also do not use condoms when having sex with their partners and when the customer looks clean and attractive.

- **Lack of Knowledge on the Importance of Condom Use**

  - A former WIP admitted she had no knowledge about condoms and its importance as protection and contraceptive when she was engaging in prostitution.[99]

  - A former WIP said she used condoms when her customers were foreigners. It was a German customer who told her that using a condom would protect both of them.[100]

  - A former WIP said she used pills to prevent pregnancy, but she has undergone abortion five times and has had STIs.[101]

- **Lack of Knowledge on VCT**

  Some young women in prostitution did not know where to get VCT. [102]

iii. Issues Affecting Women in Prostitution

- **Harassment, Arrests and Abuse of WIPs**

  Harassment and arrests of women in prostitution are ongoing. [103]

  - The peer educators and WIPs reported the frequent arrests of WIPs. They said that women were being forced to have sex with police officers inside police cars and police stations (ex. Manila, Marikina, Pasay and Caloocan). In addition, they reported that the police would steal their cell phones and money, and some would just leave them on the street without any money. [104]

  - Under Mayor Rodrigo Duterte's term in Davao, no arrests were made of WIPs.[105]

  - The Lawig Bubai peer educator and Talikala staff reported physical abuses by clients who beat the WIPs when the latter demanded the use of a condom and when they were suspected of having infected their clients with STIs.[106]

- **Abusive Partners**

  Many women in prostitution have male partners who batter them when they have no earnings from prostitution.[107]

- **Discrimination against Women in Prostitution**

  According to an officer of Babae Plus, a support group for HIV-positive women, even amongst their members some OFWs discriminate against WIPs. The WIPs complain of being treated in a condescending manner by the OFWs. Also, she observed that the WIPs themselves hardly open up during sharing sessions amongst members.

- **Knowledge of Positive Status**

  Some women in prostitution discover that they are HIV-positive through a system of routine check-ups at the Social Hygiene Clinics of the City Health Office (CHO) when they try to get their social hygiene cards.[108]

- **Unwanted Pregnancies and Multiple Abortions**

  Some WIPs had several unwanted pregnancies and underwent multiple abortions.[109]

- **PLHIV Women who Continue to Engage in Prostitution, Difficulty in Divulging Status and Fear of Discrimination for Being Positive**

  A 25-year-old, HIV-positive woman who still engages in prostitution admitted that she does not use condoms sometimes because her customers do not like using it and she finds it difficult to admit her status since the customers would ask, "Why, do you have a disease?"[110]

b. Gays, Bisexuals, Transgenders in Prostitution

Gays, bisexuals and transgenders are pushed into prostitution for various reasons, including abuses based on their sexual orientation and gender identity. Gays, bisexuals and transgenders in prostitution are subjected to harassment, arrests and abuses.

i. Push Factors

- **Abuse based on sexual orientation and gender identity**

  One transgender was forced to leave home because her father battered her. She ended up in prostitution.[111]

ii. Harassment, Arrests, and Abuse of Gays and Transgenders in Prostitution

- The police frequently arrest and steal from gays and transgenders in prostitution.[112]
- A transgender recounted being caught whilst streetwalking in Makati. She tried to run away, but she was caught and taken to jail. She said that when the policemen found out she was a transgender, she was beaten up and harassed because, according to the police, she was misrepresenting herself as a woman.

c. Young People in Prostitution

Young people are pushed into prostitution for reasons such as being out-of-school, early sex, early pregnancies, incidence of runaways, peer pressure and prostitution, drug use and prostitution, and sexual abuse. Other concerns regarding young people in prostitution include their young age in entering prostitution.

i. Push Factors

- **Girl-children and young women who are out-of-school and/or have early sex and early pregnancies**

  Many girl-children and young women who are out-of-school and/or have early sex and early pregnancies end up in prostitution.[113]

  - One woman had early sex with her boyfriend. When her mother found out, her mother scolded her and told her to just enter prostitution. Because of her mother's demeaning treatment and her sense that she was being driven away from home, she left her family and engaged in prostitution. She is still in prostitution and was not a member of Lawig Bubai at the time of the FGD.[114]
  - One 15-year-old girl felt her mother was not giving her the attention she needed although she was the youngest of her siblings. She left home, but continued going to school. After she finished high school, she became a tambay (staying out with friends doing nothing specific) and subsequently had sex with her boyfriend. She met a WIP and started engaging in prostitution herself since she was no longer a virgin. She is still in prostitution and expressed her desire to stop if given a scholarship to support her college education. She is a member of Lawig Bubai.[115]

- A 13-year-old was asked to leave home since she was always out and about (a lakwatsera). She used vulca seal as a sniffing drug and had sex with her boyfriend at age 12. She is now a guest relations officer and a member of Lawig Bubai.[116]

- **Boys, gays and transgenders who are out-of-school**

  Some out-of-school boys, gays and transgenders end up in prostitution.[117]

- **Incidence of runaways**

  One young gay man was forced to leave home because his father brought home a new partner whilst his mother was working abroad as an OFW. He ended up in prostitution, and he discovered he was HIV-positive at age 19.[118]

- **Peer pressure and prostitution**

  Based on the accounts of peer educators, some 17- and 18-year-old females in prostitution ended up in prostitution because of peer pressure.[119]

  At the Cebu International Convention Center (CICC) reclamation area, many girls in prostitution are called 'karton girls' because they lie down on cardboard boxes when they entertain customers. They charge from P50 to P300. Some do blowjobs for P10 to P20. They use that area because it is isolated and that is where they hang out at night. Both girls and gays engage in prostitution at the CICC.

- **Drug use and prostitution**

  A peer educator says there are young boys who engage in prostitution with gays for want of money to buy material things and support vices like rugby sniffing.[120]

- **Victims of sexual abuse**

  The peer educators' narrated that some 13- and 14-year-old females in prostitution had been victims of rape and/or physical abuse. They were forced to leave home because they had issues with their stepfathers and/or they feared being raped.[121]

  - A peer educator and counsellor said that one 13-year-old boy had been forced to have sex with a 24-year-old gay. The boy acquired STI afterwards.[122]

  - In another case, a gay person became a victim of human trafficking wherein the sexual abusers were young males.[123]

ii. Ages of Children, Adolescents and Young People in Prostitution

One participant revealed that their barangay has 15- to 18-year-old people engaged in prostitution. There are even boys entering prostitution at 9 years of age.

d. Freelance People in Prostitution

Freelance people in prostitution tend to be difficult to reach; hence, their access to VCT is delayed.

Delayed VCT of those engaged in freelance prostitution; engaging in prostitution despite HIV status

A young gay man engaging in freelance prostitution discovered he was HIV-positive when he tried to donate blood through a blood bank. However, he did not get the proper VCT, and he did nothing about his positive status. He even continued engaging in prostitution without using condoms. He got a confirmatory test only a year later, when he met a volunteer doing outreach amongst people in freelance prostitution.[124]

e. Vulnerabilities of Clients of People in Prostitution and Their Partners

Clients of PIPs and their sexual partners include mobile populations that are difficult to reach. Many male Filipino clients of PIPs do not use condoms, making them and their partners vulnerable to STI and HIV. [125]

i. Mobile Populations

Clients of PIPs include construction and cargo ship workers whose jobs tend to be mobile, making them and their sexual partners vulnerable to STI and HIV.

ii. Low Condom Use

Many male clients of PIPs, especially Filipino clients, do not want to use condoms.

3. Men having Sex with Men, Bisexual Men and Transgender Males to Females

MSMs, bisexual males and transgender males to females are vulnerable to HIV for various reasons, including early sex, risky sexual behaviour, prevalence of social networking sites and MSM and transgender clubs, low condom use, and low knowledge of HIV. Another issue involving these populations is discrimination based on sexual orientation and gender identity.

a. Vulnerability to HIV

i. Early Sex and Risky Sexual Behaviour

Many MSMs, bisexual males and transgenders engage in early sex and risky sexual behaviour with multiple sex partners without using protection. They can start as early as age 12. Some have had partners by the hundreds at ages 13-19. By age 18-23, some are already diagnosed as HIV-positive.[126]

- One participant said, "Before you do anything, you look for a partner. Before you sleep, you look for a partner. Condom use becomes a bother."
- Another participant confessed, "You look for partners on the streets, and you have sex anywhere convenient at any time."

- One young adult said that he had had risky sex by the hundreds and admitted to having been sexually addicted.[127]
- A peer educator added that many gays as young as 13 have contracted STIs.[128]

ii. Prevalence of Social Networking Sites and MSM and Transgender Clubs

IWAG Dabaw, an NGO catering to MSMs and transgenders, raised their concern regarding the existence of social networking sites for MSMs looking for sex. Planetromeo.com and guysformen.com are two of the sites encouraging risky behaviour amongst MSMs. Many MSMs,[129] bisexual men and transgenders connect with each other through social networking sites and engage in casual sex.[130]

The prevalence of MSM and transgender clubs also makes it easier for MSMs to indulge in sex, particularly with multiple sex partners and without protection.[131]

iii. Low Condom Use

Some MSMs, bisexual men and transgenders do not use condoms during sex with their loved ones and/or if they are attracted to the casual sex partner.

MSMs and transgenders complained of pain during anal sex because the condoms are dry when being used. They raised the need for lubricants and thought it would be good if the government started distributing lubricated condoms. Also, some complained that the condom sizes in the Philippines are often too large for them.[132]

iv. Low Knowledge of HIV

Most people find out about HIV only when they become infected.[133]

b. Discrimination Based on Sexual Orientation and Gender Identity

A peer educator in Davao says they are unable to help the young gays who have STIs since the young gays seem to be ashamed. They do not seek help, fearful of what other people might say about them.[134]

i. Some gays are not out yet; thus, they are not members of gay groups.[135]

ii. Some say it is easier to admit they are positive than admit they are gays.[136]

iii. Being positive and being gay subject them to different types of discrimination.[137]

4. People Who Inject Drugs

PWIDs may have various reasons for injecting drugs. These may include psychological problems and the physical demands of work. Other issues involving PWIDs include the use of children in drug running and pushing, male PWIDs subjecting their female partners to gender-based violence, and the harassment, arrests and abuse of PWID peer educators.

a. **Push Factors**

i. **Psychological Problems**

Some PWID peer educators explained that many PWIDs resort to drug use as a means to forget their psychological problems.[138]

ii. **Physical Demands of Work**

Some fisherfolk PWIDs who dive for an hour or two for spear fishing use drugs to keep them warm under water.[139]

b. **Other Issues**

i. **Use of Children in Drug Running and Pushing**

One father forced his daughter to be a drug runner and pusher. The father would beat the girl if she refused to do what was asked of her.[140]

ii. **Women Partners of Male PWIDs Being Subjected to Gender-Based Violence**

Peer educators noted that some PWIDs subject their sexual partners to violence. Whilst on drugs, the PWIDs become aggressive and afraid of nothing. They added that after the drug wears off in a few hours, the PWIDs become violent and aggressive.[141]

iii. **Harassment, Arrests and Abuse of PWID Peer Educators**

Harassment and arrests of PWID peer educators are ongoing.[142]

5. **Overseas Filipino Workers**

OFWs are vulnerable to HIV for reasons including risky sexual behaviour, low condom use, low knowledge of HIV, need to give financial support to their families, engaging in prostitution and sexual abuse.

a. **Vulnerability to HIV**

i. **Risky Sexual Behaviour**

- One female OFW said she engaged in unprotected casual sex whilst she was abroad and subsequently found herself HIV-positive.[143]
- Two MSM OFWs working in Dubai said they were engaged in unprotected casual sex. Subsequently, they discovered they were HIV-positive.[144]
- One HIV-positive former seafarer admitted that he used to engage in risky sex at every port where their ship docked.
- Some participants said many of their HIV-positive beneficiaries are seafarers.[145]

ii. Low Condom Use

Mary of the Sea Seafarers Family Association said that their seafarer-beneficiaries get tested regularly. However, the seafarers do not use condoms when they have sex with their partners in the Philippines because they had been away for nine months or so.[146]

iii. Low Knowledge of HIV

Many OFWs revealed that they had lacked knowledge on HIV transmission and prevention when they left for work abroad and eventually found themselves HIV-positive.[147]

iv. Need to Provide Financial Support to Families, Engaging in Prostitution

Some women OFWs take on boyfriends to support them and their families financially. Some women domestic helpers in Singapore engage in part-time domestic work where they have sexual relations with their employers, who eventually support them financially.[148] Some of these women OFWs eventually become HIV-positive.

Because of their inadequate salaries, some male OFWs in Saudi engaged in prostitution to be able to send money home to support their siblings. Eventually they became infected with HIV.[149]

v. Sexual Abuse

Some women OFWs were raped and became infected with HIV as a result of the rape.[150] One woman OFW who became HIV-positive as a result of rape expressed regret that she was unaware of PEP as a means to prevent HIV transmission at the time the rape occurred.

6. People Living with HIV

PLHIVs and their sexual and injecting partners are vulnerable to HIV infection or re-infection for reasons such as risky sexual behaviour, low condom use and non-disclosure of HIV status to partners. Other issues involving PLHIVs are high incidence of HIV amongst young people and MARPs, lack of information and access to PEP for rape victims, women's issues related to HIV (ex. high incidence of HIV amongst women OFWs, WIPs, wives of HIV-positive men, PLHIV women burdened with domestic work, lack of knowledge on VCT), implementation of the PMTCT policy, parents' delay in informing the child of his/her HIV-positive status versus the rights of the child, discrimination against PLHIVs and lack of employment opportunities for PLHIVs.

a. Vulnerability to HIV

i. Risky Sexual Behaviour

Some single PLHIV women meet their HIV-positive foreigner-boyfriends in chat rooms, and many of them want to have children.[151] Note: Every person's right to have children is inherent. To protect the right of PLHIVs to have children, PMTCT service providers give reproductive health counselling to assist PLHIVs in making reproductive choices, including timing of any possible pregnancy, available PMTCT services and risk reduction (ex. reducing the risk of re-infection with another HIV strain). At the moment, however, many PLHIVs do not avail of these counselling services.

ii. Low Condom Use

- Some HIV-positive people do not use condoms consistently.
- PLHIVs have difficulty negotiating condom use for various reasons including fear of discrimination.[152]

iii. Non-Disclosure of HIV Status to Partners

Some HIV-positive men and women have not disclosed their status to their partners.[153]

- Alliance against AIDS in Mindanao (ALAGAD Mindanao), an NGO focusing on the prevention of STIs, HIV and AIDS, had a case where the man was confirmed as HIV-positive. ALAGAD encouraged him to invite his wife for VCT. However, he was making excuses not to have his wife tested. They even had a case where the husband died of AIDS without his wife knowing that he had AIDS.[154]
- One PLHIV woman expressed fear of marriage breakup if she discloses her status.

b. Other Issues

i. High Incidence of HIV amongst Young People and MARPs

In the Cebu FGDs, the participants said many of their PLHIV beneficiaries are 15 to 24 years old and are classified as women in prostitution, PWIDs and MSM/transgenders.[155]

ii. Lack of Information and Access to PEP for Rape Victims

One OFW who became positive as a result of rape said she wished she had known about PEP at the time she was raped so she could have prevented HIV transmission.[156]

iii. Women's Issues Related to HIV

- High HIV incidence amongst women OFWs, WIPs and wives of HIV-positive men

  In the NCR FGDs, the participants said many of their women PLHIV-beneficiaries are OFWs, WIPs and wives of HIV-positive men who did not inform them of their status.[157]

- PLHIV women burdened with domestic work

  A Babae Plus officer said that during their trainings, some PLHIV women leave early because they still have to do the cooking at home.

- Lack of knowledge on VCT

  Some participants from Manila-based NGOs/plus groups observed that women are missing in VCTs.[158]

iv. Implementation of PMTCT Policy

- One PHLHIV woman who was five months pregnant at the time the FGD was conducted went to Vicente Sotto Sr. Memorial Medical Center (VSMMC) for a check-up, but she said it seemed like the hospital's protocol was not yet in place. She went to a private hospital named Chong Hua, but the costs were high and beyond her budget. She said that she considered giving birth in Manila, where hospitals have experience in handling PMTCT, but she decided to stay in Cebu.

- Babae Plus has HIV-positive women members who expressed their desire to have children. Although some Babae Plus members had trained in PMTCT, at the time of the FGDs, some of its members expressed the need to get PMTCT training.[159]

- One OFW who was pregnant and HIV-positive related her experience at the Philippine General Hospital (PGH) during her follow-up check-up: the physician seemed to assume that the foetus she was carrying was also HIV-positive. (Note: It was not clarified during the FGD when she went to PGH.)

v. Parents' Delay in Informing the Child of His/Her HIV-Positive Status versus the Rights of the Child

A seafarer's wife who did not know of her husband's HIV status eventually became HIV-positive. Without knowing her HIV status, she became pregnant and unknowingly transmitted HIV to their child. She and her husband are now finding it hard to inform the child of the child's HIV status.[160]

vi. Discrimination against PLHIVs

The status of some pregnant PLHIVs became public knowledge because their chart could be read by anyone at the hospital delivery room. Still others experienced getting a sign posted on their hospital bed saying, "practice precaution".[161]

vii. Lack of Employment Opportunities for PLHIVs

- A Cebu Plus officer expressed the need to provide employment for PLHIVs.[162]
    - Many HIV-positive OFWs and women have no paid work.[163]
    - Positive women expressed the need to provide employment for women PLHIVs.[164]
- Fear of Employment Discrimination
    - Some PLHIVs fear that they might get discriminated, terminated from work or denied employment if they disclosed their status. Other PLHIVs told their fellow PLHIVs that disclosing their HIV status at work was not needed, so they need not worry about losing their jobs or being discriminated.[165]
    - No member of Babae Plus ever applied for work in companies because they are either ashamed or afraid of discrimination and stigma.[166]

VII. INTERVENTIONS BASED ON FINDINGS FROM THE FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

This section discusses the findings on interventions according to the following sub-sections: capacity building on gender and children's rights trainings, gender and child rights policies, prevention, abuse, care, support and treatment, and discrimination, amongst others.

The following responses to HIV were lifted from the FGDs, consultations and KIIs. This study examined the responses to HIV in relation to prevention, care, support, treatment and programme management, taking into consideration the different gender and age concerns.

A. PREVENTION

1. Capacity Building

a. Gender Training

Talikala gives their beneficiaries trainings on women's issues and women's rights, including social issues affecting women. Each Talikala gender training usually lasts three days. One specific type of training is for staff development whilst another type is for women and their partners. The content includes a situationer on issues faced by women, power relations, gender stereotyping,and history of women's oppression. Talikala has a programme under UNICEF which empowers women through awareness of their rights.

ALAGAD has two training types: one for its staff and another for its beneficiaries. The contents of basic training include HIV/AIDS, gender and human rights perspective, and gender orientation. For the staff training, ALAGAD also equips the staff in VCT and handling disclosure. Since many PLHIVs in Davao City are MSMs, ALAGAD ensures that their service providers are oriented on gender-sensitive handling of sexual orientation issues.

Brokenshire, an academic institution and hospital addressing women's health-related needs and reproductive health needs, conducts gender orientation, training on patients' rights, medicalisation of childbirth and Lamaze for medical practitioners. These sessions helped some obstetrician-gynaecologists broaden their understanding of certain women's issues. The trainings even led to changes in certain hospital policies (ex. no male attendants are allowed in the delivery room).

Brokenshire gives gender-specific trainings, though not specific to HIV. They set opportunities for problem solving where the participants find ways to make their programmes and policies more gender-responsive. In cases where a woman wants to undergo ligation against the will of her husband, they inform the woman of her right to self-determination.

In Cebu, the Remedios AIDS Foundation (RAF), an NGO catering to youth and PLHIVs, conducts trainings on gender sensitivity, gender and sexuality, and HIV/AIDS. Cebu Plus, a support group for PLHIVs, organises gender sensitivity training amongst its members.

Babae Plus holds gender training and leadership training, but because the funds are activity-based, no long-term programmes and funds can sustain these trainings.

Reproductive Health and Wellness Center (RHWC), a government centre for WIPs, stresses the importance of evaluating and integrating a module that tackles the unfaithfulness of men in relation to gender relations and that integrates behavioural change in gender training.

The City Health Offices in Metro Cebu conduct gender trainings for their staff and incorporate these into their trainings on STIs.

A trainer who is a Cebu Plus member noted that women's issues are not discussed in the Pre-Departure Orientation Seminar (PDOS).

One Bidlisiw [167] beneficiary who is engaged in prostitution shared that she participated in a three-day training where they had basic gender and HIV training, including HIV transmission and its signs and symptoms.

At the time the Cebu FGD for children and young people was conducted, participants from certain groups had not yet undergone training on gender. At the time of the Davao FGD, some PLHIV participants had not yet undergone gender training.

B. CHILD RIGHTS TRAINING

At the time the Cebu FGD for children and young people was conducted, participants from certain groups had not yet undergone training on the rights of children and young people, whilst a positive support group was still planning to hold trainings for the youth.

Kaugmaon's training on children's rights covers sex and gender, sexuality and drugs. Kaugmaon carefully considers its approach when training 10- to 15-year-olds. They give information on basic children's rights, HIV and AIDS. Kaugmaon's peer educators do community outreach. They initiate games that are connected with the topics of early pregnancy, substance abuse, HIV, STI and violence against women and children (VAWC). The children show interest. Sometimes, after a session, the beneficiaries approach the peer educators, and they are referred to Kaugmaon.

IWAG Dabaw has a child rights training that tackles child-related laws and is then echoed to children in the community because many of them, including gay children, are abused. The problem of adult gay men having sexual partners who are minors is ongoing. Thus, the staff also campaign amongst adult gay beneficiaries that such practice is a violation of the law. (Note: More awareness-raising needs to be conducted amongst gay men to stop their sexual engagement with minors.)

RAF Cebu also organises basic training on children's rights and integrates training on adolescent sexual health and reproductive rights for the youth under their HIV and AIDS programme. RAF Cebu has a Peer Education Programme for young people, especially on prevention. Their programmes train young people on empowerment and develop them to become peer educators and eventually advocates and leaders. In the communities where they work, RAF has also created a committee specific for women and youth.

Lawig Bubai has parent's education wherein they teach parents how to take care of their children and inform them of children's rights and the responsibilities of a mother.

2. Gender and Child Rights Policies

a. Gender Policies

Talikala practises no victim-blaming and non-judgemental attitudes in dealing with girls and women in prostitution. They also ensure a feedback mechanism amongst the beneficiaries to monitor and evaluate lapses amongst the staff.

b. Child Rights Policies

An organisation educating young people on children's rights has a child protection policy that states it must be clear to the staff that children must be treated with utmost care. Hence, whenever they have activities, every child must be frisked for rugby and other similar substances. A male staff must always sleep in a separate room apart from the girls. The organisation also asks lesbians to sleep in a room separate from the heterosexual girls. [Notes: (1) Instead of frisking, they can institute a policy that no rugby and other similar substances should be brought to their activities. Sexual harassment can happen even if frisking is done by the same sex. (2) There is concern that, without proper awareness on sexual orientation, gender identity and sexual abuse, the lesbians may feel discriminated if they are required to sleep in a separate room. Also, it was unclear whether they separate dyke lesbians from femme lesbians

or combine them in one room. If they combine femme lesbians with dyke lesbians, then there is risk of abuse within that setup as well.]

Talikala also formulated its own child protection policy. Three children participated in its formulation. One policy is that in every activity, the language and methodology of facilitators must be child-sensitive and child-friendly. In choosing a venue, a hospital must be nearby in case of emergency. The organisation has no male staff members because its beneficiaries are girls, young women and women. And in every health check-up, a staff must accompany each child or woman in order to protect him or her from any abuse or trauma.

3. IEC and Behaviour Change Communication (BCC)

a. Risky Sexual Behaviour, STI, RTI and HIV

i. IWAG Dabaw informs MSMs of the alarming rise in the number of HIV-infected MSMs and transgenders. They hold campaigns to change risky behaviour amongst MSMs and transgenders.

ii. RAF Cebu provides MSMs with counselling and access to commodities. Those who are sexually active undergo a prevention programme for a complete package of interventions.

iii. Talikala has HIV and AIDS primers/comics depicting street situations. A lot of WIPs spend their time in the streets. Talikala uses language that children and young people in the streets can understand. For girls who are not yet sexually active, they campaign to delay engaging in sex. But amongst children and youth in high-risk situations, they distribute condoms and educate them on the risks of not using condoms.

iv. The peer educators of Mindanao Advocates, a support group for PLHIVs, focus on prevention using messages such as "never get infected" and "never infect others."

v. Cebu Plus has been advocating that the members of the HIV-positive community live a healthy lifestyle, support one another to live healthily and avoid risky behaviour.

vi. A Cebu Plus peer educator for OFWs said that the time devoted to HIV during PDOS is very limited. In the past, it was only 15 minutes; now it ranges from 30 minutes to one hour. In PDOS he explains what HIV and AIDS are, HIV transmission, and ABC,[168] and then he gives his testimony. He said many people focus on the testimony.

vii. One NGO says their general module on HIV can be applied to women.

b. Condom Use, Fertility Management and Reproductive Rights

i. The RHWC observed that their MSM beneficiaries have a high level of awareness on the importance of using condoms, but have a very low level of consistency in using it.

- Their MSM beneficiaries prefer to 'skim' (the act of petting each other).
- Condoms are not readily available
- The MSM beneficiaries cannot afford condoms.

- If they love a person, then they do not use condoms.

The RHWC receives negative feedback from conservatives in communities. They get blamed for the disintegration of marriages when they discuss condoms and other family planning methods in their effort to empower the married women in communities.[169]

ii. Talikala trains women and girl-children in prostitution to negotiate condom use in such a way that they can convince their clients to use protection. Talikala discusses the anatomy of a woman's reproductive system and fertility management. However, they get reports of male clients beating up the women because of their demand to use condoms.

iii. One group catering to WIPs does not teach minors about pills and does not give them condoms. Instead they tell them to avoid having sex and to go to school first. They teach them that, being young girls, their uterus is not yet ready for pregnancy.

iv. The members of an organisation catering to wives of seafarers does not have regular trainings except on proper condom use.

v. When a young WIP, a beneficiary of an organisation catering to WIPs, was asked if she had joined discussions on reproductive rights, i.e., the right to choose when to have sex, if and when to get pregnant, she replied that she had not attended such discussions.

vi. In Cebu and NCR, many providers do not teach the use of female condoms. Davao service providers tend to teach the use of female condoms, but they are concerned about the cost and availability. Knowledge on how to use female condoms is also lacking.[170]

vii. An organisation catering to WIPs teaches their beneficiaries about both male and female condoms, but they show only pictures.

viii. One organisation catering to young people uses only the hand to demonstrate the female condom. They do not demonstrate male condoms because it is against their organisation's policy to show condoms.

ix. A participant from one NGO said that before they conduct condom demonstrations for the youth, they ask them if they want to be taught how to use condoms. If the youth engage in sex, then the NGO teaches them how to use condoms and gives a demonstration. Kaugmaon added that a particular group has similar concerns. If a group is not into sex, then Kaugmaon just provides information on condoms. Amongst the Muslim youth, they usually do not demonstrate condom use.

c. Need for Gender- and Age-Specific IEC/BCC

i. When the member organisations of ALAGAD ask for IEC materials, ALAGAD gives its standard IEC, and the partners have the option to make the materials gender-specific. ALAGAD involves members in their process of making their IEC materials.

ii. Those in the provinces raised a concern that sector/issue/MARP-specific IEC and BCC materials do not reach the NGOs/service providers/support groups in the provinces.

iii. Pinoy Plus, a support group for PLHIVs, had a three-year project with UNFPA which had different messages for MSM, youth and WIPs. But because the project ended in 2007, the materials are not being republished.[171]

4. Voluntary Counselling and Testing

a. Counsellors from an NGO in Cebu have a system of assessing the risk factors of people who go to them for VCT (including referral for testing), and they give appropriate counselling for the risk factors identified. This may include counselling on risky sexual behaviour, practising contraception, etc. However, the reach seems to be on a limited scope to clients who go to them for VCT. Also, the intervention seems to be on a person-to-person basis, which depends on the questions asked by the counsellor and the responses of the client.

b. After being trained on behavioural and gender aspects, the RHWC peer educators undergo HIV anti-body testing to experience what it is like and to understand and be able to deal better with their peers, especially when encouraging HIV anti-body testing. The RHWC has a standard VCT. When counselling MSMs, they use the standard VCT and include gay issues such as risky sexual practices/behaviour.

c. One private hospital has difficulty convincing its personnel to discuss with patients the importance of HIV anti-body testing.

d. An organisation for wives of seafarers encourages the OFWs to get tested. However, when asked if the wives of OFWs are also tested, the organisation members replied that the wives are not tested and only the husbands get tested before leaving for work abroad.[172]

e. Talikala uses illustrations for children during their VCT.

f. The Council for the Welfare of Children (CWC) Committee on Children and HIV AIDS is looking into minors' access to testing, counselling and treatment of STIs.[173]

g. Positive young adult MSMs use blogs and social networking to encourage VCT amongst MSMs, transgenders, and bisexuals, and they have been successful.[174]

5. Peer Educators

RAF Cebu has a Peer Education Programme for young people which uses peer-to-peer approach, especially on prevention. Its Youth Zone programme includes counselling for affected families. In RAF programmes, young people are trained for leadership positions that empower them. RAF also develops youth volunteers to become peer educators and eventually advocates. In each community where they work, RAF also created a committee specific for women and youth. PLHIVs receive equal privileges as leaders in the organisation.

One PLHIV support group does not handle PLHIVs who are severely depressed or suicidal. They expressed the need to strengthen their linkages with other groups since they provide only basic counselling. The PLHIV support group added that they lack the capacity to handle PWIDs; thus, they partner with the City Health Office. They said they look forward to having a peer educator in the PWID sector.

6. Post-Exposure Prophylaxis

a. PNP Medico-Legal

Dr. Jaime Leal, formerly of the Women and Children Protection Center (WCPC), Crame, and now detailed at the Philippine National Police (PNP) Baguio, revealed that WCPC Crame has no referral system for HIV. Within the PNP, it has no protocol, guideline or budget on HIV and sexual abuse. For example, he said the PNP has no protocol on how to prevent HIV transmission related to sexual abuse and no guidelines on the provision of PEP.[175]

Dr. Leal added that there are HIV materials for police and that the PNP has a resource book on HIV, but it has low dissemination. He said that there is no referral system on HIV because awareness of HIV transmission from a perpetrator of sexual abuse is low and there is no training related to this. The crime lab trainings focus on documentation, DNA, and STI but not on HIV.[176] He stressed that the medico-legal officers must follow a guideline/protocol and must be educated on HIV and PEP provision. He noted that viral tracking of HIV can be done with DNA examination.[177]

He said that the PNP has no available HIV testing and has no budget for it. WCPC has funds only for transportation and follow-up of patients. Most WCPC patients are poor and cannot even afford to pay for their transportation costs to and from their clinic. The decision to allocate the budget would have to come from the PNP head.[178] Moreover, the PNP has no desk/office that addresses sexual abuse of gays, bisexual men and transgenders.[179]

As far as Dr. Leal knows, at one public hospital, the referral system for HIV VCT for sexual abuse victims is not part of the protocol.[180]

b. Other Providers

Based on the responses of the participants, it seems many NGO and government service providers are unaware that PEP can be used as a standard procedure to prevent HIV transmission to rape victims. One NGO said information and access to PEP is a matter that needs to be addressed.

Cebu City has no PEP for rape victims but only for health personnel who accidentally pricked themselves.[181]

In a brief interview with a researcher of the UP PGH Women's Desk, she said women victims of rape can avail of PEP referral from the PGH obstetric-gynaecologic department. Because the interview was conducted only on August 28, 2010, this information needs to be verified directly with their obstetric-gynaecologic department.

C. ABUSE

1. Abuse of Children and Young People

A peer educator for young people said that their group has a women's desk and that the Sangguniang Kabataan has trainings on counselling regarding abuse of children.[182]

An adolescent female officer of a youth organisation said they attended discussions on sexual abuse given by an NGO catering to young people and that they learnt about going to the police to have the incident recorded in the police blotter and about having a medical examination to prosecute the perpetrator. (Note: There is confusion amongst service providers and beneficiaries on proper criminal prosecution. The proper initiation of criminal prosecution is to file a criminal complaint with the police and not merely have the incident recorded in the blotter. An alternative is to file the criminal complaint directly with the Public Prosecutor's Office). She added they learnt that an act is considered sexual abuse if they are being forced to have sex. She shared that she experienced abuse from her first boyfriend, but she was unaware then of groups supporting women victims of sexual abuse, so she did not file a complaint.[183]

Tambayan, an NGO catering to out-of-school youth, teaches children to be careful with whom they go and not to engage in sex just for the money.

2. Separate Services for Victims

VSMMC has a 'Pink Room' where women and women victims of violence are referred for counselling. Transgender and bisexuals can also access this Pink Room.

C. TREATMENT, CARE AND SUPPORT

1. Treatment of STI/RTI and Emergency Contraception

A researcher of the UP PGH Women's Desk says that although they have an agreement with the obstetrics-gynaecology residents to provide EC, some doctors inform rape victims about this option only if they ask about it and cite their religious belief as an excuse for not giving the proper information or for failing to make the proper referral for EC.

One public hospital treats STIs of rape victims, but the hospital has no policy requiring the doctors to provide counselling and supplies for EC.

2. Integration of Reproductive Health Services

The NGOs expressed the need to integrate reproductive health services (pap smear, check-up, antiretroviral drugs or ARV) in a treatment hub instead of sending patients back and forth to hospitals.[184]

3. PMTCT

a. VSMMC

PLHIV support groups cited the case of one doctor assigned to the HIV/AIDS Core Team (HACT) who had to call the OB for every PMTCT case. At the time of the FGD, the doctor had not yet told the obstetrician-gynaecologist that the pregnant woman whom she referred was HIV-positive.[185]

To respond to the PMTCT concerns of HIV-positive women, the hospital held a workshop recently to discuss the handling of HIV-positive pregnancies and PMTCT. The workshop was attended by paediatricians, obstetrician-gynaecologists and key personnel of the hospital. Family planning concerns were also integrated during counselling.

b. Others

Although some Babae Plus members have undergone training on PMTCT, at the time of the FGDs, some of its members still cited the need to have trainings on PMTCT.[186]

One NGO occasionally holds trainings on PMTCT, but some long-time active members of a PLHIV support group still expressed the need for intensive capacity building training on PMTCT, including possible HIV transmission through breastfeeding.[187] Also, at the time of the FGD, some PLHIVs from one PLHIV support group said they had not undergone any training on PMTCT.

Some OFW peer educators admitted during the FGD they were unaware of PMTCT.[188]

4. Shelter

Positive Action Foundation of the Philippines, Inc. has a shelter for PLHIVs, but this is only for MSMs.[189]

5. Affected Families of PLHIVs

Babae Plus had an exemplary project with UNICEF wherein they used storytelling to raise the awareness of children on the HIV status of parents.[190]

6. Referral for Safe Abortion

Talikala said they advise girls not to use abortion as a family planning method. Whilst they recognise that a woman has a right to opt for safe abortion, they still discourage their beneficiaries from undergoing such procedure. Instead, they stress that pregnancy can be prevented and inform the women on how to control their fertility.

The healthcare providers of Brokenshire conduct counselling for their beneficiaries only on family planning methods and not on safe abortion.

ALAGAD holds sessions with women PLHIVs to discuss their options if they get pregnant, including safe abortion.

D. DISCLOSURE

1. Disclosure to Partners of STI and HIV-Positive Status

In most cases, girls/women in prostitution are afraid of disclosing to their partners that they have STIs. They prefer that other people help them discuss it with their partners. In cases like these, Talikala organises counselling sessions for their partners.

Once Tambayan confirms that a girl got infected with STI, they ask the girl to identify her current partner and from whom they think they got the infection. Then a staff requests the latest partner or the current partner to undergo tests.

A government health centre catering to WIPs has difficulty encouraging PLHIVs to disclose their positive status to their partners because some individuals just come to have themselves tested, but do not return to get the results. They do not even leave their contact numbers.

An NGO catering to PLHIVs encourages disclosure, but if their beneficiary is not yet ready to divulge his/her status to the partner, then they opt for prevention. They strongly encourage consistent condom use and remind the PLHIVs of their obligation to tell their partner. This NGO had a case where they encouraged an HIV-positive man to invite his wife for VCT. However, he made excuses not to have his wife tested. They even have a case where the husband died of AIDS without his wife knowing he had AIDS.[191]

2. Right of Children PLHIVs to Know their Positive Status

Babae Plus developed a training module for its members on HIV in the context of the Convention on the Rights of the Child. Potential ways of disclosing their children's positive status was facilitated at the sessions. Some mothers were afraid that the disclosure would stress the child and affect their schooling. Some members have already disclosed their children's status; still others who have not yet done so because they themselves have not yet told their status to their partners.

E. SPECIFIC GROUPS

1. Prevention Interventions amongst MSMs and Transgenders

a. Condom Use and Behaviour Change

A member of a national organisation of PLHIVs observed that the workshops he attended in Manila seldom stressed that MSMs have a choice to insist on using condoms and to just look for another partner should the potential partner refuse.

Participants of the Cebu FGD of MSMs observed that the specific needs of MSMs in relation to gender are not addressed, saying that adult MSMs, young MSMs and transgenders have different needs. Questions were raised on how to educate MSMs, whether it should be age-specific or talk about change of behaviour and having exclusive partners.

b. Need for HIV Education Tailored to MSMs and Transgenders

One NGO catering to MSMs organises HIV 101 training for MSMs, but the input is general and not specifically geared for MSMs. They also use their general module on peer educators for the MSM peer educators. Iwag expressed the need to tailor-fit the training for young and adult MSMs.

c. Outreach for 'Out' Gays and Transgenders, and Fear of Discrimination Based on Sexual Orientation

One NGO caters only to gays and transgenders who are 'out of the closet'. They reached out to closeted gays and bisexuals in the past, but they experienced difficulty because of the closeted gays' and bisexuals' demanded to maintain confidentiality, and many of them were not open to linking with them. Many closeted gays and bisexuals do not even want to be associated with this NGO in public because of fear of being identified as gay. The NGO eventually stopped reaching out to closeted gays and bisexuals. The outreach programmes of this NGO do not cover some closeted gays and bisexuals although they practice risky sexual behaviour. (Note: Here is where the outreach for the general population would be important.)[192] This NGO added they have no specific programme for transgenders.

In the NCR regional consultation, NGOs and service providers revealed their lack of awareness on gender identity issues and rights.[193]

d. Sexual Abuse and Abuse between Intimate LGBT Partners

An effective referral system on issues related to sexual abuse/abuse between LGBTs seems to be lacking.[194]

e. Lack of Recognition of Bisexuality

Some MSM participants who provide services to PLHIVs fail to recognise the bisexuality of some MSMs, thereby failing to address the risk of HIV transmission from male bisexuals to their female partners.[195]

f. Lack of Access to Lubricants and Small-Sized Condoms

MSMs, transgenders and bisexuals in Cebu complained of pain when a condom is inserted because it is dry. They raised the need for lubricants and thought it would be good if the government started distributing lubricated condoms. Some of them also complained that condom sizes in the Philippines are often too large.[196]

2. Prevention Interventions amongst Children and Young People

a. The DepEd in Cebu has a pilot project with UNICEF called Power of Youth that includes HIV education for Cebu City students.

b. The youth peer educators said pictures of STIs including gonorrhea are effective in raising awareness on STIs.[197]

c. Kaugmaon ensures that young people understand that men and women have equal rights and responsibilities when it comes to their actions and behaviour, especially in engaging in sex and getting pregnant.

d. One organisation catering to young people raises awareness of STI, HIV and AIDS. They discuss the consequences of engaging in early sex and risky sexual behaviour. They teach the different STIs, show pictures of STIs and give information on treatment. They also teach the children not to engage in sex just for money. But their peer educators sometimes find it hard to share information because some participants are not open to talking about sex.

e. Tambayan has rules for their girl-children beneficiaries infected with STI. On the first infection, the staff takes care of the fare, check-up and medication. On the second and third infections, the girl-child is responsible for the expenses incurred and will have to undergo counselling. (Note: It is suggested that counselling be done after the first infection.)

f. The Tambayan peer educators said that *budats* [198] are increasing in their communities, and other children are learning about sex from the budats. To address this, they teach children to be careful, they hold community outreach activities, they incorporate theatre arts in information sharing, and they assign peer educators in the communities.

g. A peer educator in a social hygiene clinic said they use 'character formation' instead of 'condoms'. When raising awareness amongst church groups, some organisations use 'correct choice' instead of 'condoms'.[199]

h. In the FGDs, many newly infected PLHIVs said they did not learn about HIV transmission and prevention in school.

3. People in Prostitution and Their Clients

a. Women in Prostitution

Talikala educates women in prostitution about HIV and AIDS through drama.

Some peer educators working with WIPs cum PWIDs in Barangay Kamagayan distribute condoms and advise them to inform their customers ahead of time that condoms will be used.

Certain bars also give out condoms.

Through training, a woman in prostitution in Cebu learnt that if she did not like a customer, she could make an excuse by saying "I'm busy" or "I have to go early".

i. Discrimination against Women in Prostitution

Babae Plus has been addressing the issue of discrimination against WIPs amongst their members. They have been able to lessen discrimination, but they have new members who still discriminate against WIPs.

ii. Empowerment

Talikala delivers trainings on human rights to empower women and children. Two Talikala beneficiaries who participated in the FGDs were able to leave prostitution successfully when Talikala employed them.

b. Cebu City Health Office

CHO Cebu conducts weekly hygiene check-ups for all establishment-based people in prostitution as a requirement for the health cards of adults. CHO Cebu does not issue health cards to minors. They also organise outreach clinic twice a month for freelance PIPs, regardless of age. They accept walk-in check-up regardless of age, sex and gender. Provider-initiated HIV testing and counselling is offered to all PIPs who are female, male or LGBT. They also distribute condoms in the bars.

c. Clients of People in Prostitution

In the FGDs, no particular service provider mentioned that they specifically target PIP clients.

4. PWIDs

a. Zamboanga Experience

Zamboanga harbours a success story of community-NGO collaborative intervention wherein they established a shelter or space in a barangay where PWIDs can bond and attend awareness-raising and behavioural change workshops. The shelter was established with the express knowledge and approval of the barangay. The shelter has strict rules against drugs, gambling, smoking, drinking, stealing and lying. The PWIDs can play games like darts or chess, and musical instruments such as the guitar. Under a programme, the PWIDs – some of them females in prostitution or OSY – can go to the beach for training and undergo counselling. They attend daily lectures on STI and HIV. Parts of the body, including sexual organs, are taught using clay. The initiative also has separate counselling programmes for the families of PWIDs and joint counselling programmes for the PWIDs, their families and friends where they discuss relational and communication issues. Needles are not distributed, but the participants are taught how to clean needles.[200] The male PWIDs in the shelter were 12 to 20 years old, whilst the women were in their 20s.[201]

An NGO's members accompany PWIDs to the City Health Office for their check-up, especially since the latter have no money for transportation.[202]

An NGO tried referring children PWIDs to the City Social Welfare and Development office, but the children would secretly leave the office premises. The children preferred to stay at the NGO's premises, where they were free to roam, leave whenever they wanted, and just play and learn at the same time.[203]

As a result of the project, the number of STIs went down. The PWIDs' outlook and behaviour began to transform. Some PWIDs who did not usually bathe started bathing. Concerned about the PWIDs' intent to change, the community began monitoring their progress. To contribute to the their desire to change, the barangay started hiring some PWIDs as tanod (community

guards). Some WIPs eventually left prostitution and opened small businesses. Others found work abroad. The PWIDs used to number 134, but now they are few.[204]

b. PWID Experiences as Peer Educators

The PWID peer educators in Cebu said that if they have an ongoing project, they visit their beneficiaries every day, especially if they will be distributing IEC materials and giveaways such as caps and handkerchiefs with messages on prevention. The messages in these giveaways include (1) Stop or avoid using drugs; (2) If you use drugs, do not inject; (3) If you inject, do not share needles and syringes; and (4) If you share, make sure you clean the needles and syringes with Clorox or bleach.

F. OTHER CONCERNS

1. Greater Involvement of Persons with AIDS and Meaning Involvement of Persons with AIDS

a. ALAGAD Mindanao helped form the Mindanao Advocates, an organisation with PLHIVs as members. Mindanao Advocates is not a member of the local AIDS council yet. It has three PLHIV volunteers. ALAGAD encourages its members to implement Greater Involvement of Persons with AIDS (GIPA) and Meaning Involvement of Persons with AIDS (MIPA).

b. At the time of the FGD, a PLHIV support group was drafting a resolution for GIPA and MIPA to be recommended for implementation throughout the Philippines. The PLHIV organisations in the provinces felt they were not represented in national PLHIV organisations. In Cebu, the participants had different issues such as the existence of many PWIDs.

c. The members of one PLHIV support group said holding gatherings is difficult because they have no funding. They explained that gatherings are a therapy for them since they are able to help younger/newly infected PLHIVs.

d. The country coordinating mechanism ensures broad representation of stakeholders, thereby making its endorsement of proposals to the Global Fund to Fight Aids, Tuberculosis and Malaria representative of stakeholders throughout the country. Increasing the participation of civil society organisations is being done through fora organised by the PNAC, civil society organisations' implementation of various HIV projects, their inclusion in the AMTP Operational Plan development and their coalition that monitors the country coordinating mechanism.

2. Discrimination and Lack of Awareness of Protection under RA 8504

An effective referral system seems to be lacking when addressing complaints against the stigma towards PLHIVs.[205]

3. City Health Office

For monitoring, the Cebu and Davao CHOs collect sex-disaggregated data and use the data for planning and designing programme activities and logistic requirements (ex. IEC materials, training, facilities). CHO Cebu said no focal person is in charge of ensuring the gender and age responsiveness of their services and programmes.

4. General Concerns on Treatment, Care and Support

Members of PLHIV organisations expressed their difficulty in not having a CD4 counting machine in Cebu and in the delay in the release of confirmatory results and in receiving ART.

G. SUMMARY OF RESPONSES

The findings of the assessment with regard to prevention programmes, interventions and activities show the need to make these programmes more gender- and age-responsive. Some NGOs train their staff and project partners on gender. But after they were probed on how gender is applied in their project implementation, it would appear that gender needs to be mainstreamed in all aspects of these programmes. Projects being implemented by some NGOs incorporate age-responsive activities like training on child rights and set interventions that recognise the developing capacities of young people.

1. Prevention

a. Training

A number of NGOs are undertaking gender trainings and age-responsive trainings for their staff and constituents. Most often, however, gender is incorporated as one of the topics in other training activities. In-depth examination of how gender, gender stereotyping, gender roles/ constructs, gender violence and how these affect HIV and AIDS transmission and prevention, are hardly discussed. Most FGD participants coming from the vulnerable groups could not remember any gender training that they had attended when prompted.

The HIV 101 training is given to all partners, beneficiaries, clients, and target groups of HIV intervention. The training includes basic information on HIV and AIDS, and modes of transmission and ways to prevent transmission of HIV. Training on proper condom use is also part of HIV 101 given to all those involved in HIV work. But negotiation skills for condom use and capacity building for empowerment are generally not part of this training.

Generally, WIPs, MSMs, bisexuals and transgenders were not given training to empower them to negotiate for condom use. Skills training and re-integration activities such as education/ alternative learning systems and livelihood support programmes were operational on a very limited scale.

The gender aspects of condom use were not considered and taught. Female condoms are not commonly available and distributed in the Philippines. Some NGOs do teach their use, but are concerned about their cost and availability. Although female condoms promote control of HIV transmission by women, lack of knowledge on how to use them is widespread.

NGOs working with children and adolescents have conducted age-related trainings (i.e., rights of the child, child protection and laws to protect minors, etc.). Ways and steps to be considered when working with children (like the inclusion of the CWC in the PNAC strategic planning activities) are being introduced in the HIV and AIDS interventions, especially because of the recent trend of HIV infections occurring amongst younger persons.

b. IEC/BCC

According to all the FGD groups, specific gender- and age-responsive IEC and BCC materials are lacking. Although some organisations have IEC/BCC, there is concern with regard to the reach and effectiveness of their programmes. The effectiveness of such programmes depends on the methodology used, programme consistency, and monitoring and evaluation of actual behaviour changes.

IEC materials on condom use and other HIV concerns are widely available, but most of these materials are not tailored to specific vulnerable groups like women, MSMs/bisexuals/ transgenders and youth.

c. Peer Educators

Most of the peer educators' trainings and outreach activities have not included gender-related concerns and age-sensitive activities. Except for the peer educators working with one NGO in Cebu where the rights of adolescents and children are intrinsic to how they implement their projects, this has not been seen in other NGOs. Even government interventions have not incorporated gender aspects into the peer educators' programme.

d. Voluntary Counselling and Testing

Many issues concerning implementation, privacy and effectiveness surround VCT. Gender-sensitive and age-appropriate protocols have not been established. Moreover, counselling given to all who undergo VCT is usually 'generic'. The question of access – both in terms of physical (i.e., location, distance) and socio-cultural (i.e., stigma and discrimination, fear of disclosure) aspects – is one of the issues confronting those who undergo VCT. Furthermore, there is a delay in the release of confirmatory results. For HIV testing that is required or part of a routine practice (ex. for overseas employment), service providers are not equipped to handle persons diagnosed as HIV-positive. Privacy is also a matter of high concern since privacy is not respected when a positive reading/result is seen. Health service providers themselves do not observe confidentiality and privacy when dealing with HIV cases. The need for a CD4 counting machine in Cebu was also raised.

2. Treatment, Care and Support

Various issues abound regarding treatment, care and support interventions. However, most of these issues are related to medical needs and services like delayed delivery or non-delivery of ARVs. Some NGOs also expressed the need to integrate reproductive health services (ex. pap smear, check-up, etc.) in the treatment hubs instead of sending patients back and forth to different health facilities.

Gender- and age-responsive aspects of the treatment, care and support services have been emphasised amongst the members of Babae Plus, the positive women network in the country, through training sessions and workshops and with the assistance of donors and government agencies. Awareness in terms of rights, advocacy to fight stigma and discrimination, and providing support to make lifestyle changes are some of the ways in which these trainings are being translated into action.

Additional training on gender was cited as necessary amongst MSMs and other PLHIVs, and on sexual orientation and gender identity amongst NGOs.

3. Programme Management and Policy Support

The KIIs with national stakeholders and programme managers have shown that the extent of gender- and age-responsive programmes and interventions at the national level was much less than desirable. The AMTP IV lacks specific provisions on how to integrate gender or age concerns into the planning and implementation of interventions. Dr. Ferchito Avelino of the PNAC Secretariat recognises that RA 8504 is gender-blind and, as such, marginalises women and girls, and does not take into account the unique behavioural differences of groups like the MSMs/bisexuals/transgenders.

HIV prevention programmes like IEC materials are not tailored for specific vulnerable populations, and gender or age distinctions are hardly considered. Age-appropriate information also seems to be lacking. Specific materials for MSMs/bisexuals/transgenders are just being developed, and there is concern if these materials are appropriate for the whole MSM population (including transgenders/transsexuals).

Other aspects of the HIV Prevention Programme like condom use training and negotiation and peer education, have no guidelines on implementation amongst minors or those below age 15 despite STI cases in this age group. Gender violence is also not integrated or seen as an area of concern for the HIV programme.

In terms of monitoring and evaluation, the NEC, in collaboration with the CWC-HIV Committee and UNICEF, has taken steps to revise the Surveillance and Registry data to reflect realities on the ground and to capture behavioural issues related to age and gender. For example, in the IHBSS conducted in 2009, the sample included age grouping of 15- to 17-year-olds because of the realisation that new HIV cases are coming from a younger age group. There was also a conscious effort to seek out women/girl PWIDs although most of the known PWIDs are men. The PWID sample now has 10-15 per cent female representation. The IHBSS sample includes 55-65 per cent 15- to 24-year-olds; in this age group, 6-21 per cent are 15 to 17 years old.[206]

On information on gender relations and vulnerability, the NEC asserted that although there are no specific indicators on these, some questions in the IHBSS cover these concerns. Examples: Who negotiates condom use, the woman or the man? Amongst MSMs, is it you or your partner who negotiates for condom use? Previously, the IHBSS asked only for the civil status; this time 'living with a partner' was added. According to the NEC, the agency "recognises that there are gender- and age-related issues that are very specific. But we might not be ready to take all of them on at the same time. The things that won't rock the boat so much, we can do something about, one at a time. In other countries, they usually have specific programmes for minors".

Some research has been conducted amongst women OFWs and wives of seafarers, but the results of these studies are not easily accessible. However, the PNAC is taking steps to make all the relevant research on HIV and AIDS available.

Age-responsive programmes are just being started with coordination amongst the NEC, NASPCP, PNAC and CWC. Protocols and training on how to handle children are being undertaken. The DOH paediatric HIV management guidelines were finalised and disseminated in 2009, building on the work by Crossing Borders as early as 2006.

In summary, Dr. Avelino gave this comment on issues of gender and age in HIV and AIDS:

> *"Wala pang ginawang* gender na particular to HIV and AIDS. Walang gender person sa PNAC. I've been asking around on who can help PNAC with the gender issue. Iyung problema, iyung mga tao, masyadong babae. Ang mahirap sa amin, 'di lang kami women. X x x [G]rupo ng straight, ng bakla, ng women, ng matanda, ng bata. Closeted and the open. There's a consciousness of gender issues, but as for operationalising, we're just starting. (Nothing has been done on gender in relation to HIV and AIDS. We do not have a gender person in PNAC. I've been asking around on who can help PNAC with the gender issue. The problem is, the people [who are gender experts] look only at women's issues. The difficulty with us is that we are not only women. We have x x x, the straight and the gays, the women, the old persons, the children, the closeted and open. There's a consciousness of gender issues, but as for operationalising, we're just starting.)"

VIII. ANALYSIS OF GENDER AND AGE RESPONSIVENESS

A. PROGRAMME AREAS

NGOs lack gender- and age-responsive programmes, and many representatives from NGOs acknowledged this. Amongst the organisations and service providers involved with HIV and AIDS, the question that came up most often was how to operationalise and integrate gender- and age-specific responses in the activities being undertaken. Some even commented that the FGD questionnaires would be useful in making their programmes more gender- and age-responsive. The process itself of going through the FGDs and regional consultations was important in their reflection, analysis and assessment of the gender- and age-responsiveness of their programmes.

To have an effective response to HIV, not only is education needed on STI/HIV, fertility management and other SRHR concerns; addressing the push factors is likewise needed as a means of prevention. This is where the collaborators should examine how providers can work towards an interdisciplinary and holistic approach in preventing HIV transmission and giving VCT, care, support and treatment by considering gender and age issues and concerns.

Interventions are needed to eliminate risky sexual behaviour, promote safe sex, reduce vulnerability to HIV transmission, eliminate violence and discrimination based on gender/sexual orientation/gender identity/age, and empower women, men, children, young people and LGBTs.

In the context of sexual abuse, women, children, young people and LGBTs are particularly vulnerable since many abusers specifically target them. In addition, if these women, children, young people and LGBTs are poor or out in the streets without any means to support themselves, they become easy prey to people who take advantage of their situation.

1. Prevention

a. IEC/BCC

i. Rights-Based Approach

Prevention and treatment, care and support programmes should integrate a rights-based approach where the full range of rights such as gender and children's rights, reproductive health rights, HIV, right against intimate partner abuse, right against sexual abuse, legal remedies, non-discrimination and equality based on gender and age including sexual orientation and gender identity, are discussed. Modules must be standardised to cover these topics and cater to the different gender and age concerns of particular groups. Sharing of resources would be important.

During the national consultation, a participant suggested having continuous 'market' research on who the clients are and how to best respond to them, and doing regular in-house monitoring of interventions to ensure the gender- and age-responsiveness of programmes.[207]

Equality and Non-Discrimination

In dealing with gender and age concerns, issues need to be addressed regarding equality and non-discrimination based on one's gender, sexual orientation, gender identity and age. Interventions must be made to prevent discrimination and to work towards equality based on one's gender, sexual orientation, gender identity, and age.

Behavioural change and interventions that empower women, girls, men, boys, MSMs, bisexuals and transgenders are important in achieving true equality and non-discrimination based on gender and age.

ii. Gender and Age Aspects of Risky Sexual Behaviour

Whilst many people engage in risky behaviour because of their choice, others are coerced, forced or intimidated to have sex because of pressure from older people and male gang members, or they were victims of physical sexual abuse. Others enter prostitution for various reasons including early pregnancy, running away from home, being thrown out of the home by parents, or dire economic circumstances. Still others unknowingly engage in risky sexual behaviour for the simple reason that they are not practising safe sex with their partners, not knowing that their partners engage in unprotected sex with other people. Thus, messages on vulnerability to HIV should also include falling in love, entering relationships, or getting married.[208]

Factors such as gender relations, young age of a person, failure to negotiate safe sex, sexual orientation, gender identity, sexual abuse, early sex, early pregnancy, prostitution and non-disclosure of HIV status to one's partner compound one's vulnerability to HIV. The HIV interventions, therefore, must consider these issues at different levels: personal, family, school, community, and policy and programmatic levels.

Based on the accounts of the FGD participants, many MSMs, male bisexuals and transgenders engage in risky sexual behaviour that can involve multiple sex partners and

numerous sexual encounters without practising safe sex. Messages to change risky sexual behaviour should consider the context of the sexual practices of MSMs, bisexuals and transgenders, both young and old.

iii. Fertility Management, Early Sex and Early Pregnancy, and Condom Use

In terms of standards in administering comprehensive sexual and reproductive health services, it would appear from the FGDs that many service providers do not offer standard comprehensive SRHR information, supplies and services.

- **Full Range of Contraceptive Methods**

  Many organisations do not offer standard information regarding the full range of modern contraceptive methods such as permanent methods like vasectomy and ligation. Another example is EC, which is seldom discussed by service providers as a means to prevent unintended and unwanted pregnancies resulting from unprotected sex, failed contraceptives and rape cases.

- **Risks of Early Sex and Early Pregnancy**

  When discussing messages on avoiding early sex, risks of early sex and risks of having multiple sex partners, many service providers fail to include the correlation of cervical cancer to early and unprotected sex and multiple sex partners, and the correlation of maternal mortality and morbidity to early pregnancies and childbirth. Information on the vaccine for certain types of human papilloma virus to prevent cervical cancer should also be included in the messages.

- **Condom Use**

  Most NGO and government service providers stress the importance of consistent condom use. Nonetheless, the compliance by their beneficiaries and even by PLHIVs is not consistent, especially when the sexual partner is their loved one or somebody to whom they are attracted. Messages should say that loving and caring for one's sexual partner includes not getting oneself or the other person infected, and that everybody has a responsibility to address public health concerns such as STIs, RTIs and HIV.

  Service providers should advocate for 100 per cent and consistent condom use regardless of whether sex is with a loved one. With this standard, more and more people will use condoms and demand condom use. Informing a sexual partner or potential sexual partner that condoms will be used every time they have sex should also be a practice.

  When women demand that their male partners use condoms but the male partners insist on having sex without condom, this is a clear example of lack of respect for women's rights. Messages should include respect for women's rights and being empowered to say no to sex under circumstances that one does not want.

- **Female Condom**

  Access to information on and supplies of female condoms must be addressed to increase women's empowerment in using condoms for protection and fertility management.

- **Re-infection**

  PLHIVs engaging in unprotected sex with other PLHIVs are at risk of re-infection with another strain of HIV, thus the importance of raising awareness on condom use. However, gender relations and the young age of a PLHIV have an impact on one's power to negotiate condom use.

iv. Sex Education

The ineffective implementation of the HIV law in providing HIV education in schools, communities and workplaces, and the lack of ARH/sex education have had a significant impact on the inadequate knowledge of MSMs, PWIDs, PIPs and the general population, most especially children and young people, on HIV transmission, HIV prevention, risky sex, risky behaviour and safe sex, amongst others.

v. HIV Education

HIV education must target the widest possible audience to reach as many people as possible. The requirement under RA 8504 to teach HIV education to OFWs and in all schools, workplaces and communities must be fully implemented.

The integration of gender and age in HIV orientation modules must be developed further. Such modules must be continually monitored and evaluated for gender- and age-responsiveness.

vi. Justification of Unfaithfulness

In the FGDs, the participants cited that many men justify their unfaithfulness to their wives and partners.[209] Justification for unfaithfulness is a manifestation of gender relations: men make excuses that having increased libido is in their nature, thus having multiple sexual partners is natural for them, even if they are in a committed relationship. Many women tend to merely accept their husband or male partner's unfaithfulness. Messages must state that women should not tolerate this behaviour and that men, women, MSMs and transgenders must all be faithful to their partners.

Efforts must be channelled towards changing discriminatory practices that tolerate men's having extramarital relationships or multiple partners even when they are in a relationship.

vii. Religion

Interventions must consider that cultural and religious practices discriminating against gender and age must be eliminated. Progressive laws and policies in predominantly Catholic countries and predominantly Muslim countries must be incorporated into the modules to eliminate discriminatory cultural and religious practices that have an impact on gender and age.[210]

With regard to family planning, Muslim religious leaders in the Philippines have issued a Fatwah respecting the right to access family planning information and services. Discussing this Fatwah and progressive interpretations of the Quran on gender and age would be useful in organising trainings and outreach programmes.

viii. Disproportionate Impact of Gender on Employment Opportunities

Lack of available jobs, job segregation, and unequal pay for work of equal value affect women and LGBTs disproportionately because of prevailing discrimination against women as a gender and against LGBTs. Therefore, addressing discrimination against women and LGBTs, including job discrimination, is important.

ix. Target Population

Prevention programmes must target MARPs, MARYPs, vulnerable groups and the general public, and must be done in an institution-based setting such as a school, workplace or community.

Data from 2006 showed that infections through unprotected sex were passed through heterosexual (55 per cent), homosexual (29 per cent) and bisexual contact (15 per cent). From 2007 to 2009, infections through unprotected sex were passed through homosexual (41 per cent),[211] heterosexual (32 per cent), and bisexual (28 per cent) contact.[212] In 2009, infections through sexual contact were 42 per cent from homosexual contact, 31 per cent from bisexual contact, and 27 per cent from heterosexual contact.[213] The data show that many new infections are from homosexual contact and that the combined heterosexual and bisexual infections are higher than purely homosexual contact, thus stressing the importance of targeting MARPs (including MSMs, bisexuals and transgenders), MARYPs, vulnerable groups and the general population, including those who consider themselves heterosexual, and practising MSMs and bisexuals who do not consider themselves under MSMs or bisexuals.

Media must also be used to the full extent because of its recognised reach.

b. Peer Education

A recommendation at the national consultation is for peer education to consider the age, sex and gender [214] of the beneficiaries.

c. VCT

The intervention of some NGOs seems to depend on the questions asked by the counsellors and the clients' responses, whilst other NGOs/service providers lack an effective system of assessing risk factors and giving appropriate counselling for such risk factors. A recommendation is that the AO on VCT be implemented effectively and that NGOs/service providers with protocols/guidelines on assessment of risks and pertinent counselling share their skills/materials/resources to other NGOs/service providers/support groups.

With regard to access to VCT, gender and age should both be considered along with equality and non-discrimination based on gender and age. Counsellors must be gender- and age-sensitive when doing counselling.

The VCT must be child-friendly.[216] To ensure that a minor gets the results even without the help of the parents, RA 8504 should expressly state that the results could be released to the person who submitted himself/herself to the test, whether such person is an adult or a minor.

Multiple Burdens and Delay in Health-Seeking Behaviour of Women

The multiple burdens of women such as working, taking care of children and doing household chores, create an impact on their full participation in trainings for PLHIVs, as observed by Babae Plus.[217] The women's recognised delay in health-seeking behaviour makes them less visible at the VCTs, as noted by participants in the NCR VCTs.[218] The situation is different for WIPs actively seeking VCT at the CHOs, for example in Cebu and Davao, because of the requirement to have their health cards renewed every month.

Service providers should discuss the usual problem of women's health-seeking behaviour— that they tend to the health of their family members but not their own[219] — to enlighten women about the risks to their health when they delay medical attention and the possible impact of this to their family as well.

d. Abuse

i. Intimate Partner Abuse and Sexual Abuse

Efforts should be done towards zero tolerance of intimate partner abuse and sexual abuse. Abusive partners and sexual abusers must also be investigated and prosecuted effectively. To achieve this, service providers and beneficiaries need to be capacitated on proper criminal prosecution of intimate partner abuse and sexual abuse.

ii. Lack of Effective Referral System on Intimate Partner Abuse and Sexual Abuse

Service providers working on HIV should set up an effective referral system on issues related to intimate partner abuse and sexual abuse such as medical and legal remedies and counselling.[220]

To address the sexual abuses and intimate partner abuses of MSMs, bisexuals and transgenders, there must be service providers catering to these issues and an effective referral system for such services. The PNP and other medico-legal centres should deliver the same service for sexual abuse of MSMs, bisexuals and transgenders.[221] A law providing legal recourse for intimate partner violence amongst MSMs, bisexuals and transgenders is also needed.[222]

iii. Protocol on STI/RTI, EC and PEP for Sexual Abuse Victims

Guidelines/protocols should be produced, covering the provision of medical services, including medico-legal services and other services such as antibiotics to address STIs/RTIs, emergency contraception to prevent unwanted pregnancies and PEP to prevent HIV transmission to rape victims. NGO and government service providers also need to be capacitated regarding the treatment of STIs/RTIs and making EC and PEP a standard procedure for rape victims, especially since many are still unaware of the use of EC and PEP.

The service providers in barangay VAWC desks, crisis centres, PNP women's desks, medico-legal clinics, crisis centres, HACT and other hospitals, gender focal persons at consulates, and PDOS providers should raise awareness of such protocol to be able to address properly the health impact of sexual abuse.

A budget needs to be set aside for HIV testing and PEP provision at medico-legal centres. Capacitating medico-legal officers in offering HIV testing and PEP is very crucial since the window to test for HIV and to start PEP is limited to only three days.

2. Treatment, Care and Support

With regard to access to care, support and treatment, gender and age must be considered along with equality and non-discrimination based on gender and age.[223] Child-friendly treatment and care should be provided.[224]

a. PMTCT

The AO on PMTCT should be disseminated widely, implemented by all service providers outlined in the AO and monitored regularly. The AO states that the HACT shall provide maternal services. The HACT should always include obstetrician-gynaecologists assigned to handle PMTCT cases. These team members must be trained to handle PMTCT cases and must continually train new team members on their protocols in handling PMTCT. In practice, some service providers do not give the full range of information and education needed, and they proceed with risk assessment.

Even with the AO on PMTCT, effective implementation seems to be lacking since the services still depend on who heads the HACT. The frequent turnover of staff in the HACT, hospitals and VCT providers also affects the proper implementation of the AO on PMTCT.

The AO on PMTCT should be amended to clearly state that a pregnant PLHIV should be referred immediately to the treatment hub to access PMTCT services and be assessed for ARV treatment eligibility. The AO on PMTCT should also be amended to clearly state that service providers should give access to information, supplies and services on the full range of effective temporary and permanent modern contraceptive methods. Pregnant PLHIVs should be given proper PMTCT care and not discriminated during pre-natal, delivery and post-natal care.

Intensive activities to raise awareness on PMTCT must be done in schools, workplaces, communities, hospitals and the organisations of service providers. PLHIV groups need to be continually capacitated on PMTCT and urged to echo PMTCT to their members.

b. Referral for Safe Abortion

Service providers should include counselling on safe abortion for women who expressed their desire to terminate unwanted pregnancies. Such information can save the lives of women since the latest annual statistics show that around 1,000 women die and 90,000 women are hospitalised (YEARLY?) due to complications from unsafe abortion. Access to safe abortion lessens maternal mortality and morbidity due to unsafe abortion.

3. **Disclosure**

a. Non-Disclosure to Partners

Some PLHIVs are sexually active and yet keep their HIV status from their partners or casual sex partners. They delay divulging crucial information about their status or fail to negotiate condom use at the time they engage in sex, citing fear of discrimination. The FGDs produced accounts of husbands dying of AIDS without disclosing their status to their wives and of women who became infected with HIV because their husbands or male partners did not divulge their status to them.

The problem of non-disclosure of one's positive status by men, women and LGBTs to their sexual and injecting partners must be addressed through counselling sessions where PLHIVs will be encouraged to confess their status to their partners. This can be facilitated by counsellors with special training on counselling related to HIV, gender, children's rights, intimate relationships and abuse in intimate relationships. Such counselling is meant to facilitate disclosure and acceptance of one's PLHIV status, and to prevent any form of abuse as a result of the disclosure.

Service providers and PLHIV groups should continually stress the obligation of PLHIVs not to infect others and to prevent MTCT. Emphasis must also be made that the ongoing problem of non-disclosure of male partners places the woman at risk of HIV transmission and increases risks of MTCT.

4. **Management and Policy**

a. Development, Strengthening and Integration of Programmes

Many service providers on gender, children's rights, intimate partner abuse, sexual abuse, LGBT rights, reproductive health, STI, HIV, ARH and legal remedies are doing commendable work in their respective fields. To address gender- and age-responsiveness related to HIV, all these groups must integrate their work and programmes, and actively ensure an effective network in a referral system. Certain service providers, for example on gender, children's rights, intimate partner abuse, sexual abuse, LGBT rights, reproductive health rights and legal remedies have information, expertise, experiences and data on their fields which can aid others working in the field of HIV. In the same manner, the information, expertise, experiences and data of service providers on HIV can help others working in other fields. With such sharing, gender- and age-responsive messages and programmes will be integrated in the work of all service providers.

B. GENDER AND AGE ISSUES PARTICULAR TO CERTAIN GROUPS

Responses to HIV must take into account the gender and age aspects that relate to MSMs, PWIDs, PIPs, other vulnerable people, the general public and their sexual and injecting drug partners.

1. **Interventions for Young People**

Interventions for children and young people should address the push factors leading to risky sexual behaviour and risky behaviour, elimination of discrimination based on age, and equality of children

and young people in access to information, supplies and services. Children and young people must be empowered to make decisions and actions based on informed choice.

Intensive intervention programmes should be conducted for children and young people since many newly infected PLHIVs come from the young population.

Intervention for children and youth should include parenting skills and opening communication lines amongst family members. Activities such as team building, group sharing, discussing family problems and setting an opportunity to iron out differences in the family are very helpful in encouraging children and young people to change.[225]

Sex education in schools, workplaces and communities should include gender and age concerns such as risks of early sex and early pregnancy; delaying sexual debut; eliminating the practice of throwing out children and young children from homes because of pregnancy or because of their sexual orientation and gender identity; factors why children run away from home; risks of being out-of-school; push factors in engaging in prostitution and risks of prostitution; vulnerability to STIs, RTIs, HIV and female cancers like cervical cancer, especially at a young age; and prevention and treatment of such infections and cancers.

Such education must be done before they become sexually active and especially once they are sexually active. The FGDs results show that some service providers do not teach condom use to children. Many studies have proven that informing children and young people about reproductive health and fertility methods lessened the number of children and young adults engaging in risky sexual behaviour. Thus, it is age-appropriate to teach children about the full range of contraceptive methods.

Testimonials and sharing of experiences of peer educators are important in raising awareness and effecting behaviour change. Making full use of the media is also important in gender and age concerns related to HIV.

The following were the recommendations during the National Consultation.

a. Develop criteria to determine gender and age-responsive interventions [226]

b. Use data on children and youth[227]

c. Review existing HIV and AIDS IEC materials in relation to relevance, effectiveness and clarity of messages

d. Develop audience-specific trainings/modules.[228]

The National Consultation participants likewise raised the need to review the UNGASS 15-24 age category for young people, to possibly include 10- to14-year-olds since the onset of risky behaviour coincides with puberty[229] and to divide MARYPs according to their evolving capacities and needs.[230]

Awareness raising on STIs, RTIs, HIV, reproductive health and rights must be done amongst parents and the general public. Parents should accept their children if they are sexually active and not drive them out of the house because the child is sexually active or pregnant.

An important effort that could keep children from engaging in risky sexual behaviour and other risky behaviours such as drug use is keeping them in school and giving them financial and moral support.

If they are out-of-school, then encouraging them to take the Alternative Learning System of the DepEd or TESDA would help them get back on track in their education or hone some skill or trade. Policies and effective implementation of policies that would ensure children and OSY returned to school or learnt skills or trade would help in this endeavour.

2. MSMs, Bisexuals and Transgenders

Some MSMs and bisexuals are not out of the closet; thus, they are not members of gay groups. Reaching out to them is hard, especially if the outreach caters only to MARPs[231] and they do not identify themselves as gays or bisexuals. Thus, when targeting MSMs and bisexuals, targeting those who are out, those who are in the closet and their sexual and injecting drug partners is important. Targeting the general population is crucial as well, especially the youth, since many hardly even know how to determine their sexual orientation and gender identity.

Some service providers fail to recognise the bisexuality of some MSMs and fail to address the risk of HIV transmission from male bisexuals to their female partners. Service providers should address the risks of HIV infection through bisexual transmission.

In the case of MSMs, bisexuals and transgenders, working towards elimination of discrimination based on sexual orientation and gender identity is necessary. Since many service providers admitted their lack of awareness on gender identity issues and rights,[232] trainings to increase awareness of gender identity issues and rights should be conducted for these service providers.

a. Different Needs of MSMs, Bisexual and Transgenders

Participants in both the FGDs and the national consultation cited the need to subdivide MSMs and bisexual men according to their different needs and ages, and to identify specific needs and risks of the sub-groups to facilitate the preparation of tailor-made strategies/ interventions.[233]

Transgenders strongly suggest that they be separated from MSMs to take into account their specific needs.[234]

Age-appropriateness must also be considered for children and young people especially in light of the recent reports of new infections amongst the young population of MSMs.[235]

b. Extending Services of the Social Hygiene Clinic to MSMs

A recommendation from the national consultation was the expansion of service given by social hygiene clinics to cover MSMs.[236] CHO Cebu is noteworthy in that it extends the same service to MSMs that it gives to women. This would be a good standard for all CHOs.

c. Lack of Access to Lubricants and Small-Size Condoms

The lack of access to lubricants and small-size condoms could also be attributed to the lack of recognition of the needs of MSMs, bisexuals and transgenders by service providers, suppliers and funders.

3. PWIDs

Efforts must be done to totally eliminate PWIDs' desire to inject drugs by addressing their psychological and socioeconomic needs, and reaching out to them to make positive behaviour changes, apart from simply distributing condoms and teaching them not to share needles.

Physical and sexual abuses committed by PWIDs on their sexual partners happen in heterosexual and homosexual relationships, and should be addressed since the abuse makes the partner vulnerable to further abuses, including risks of HIV and STI infection.

4. People in Prostitution and Their Clients

The factors that push women and girl-children into prostitution include being young, being victims of sexual abuse, engaging in early sex, early pregnancy, having families who shun them because of their engagement in early sex or their early pregnancy, schools that dismiss them for being pregnant outside of wedlock, being obligated or feeling obligated as the eldest or second eldest in a large family to financially support younger siblings, and lack of adequately paying jobs for women and young women.

The factors that drive men and boys into prostitution include being young, being victims of sexual abuse, discrimination against sexual orientation and gender identity, being obligated or feeling obligated as the eldest or second eldest[237] in a large family to financially support younger siblings, and lack of sufficiently paying jobs for men and young men. All these factors compound one's vulnerability to HIV. Service providers must address these issues when conducting awareness-raising activities and prevention programmes.

a. Large Family Size and Prostitution

In activities related to prevention, service providers should address the direct correlation of having large families and poverty with prostitution.

b. Vulnerability to Abuse

Engaging in prostitution makes one vulnerable to abuses from clients or police. In prostitution, there exists a power relationship wherein the client holds economic power and gender subordination where male clients commit abuses on women, MSMs, bisexuals and transgenders.

c. Outreach and Sensitivity in Handling Cases

Outreach by service providers working with women/children/PIPs needs to be strengthened to reach more establishment- and non-establishment-based PIPs.[238]

d. Right against Intimate Partner Abuse

Raising the awareness of PIPs is also needed in terms of their rights against partner abuse and their medical and legal remedies including counselling, since many of them are in abusive relationships.

As aforementioned, organisations addressing intimate partner abuse and sexual abuse tend to be isolated from HIV service providers and vice versa. The services of service providers must be integrated and their referral system actively set in place.

e. Fertility Management

PIPs should be given access to information, supplies and services to control their fertility especially since some women in prostitution use abortion as a family planning method.

f. Children in Prostitution

Service providers must specifically include children in prostitution as their beneficiaries.[239]

g. Eliminating Demand for Prostitution, Empowering PIPs and Repeal of the Law on Vagrancy

The following aims must be addressed – (1) eliminating the demand for prostitution and airing the call to stop buying sex, and (2) empowering PIPs by educating them and building their skills.[240] Programmes to provide them with an Alternative Learning System, scholarship and employment would open opportunities for them. Counselling and peer groups would also be important in effecting positive behavioural changes.

The law on vagrancy must be repealed. The arrests and harassment of PIPs should be stopped. The Committee on Elimination of Discrimination against Women (CEDAW) recommended "educational and economic opportunities"[241] to give WIPs adequate options, "thereby reducing and eliminating their vulnerability to exploitation and traffickers"[242] and "reintegrating them into society and providing rehabilitation, social integration and economic empowerment programmes to women and girls who are victims of exploitation and trafficking".[243] CEDAW also urged the Philippines to "prosecute and punish traffickers and those who exploit the prostitution of women, and provide protection to victims of trafficking".[244]

With regard to training WIPs, the national consultation resulted in these recommendations: (1) build livelihood skills that would go beyond skills tying women to traditional roles,[245] and (2) educate them about laws on anti-child pornography, anti-trafficking and CEDAW, amongst others.[246] The participants also recommended that peer educators should not be pimps or floor managers because of the existing power relations between them and WIPs which can lead to abuses.[247]

h. Clients of People in Prostitution

Specific outreach and education programs must target the clients of PIPs and regular partners of PIPs.[248]

The fact that many Filipino male customers of WIPs do not want to use condoms can be explained by not only the lack of knowledge of HIV and of the importance of condom use in preventing transmission, but also by the prevailing machismo in Philippine society and the lack of regard for public health issues.

5. OFWs

The time allotted for PDOS is extremely limited. The time should be extended to allow for discussions on gender issues. NGOs conducting PDOS likewise recommended that education be conducted in communities, since many women applying to become domestic workers are hardly aware of reproductive health rights or hardly interested in the issue of HIV.[249]

The national consultation participants gave the following recommendations: (1) research the gender issues of different categories of migrant workers to make IEC materials appropriate; (2) train the PDOS and Pre-Employment Orientation Seminar facilitators on updates and new advocacies; and (3) update the network of referral services of different agencies.[250]

PDOS providers should also tackle sexual abuse and the medical and legal remedies for sexual abuse victims.

6. PLHIVs

It must be ensured that PLHIVs are not discriminated when they access information, supplies and services, including medical insurance, because of their HIV-positive status.

a. Testimonials

PLHIVs need to be capacitated and encouraged to give testimonials. Removing the stigma on HIV can be done partly through more talks from PLHIVs about their experiences. When one faces a PLHIV, then the problem of HIV becomes very real, and people become aware that any person can be at risk of contracting HIV for various reasons. As part of empowering PLHIVs, the decision to provide testimonials is always theirs, and testimonials should not be done without their prior expressed consent. This means that service providers must exercise open communication with the PLHIV concerned and respect their decision to give testimonials or not.

b. Lack of Employment Opportunities for PLHIVs

PLHIVs need skills training, education and livelihood assistance. Women PLHIV would already be at a disadvantage in finding employment because of discrimination against women as a gender, ex. lack of available jobs for women as a result of gender stereotyping and job segregation, and unequal pay for work of equal value.

c. Right of Children PLHIVs to Know Their Status

Service providers should stress the importance of children's right to know their PLHIV status and provide counselling for such disclosure and continued counselling as part of the standard care and support for children PLHIVs.

d. Affected Families of PLHIVs

Support programmes for affected families of PLHIVs must be continued.

e. Discrimination and Lack of Awareness of Protection under RA 8504

There is a need to raise awareness on HIV to eliminate discrimination against PLHIVs in all fields (school, community and workplace) and to build capacity regarding the acts of discrimination covered by RA 8504 and the kinds of complaints that can be filed (ex. violation of RA 8504, civil case for damages and administrative).[251]

C. SUMMARY

1. Gender-Responsiveness of HIV and AIDS Programmes

Gender reflects how behaviour, sexual or otherwise, is shaped and moulded, and how behaviour is influenced by interactions and interpersonal relationships with others. Gender considerations are essential factors in understanding HIV transmission, spread and prevention. Gender analysis

and gender mainstreaming then become crucial as HIV and AIDS projects are planned and implemented. Gender-related indicators are necessary for monitoring activities and evaluating programme and project effectiveness as part of the monitoring and evaluation system for HIV and AIDS.

Rapid scanning of the HIV and AIDS programmes, projects and activities in the Philippines shows that most interventions lack gender-responsiveness. Policies are silent about gender-based needs and differentiated roles of MARPs. Current gender-related activities are limited to a few training hours of introducing basic gender concepts (which are often not remembered by participants), a collection of sex-disaggregated data and sporadic or isolated efforts to consider the behavioural contexts of women, MSMs/bisexuals/transgenders and adolescents.

IEC materials in circulation are basically aimed at heterosexual relationships, but do not tackle the empowerment issues of women, MSMs, gays, bisexual males and transgender males to females. HIV IEC materials specifically designed for MSMs/bisexuals/transgenders and adolescents are lacking. The unique needs of women/girl PLHIVs hardly consider existing power relationships, gender roles and burdens.

Amongst MARPs, behavioural changes for safer sex practices were difficult to achieve even with sufficient or adequate knowledge about HIV prevention and transmission. For WIPs, consistent condom use is beyond their control, as customers are the decision-makers with regard to sex practices. For MSMs/bisexuals/transgenders, condom use is negotiable, but could be totally disregarded if the partner looks 'clean', good-looking or attractive to them. OFWs are also unable to negotiate safer sex when in a different country and placed in a difficult situation. PLHIVs feel that condom use is tantamount to disclosure of their HIV status.

All of these situations have underlying gender bases that need to be examined, analysed and understood in order to develop interventions that are appropriate and specific to the particular realities of each population grouping.

Since there is no mainstreaming of gender-based responses, NGOs and other organisations doing HIV and AIDS work are at different positions in the gender-responsiveness continuum – from those with no gender background or training to those that are immersed in gender and empowerment, and incorporate these concepts into various intervention activities.

The policy environment for HIV and AIDS needs improvement in being gender-responsive. RA 8504 and AMTP IV have no provisions for gender-based interventions. However, several plans seek to change this situation, as discussions are underway to incorporate gender into the interventions being planned for HIV and AIDS. At the moment, gender indicators are not part of the HIV and AIDS national monitoring and evaluation system, other than sex-disaggregated data. But the IHBSS continues to find better ways to capture gender-related data, especially behavioural information.

2. Age-Responsiveness of HIV and AIDS Programmes

In the past three years, new HIV cases have been increasing amongst young people, particularly males. The number of children of HIV-positive mothers has also risen. Appropriate responses to address young people's needs and concerns have occurred at a slower pace. Other than a few NGOs that have worked with children and adolescents through the years, other new players in

the area of adolescent sexuality and behaviour have very little prior preparation in dealing with the youth in relation to HIV. Child and youth rights are just now being recognised and applied in HIV interventions.

Compounding the risky behaviours of young people are their low level of knowledge on HIV, poor access to commodities and services, and the presence of socio-cultural and religious barriers that increase their exposure to the dangers and threats of HIV. The generation gap between those implementing HIV and AIDS programmes and the youth is wide, as evidenced by intervention activities that are not as effective and appropriate to reach the young population. For example, outdated intervention strategies are not equipped to deal with current risky behaviours amongst young people – group sex, prostitution and the strong influence of media or the Internet that shape attitudes and behaviours amongst the youth. Young MSMs/bisexuals/transgenders who are most vulnerable to the sexual advances of older MSMs/bisexuals/transgenders have no capacity to either refuse or delay sexual initiation.

Condom use amongst the youth is basically intended to prevent pregnancy. Consistent and correct condom use is not practised. Knowledge and ability to negotiate for safer sex are absent, even if actual knowledge about HIV transmission and prevention is high. Condom use has many barriers, like feeling shy about buying condoms or lacking empowerment to demand condoms during sex. The youth's vulnerabilities and risks of acquiring HIV are further compounded by existing cultural and religious barriers to essential information needed to make informed decisions. Very few schools carry sex education. HIV and AIDS are taught as a medical/scientific topic rather than as a behavioural and cultural problem that needs to be addressed at that level.

The following table summarizes the level of gender- and age-responsiveness of the National Response to HIV and AIDS. Based on Longwe's Empowerment Framework, the categories below were used to analyse the level of gender- and age-responsiveness.

a. Welfare – refers to level of interventions that meet the practical needs (like health services) of the most-at-risk groups

b. Access – refers to equal access to resources to effectively address the impact and mitigating factors of HIV and AIDS

c. Conscientisation – refers to the understanding of the difference between sex roles and gender roles which is fair and agreeable to all

d. Participation – refers to the participation in the decision-making process, policymaking, planning and administration of MARPs and, for young people, refers to the age-appropriate level of participation in HIV interventions

e. Control – refers to control over the decision-making process to achieve empowerment.[252]

HIV and AIDS Response	Level of Gender- and Age-Responsiveness of Programmes (Welfare/Access/Conscientisation/Participation/Control)
Prevention Programmes: HIV prevention activities generally lack gender responsiveness. Gender needs and roles are recognised, but programmatic actions do not reflect this. Interventions amongst MARPs are at a welfare level, where health and information needs are addressed, but participation, control and empowerment for improved quality of life is not done. Age-appropriate activities are being done amongst HIV NGOs working with the youth. Providing basic health needs is being addressed, and opportunities for developing life skills are being given.	
I. PIPs	**Gender-Responsiveness:** Programmes and activities amongst WIPs range from welfare, such as health-related interventions, to control, such as the establishment of cooperatives and NGOs managed and staffed by former WIPs. Amongst other PIPs (ex. transgenders, males), the interventions are mostly health services geared towards WIPs, and the unique realities of males or transgenders in prostitution are not taken into account. **Age-Responsiveness:** NGOs working with girls and boys in prostitution use age-appropriate special programmes. The interventions include youth-friendly health services, recognition of privacy and rights of the young person, and provision of opportunities to gain knowledge and develop skills like peer educator training and leadership. The response to young people in prostitution can be described as at a low welfare and access level.
II. MSMs/ Bisexuals/ Transgenders	**Gender-Responsiveness:** MSMs, bisexuals and transgenders receive health services (welfare level), but efforts to understand the push factors leading to risky behaviours and to address the need for equality in relationships amongst MSMs, bisexuals and transgenders, should be strengthened. **Age-Responsiveness:** An NGO in Davao provided tailored interventions to young MSMs/bisexuals/transgenders, but the project stopped due to lack of donor funding.
III. PWIDs	**Gender-Responsiveness:** Considering the illegal status of PWIDs and the difficulty in reaching them, interventions for PWIDs are often localised, donor-dependent and unsustainable. Peer educators are mostly male, and reaching female PWIDs is difficult. Interventions for PWIDs lack recognition of gender concerns or issues. In localised interventions, gender welfare level is reached. **Age-Responsiveness:** PWID interventions in certain areas in the Philippines do not take into account the specific concerns of children and young people. Policies and strategies for PWIDs must be age-responsive.
IV. OFWS	**Gender-Responsiveness:** Gender interventions for OFWs are at the welfare level. STI and HIV programmes for OFWs have minimal gender integration. Most prevention activities are focused on PDOS. However, improving the time allocation and information in PDOS is a big challenge. Some NGOs give gender trainings, whilst other NGOs conduct interventions like IEC amongst the wives of seafarers. Very little has been done to integrate gender with HIV and AIDS. Interventions are also donor-dependent, so trainings have been sporadic and unsustainable. **Age-Responsiveness:** Studies of the children of OFWs have been done, but how these studies can be made relevant to vulnerabilities to STI and HIV is being examined. These studies recommend including HIV education in both elementary and high schools to raise children's awareness of the epidemic, to prepare

HIV and AIDS Response	Level of Gender- and Age-Responsiveness of Programmes (Welfare/Access/Conscientisation/Participation/Control)
	families, and to formulate school programmes to support children whose parents are away.[253] The age-responsiveness of OFW interventions is at a welfare level.
V. Children/ Young People	**Gender-Responsiveness:** To integrate gender-responsiveness in programmes for young people, several NGOs have been implementing programmes on ARH, including relevant issues such as STI, HIV and AIDS. Some NGOs have been delivering such programmes for more than 15 years. **Age-Responsiveness:** HIV and AIDS programmes use the same strategies and intervention activities as ARH programmes. Tailor-fitting these programmes for STI, HIV and AIDS still needs to be done since the primary emphasis of ARH programmes is delay of pregnancy and life-skills development. Most ARH programmes are also geared towards heterosexual youth and marginalise the special needs of LGBT youth. In terms of the HIV and AIDS programme, age-responsiveness is at the welfare level, where interventions are to provide adolescent and youth HIV information. Access to services (ex. reproductive health, contraceptives and condoms) is hampered by lack of government support and a strong religious bias against adolescent reproductive healthcare.
Treatment, Care and Support Gender-responsiveness in care, support and treatment interventions is at the welfare and access levels. Health services and ARVs are provided, and access to information is available. For PLHIVs, the GIPA and MIPA principles and provisions have also enabled wider participation and control, but stigma and discrimination limit their access to economic resources and opportunities.	
PLHIVs	**Gender-Responsiveness:** Interventions include increasing the participation and control of PLHIVs through capacity building and formation of viable support groups. There is concern with regard to addressing women-specific opportunistic infections and handling of MTCT, but both NGOs and government agencies give access to services. Women PLHIVs expressed the dilemmas they face in disclosing their HIV status to their partners. Some have given up accessing ARTs for fear of being discovered. The women PLHIVs have organised themselves to form a support group to meet their needs and have taken steps to build their capacities to deal with their concerns as PLHIVs. **Age-Responsiveness:** An increasing number of young people are infected with HIV. Certain groups and organisations organise age-appropriate trainings for young PLHIVs on a limited scale.
Programme Management and Support The current policies and plans for HIV lack gender-responsiveness. The NASPCP, the main HIV implementing/coordinating arm of the DOH, also lacks gender-responsiveness in its approach to projects and activities. Nevertheless, the NEC has shown steps to make data collection and analysis gender-disaggregated and -responsive through research studies that delve into the various behavioural aspects of MARPs.	
	Gender-Responsiveness: There is a realisation that gender must be taken into account in the planning, implementation, monitoring and evaluation of HIV and AIDS programmes and projects. In monitoring and evaluation, there are efforts to expand the IHBSS to cover gender-based issues and surface gender determinants for behaviour. **Age-Responsiveness:** Specific steps are underway to improve age-responsiveness through a multi-sectoral involvement to look into protocols and guidelines in dealing with children and young people at various levels of HIV work (from prevention to care, support and treatment).

IX. RECOMMENDATIONS AND NEXT STEPS

A. HIV PREVENTION INTERVENTIONS

1. **Gender-Responsiveness**

   a. **Capacity Building**

      i. **Service Providers**

- Integrate the work and programmes of service providers on gender, children's rights, intimate partner abuse, sexual abuse, LGBT rights, RH, STI, HIV, ARH and legal remedies, and ensure an effective network of referral system.

- Enhance capacity building on a rights-based approach to gender, age and HIV, discussing the full range of rights such as gender and children's rights, SRHR, HIV (transmission, prevention, care, support and treatment), right against intimate-partner abuse, right against sexual abuse, relevant laws and legal remedies, non-discrimination and equality based on gender and age including sexual orientation and gender identity, 100 per cent use of male and female condoms, empowerment to say no to sex under unwanted circumstances, and encouragement of full disclosure of positive status to partners.

- Develop audience-specific training modules on gender and HIV. Include gender relations, roles and power relations, and how they relate to vulnerability to HIV transmission. Make training methods gender- and age-sensitive.

- Conduct interventions to eliminate risky sexual behaviour, promote safe sex, reduce vulnerability to HIV transmission, eliminate violence and discrimination based on gender/sexual orientation/gender identity/age, and achieve empowerment of women, men, children, young people and LGBTs.

    - Implement an aggressive campaign on the different vulnerabilities of women, WIPs, children and young people, MSMs, bisexuals, transgenders, PWIDs and the general population on personal and partner's risky sexual behaviour.

    - Cater modules to the different gender and age concerns of particular groups. The modules should include the risk factors of HIV transmission of partners, the right of a child to know her/his status, the public health issue of not disclosing one's HIV status to one's partner, and the provision of RA 8504 obliging PLHIVs to disclose their status to their sexual partners.

    - Recommend time extension for PDOS to cover relevant topics.

- Capacitate more specific support groups and peer educators from NGOs/national and local governments that cater to women, PIPs, IDUs (adult and youth), children and young people, OFWs, and MSMs/transgenders/bisexuals. Their capacity building should include gender and age issues/concerns/framework.

- Conduct awareness raising for MARPs, MARYPs, vulnerable groups, children and young people, and the general population. Targeting the general population will also address the problem of not being able to reach MSMs and bisexuals who are not out of the closet or who do not identify themselves as MSMs or bisexuals.

- Conduct HIV education targeting the widest possible audience to reach. Ensure implementation of the requirement under RA 8504 to have HIV education in all schools, workplaces and communities, and for OFWs.

- Recommend that transgenders be separated from MSM grouping. Ensure that interventions take into account that MSMs are not a homogeneous group but composed of different sub-populations with particular needs. Conduct an assessment of appropriate intervention for specific needs to facilitate the preparation of tailor-made strategies/interventions.

- Deliver specific outreach and education programmes for clients of PIPs and regular partners of PIPs. Ensure inclusion of children in prostitution as beneficiaries.

- Raise the awareness of police on the need to repeal the vagrancy law, on the rights of PIPs, and on risks of HIV transmission, amongst others. The wives and partners of these police officers should also be made aware of their risks to HIV transmission.

- Raise awareness of police on the risks of HIV transmission of PWIDs and the importance of proper intervention programmes to help PWIDs in their transformation.

- For those working on HIV, set up an effective referral system on issues related to intimate-partner abuse and sexual abuse such as medical and legal remedies and counselling.

- Conduct capacity building on the acts of discrimination covered by RA 8504 and legal remedies for discrimination against PLHIVs and discrimination based on suspected HIV status (ex. violation of RA 8504, civil case for damages, administrative). Capacitate NGOs/service providers/support groups to hold echo trainings.

- Peer education should take into account the age, sex and gender of the beneficiaries.

- Gender- and age-sensitivity trainings for PLHIVs must be promoted and sustained.

- Use media to the full extent as a tool to raise awareness on prevention, VCT and care and treatment. Encourage the participation of the media as a tool and media people as advocates.[254]

- Organise awareness-raising activities on PMTCT amongst service providers and in schools, workplaces, communities and hospitals. Ensure continued capacity building of PLHIV groups on PMTCT, and urge them to echo PMTCT to their members.

- Conduct awareness on the right to safe and legal abortion.

- Provide counselling on safe abortion for women.

b. IEC/BCC

i. Service Providers

- Review and revise current IEC materials to eliminate gender biases and stereotyping, and to promote a rights-based approach to gender, age and HIV.

    - Develop HIV IEC materials promoting gender empowerment for women, PIPS, MSMs, bisexuals, transgenders and vulnerable groups. Use inclusive language and language appropriate to the target audience. Consult with stakeholders.[255]

    - Create IEC and BCC materials catering to the specific gender and age needs of each group and sub-group.[256]

- At the individual level, interventions should consider the reach of the beneficiaries to include MARPs, MARYPs and the general population, with the end-view of empowering the beneficiaries towards equality, non-discrimination and informed choice, and providing them with skills and positive behavioural changes that would pave the way towards realisation of their full potential in aspects of their life. For example, PIPs would have the skills, education, and opportunity to leave prostitution should they decide to do so. PWIDs should be supported in their psychological, emotional and social needs to stop drug use, and ensured a continued support system to encourage them to stop drug use.

Strengthen the efforts of the national and local government, NGOs and the rest of civil society in providing skills training, education/alternative learning systems, credit line, scholarships, and employment for PIPs, PWIDs, children, young people, and OFWs. The modules should include workshops on empowerment, building self-esteem, productivity, 100 per cent condom use, intimate partner abuse and sexual abuse, and medical and legal remedies.

- Conduct awareness-raising amongst adults, MSMs, bisexuals and transgenders that they should not engage in sex amongst minors and that such acts violate RA 7610.

ii. Stakeholders

Eliminate the demand for prostitution, and air the call to stop buying sex.

c. Voluntary Counselling and Testing

i. Service Providers

- Ensure that gender and age are both considered with regard to access to VCT and that there is equality and non-discrimination based on gender and age. Counsellors must be gender- and age-sensitive when doing counselling. Child-friendly VCT should be provided.
    - Make specific/separate VCT counselling available for women, men, children and youth
    - Ensure that children and young people have access to counselling and testing.
- VCT must target MARPs, MARYPs, vulnerable groups, children and young people and the general public.
    - Develop VCT protocols that are appropriate for MSMs, Bisexuals, Transgenders and young people; Let counsellors undergo gender- and age-sensitive trainings including sexual orientation and gender identity trainings. These trainings should include rights-based approach to gender-and-age issues.
    - Encourage use of illustrations for children during VCT
- VCT must be encouraged for the sexual and injecting partners of PLHIVs, MARPs, MARYPs and vulnerable groups.
- Access to information, supplies and services on the full range of contraceptive methods, including temporary and permanent methods, should expand.
- Service providers must include counselling on safe abortion for women as a safe option to terminate unintended or unwanted pregnancies.

2. **Age-Responsiveness**

   a. **IEC/BCC**

      i. **Service Providers**

      - Review and assess current IEC materials for young people to ensure that topics and content are appropriate and relevant.

        Using pictures of STIs such as gonorrhoea is effective in raising awareness on STIs.

      - Let the counsellors undergo gender- and age-responsive trainings including sexual orientation and gender identity. These trainings should include the rights-based approach to gender and age issues.

      - Include participation of parents into HIV advocacy and training activities.

      - Strengthen the campaign targeting children and young people, especially since increasing numbers of newly infected PLHIVs come from the young population. Address the 10- to 14-year-old age group by using age-appropriate messages and methods, according to their evolving capacities and needs.

      - Interventions for children and youth should include parenting skills and opening communication lines amongst family members. Activities such as team building, group sharing, discussing family problems and giving an opportunity to iron out differences in the family are very helpful in encouraging children and young people to change.

      - Testimonials and sharing of experiences of peer educators are important in raising awareness and in effecting behavioural change.

      ii. **NGOs and DepEd**

      - Sex education in schools, workplaces and communities should include gender and age concerns such as risks of early sex and early pregnancy; delaying sexual debut; eliminating the practice of throwing out children and young women from their homes because they are pregnant or because of their sexual orientation and gender identity; factors why children run away from homes; risks of being out-to-school; push factors in engaging in prostitution and risks of prostitution; vulnerability to STIs, RTIs, HIV and female cancers like cervical cancer, especially at a young age; and prevention and treatment of such infections and cancers.

      - Keep children and young people in school, and give them financial and moral support. If they are out-of-school, then efforts must be done to encourage them to take the Alternative Learning System of the DepEd or TESDA to help them get back on track in their education or to hone some skill or trade.

      - Fully integrate HIV and AIDS into basic education subjects in school to include life skills-related topics.

- Interventions for children and young people should address the push factors leading to risky sexual behaviour and risky behaviour, elimination of discrimination based on age, and equality of children and young people in access to information, supplies and services.

B. ABUSE AND DISCRIMINATION

1. Service Providers

a. Provide victims of discrimination and violence based on gender, sexual orientation and gender identity with access to legal, counselling and medical services.

b. Strengthen the referral system on intimate-partner abuse, sexual abuse, and abuse and discrimination based on gender, age, sexual orientation and gender identity (counselling, legal and medical).

2. Policymakers/Stakeholders

Draft and implement guidelines/protocols on the provision of medical services, including medico-legal services and giving antibiotics to address STIs and RTIs, emergency contraception to prevent unwanted pregnancies, and PEP to prevent transmission of HIV to rape victims. Capacitate NGO and government service providers in treating STIs and RTIs, and in administering EC and PEP as a standard procedure for rape victims especially since many are still unaware of the use of EC and PEP.

C. CARE, SUPPORT AND TREATMENT PROGRAMMES

1. Gender-Responsiveness

a. Service Providers

i. Conduct special counselling to facilitate disclosure of HIV-positive status to one's sexual and injecting partner.

ii. Ensure that gender and age are both considered with regard to access to care, support and treatment, and that there is equality and non-discrimination based on gender and age. Service providers must be gender- and age-sensitive when providing care, support and treatment.

iii. Ensure the dissemination and implementation of the AO on PMTCT.

iv. Ensure the effective implementation of the protocol on managing abortion complications in all hospitals.

b. HACT

Ensure that the HACT always includes obstetrician-gynaecologists who are assigned and trained to handle PMTCT cases, and who must continually train new obstetrician-gynaecologists assigned to HACT on their protocols in handling PMTCT.

2. Age-Responsiveness

a. Service Providers

i. Age-appropriate protocols for children and young people with an HIV-positive status must be instituted amongst all HACTs and service delivery points.

Ensure that children and young people have access to care, support and treatment.

ii. Special counselling must be done to facilitate the disclosure of a child's HIV-positive status, and continued counselling must be given as part of the standard care and support for children PLHIVs.

iii. Child-friendly treatment and care should be provided.

b. Policymakers

Policies and effective implementation of such policies that would ensure children and OSY go back to school or learn skills or trade would help in this endeavour.

D. PROGRAMME MANAGEMENT AND SUPPORT

Stakeholders, Policymakers

1. Continuously develop and enhance gender and age indicators related to HIV, and involve programme implementers in developing the indicators.
2. Hold periodic monitoring and evaluation of gender- and age-responsiveness in prevention, VCT, care, support and treatment.
3. Integrate gender and age issues/rights/framework in all the programmes of stakeholders and policymakers on HIV.

E. LAWS AND POLICIES

1. Repeal the vagrancy law.
2. Pass a comprehensive reproductive health care bill into law to ensure access to sexual and reproductive health information, supplies and services including the full range of modern contraceptives methods and sex education including ARH.
3. Enact a law on non-discrimination and enforcing policies and practices that promote equality and non-discrimination of LGBTs.

4. Repeal the punitive provisions imposing penalties on women who induce abortion and those who assist them.

F. ADDRESSING ROOT CAUSES

1. Eliminate discrimination based on one's gender, sexual orientation, gender identity and age. Work towards de jure (in law) and de facto (in fact) equality and non-discrimination based on one's gender, sexual orientation, gender identity and age.

    a. Eliminate discriminatory laws, policies, customs and practices that perpetuate discrimination based on gender, sexual orientation, gender identity and age.

    b. Work towards de jure and de facto equality and non-discrimination of LGBTs including the enactment of a law on non-discrimination and enforcing policies and practices that promote equality and non-discrimination of LGBTs.

2. Work towards zero tolerance of intimate-partner abuse and sexual abuse, and towards effective investigation and prosecution of abusive partners and sexual abusers. Capacitate service providers and beneficiaries on the proper criminal prosecution of intimate-partner abuse and sexual abuse.

3. Address the root causes of prostitution including early sex and early pregnancy, poverty, high number of siblings, lack of jobs, low-paying jobs in the Philippines, sexual abuse and abuse of children/out-of-school youth.

4. Strengthen sexual and reproductive rights education amongst children and young people (in-school and out-of-school) to discuss the risks of early sex and early pregnancy, the importance of finishing one's education and having a career, and VAW.

5. Address the root causes of intravenous drug use – out-of-school youth, dysfunctional families, lack of counselling for OSY and IDUs, poverty, high number of siblings, inaccessible/expensive education, OFW parent/s and availability of drugs through the black market, amongst others.

6. Address the root causes of poverty including lack of jobs.

7. Address the needs of people in prostitution, OSY and IDUs such as counselling, centres (including counselling, recreation), skills training, education, credit line and employment.

8. Incorporate parenting skills in the educational system and pre-marriage counselling seminars. Cover topics like respecting the rights of children and keeping communication lines open, amongst others.

9. Reinforce and effectively implement non-discrimination of HIV status or suspected status. Enforce policies and promote practices on equality and non-discrimination of HIV status and suspected status.

10. Repeal the law on vagrancy and stop the arrests and harassment of PIPs.

11. Work towards eliminating intravenous drug dependency by providing services and referral that would address the dependency.


O ANG HIV?
Human
Immunodeficiency
Virus
ANO ANG AIDS?
Acquired
Immune
Deficiency
Syndrome

ENDNOTES

[1] The term MSM as used in this report covers boys and men including gay boys and gay men.

[2] This paper follows the following United Nations definitions to describe different groups of young people: adolescents: 10- to 19-year-olds (early adolescence 10-14; late adolescence 15-19); youth: 15- to 24-year-olds; young people: 10- to 24-year-olds.

[3] Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Gen. Rec. 15, para. c.

[4] See CEDAW, Gen. Rec. 15, para. d.

[5] UNESCO's Gender Mainstreaming Implementation Framework 2002-2007.

[6] World Health Organisation, Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to improve responsiveness to women's needs.

[7] IPPF, UNFPA, and Global Coalition of Women and AIDS, Report Card: HIV prevention for girls and young women.

[8] IPPF et al., Report Card.

[9] World Health Organisation, Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to improve responsiveness to women's needs.

[10] Ibid.

[11] See Deutsche Gesellschaft für Technische Zusammenarbeit, 'What Makes HIV Programmes Gender-Responsive? A guideline document produced by the German BACKUP Initiative'.

[12] 'Harmonized Gender and Development Guidelines for Project Development, Implementation, Monitoring and Evaluation', Second Edition, June 2009.

[13] Ibid.

[14] UNGASS on HIV/AIDS Goal for Young People for 2010.

[15] The WHO defines young people as 10 to 24 years old. However, for advocacy reasons, in keeping with the UNGASS Declaration of Commitment where the wording used is "…young men and women 15–24", all indicators reported for 15- to 24-year-olds in this document are reported for young people. As cited in WHO, Access to Health Services for Young People for Preventing HIV and Improving Sexual and Reproductive Health.

[16] IPPF et al., Report Card.

[17] IPPF et al., Report Card.

[18] Philippine National AIDS Council (PNAC), 'UNGASS Country Report of the Philippines', January 2008 to December 2009: Follow-up to the Declaration of Commitment on HIV and AIDS, United Nations General Assembly Special Session (hereafter PNAC 'UNGASS Country Report', 2010).

[19] Ibid.

[20] Panadero, 'Status on the National Response: The Philippine Progress Report on HIV/AIDS', Proceedings of the 1st HIV Summit: Call for Action and Broad-Based Responses to AIDS by Leaders, 2010.

[21] 2007 MDG Philippine Report; PNAC, 'UNGASS 2010 Country Report'.

[22] 'Philippines UNGASS Report', 2008.

[23] 'DOH wants HIV/AIDS subject in school curricula', Philippine Daily Inquirer, http://newsinfo.inquirer.net/breakingnews/nation/view/20100402-262046/DoH-wants-HIVAIDS-subject-in-school-curricula.

[24] PNAC, 'UNGASS Country Report', 2010, p. 7.

[25] Eric Tayag, 'Tracking HIV', Proceedings of the 1st HIV Summit: Call for Action and Broad-Based Responses to AIDS by Leaders, 2010 [hereafter Tayag, 'Tracking HIV', 2010]

[26] Tayag, 'Tracking HIV', 2010. Also, according to Tayag, "All regions have reported at least one case in the last 25 years. Only eight of our provinces have yet to report their first case."

[27] PNAC, 'UNGASS Country Report', 2010, pp. 6-7.

[28] PNAC, 'UNGASS Country Report', 2010, p. 14.

[29] Tayag, 'Tracking HIV', 2010.

[30] The IHBSS measures behavioural risk factors through face-to-face surveys, and HIV and syphilis prevalence through blood testing. The DOH has conducted the IHBSS every two years since 2005. The 2009 IHBSS was the third round.

[31] PNAC, 'UNGASS Country Report', 2010, p. 14, citing IHBSS 2009.

[32] PNAC, 'UNGASS Country Report', 2010, p. 13, citing IHBSS 2009.

[33] Used in this context to include transgenders.

[34] Used in this context to include transgenders.

[35] PNAC, 'UNGASS Country Report', 2010, p. 20.

[36] Used in this context to include transgenders.

[37] PNAC, 'UNGASS Country Report', 2010, p. 20.

[38] PNAC, 'UNGASS Country Report', 2010, p. 14. In 2007, 31 per cent of newly infected cases were OFWs.

[39] National Epidemiology Center, April 2006 Monthly Update, HIV/AIDS Registry, 2006, http://www.doh.gov.ph/ NEC/hiv/april_2006.pdf (stating that out of the total cases of HIV, 17 per cent are domestic helpers, 7 per cent are entertainers, and 6 per cent are health workers).

[40] 'Proceedings of the National Dissemination Forum', 2008.

[41] '2008 and 2009 Philippine HIV and AIDS Registry'.

[42] PNAC, 'UNGASS Country Report', 2010, p. 10, citing data from DOH-NASPCP.

[43] Zablan, Marquez and Laguna, 2004, as cited in Cabigen, Emily Christi A., Health Sector Response to HIV/AIDS Prevention and Control: The Philippines country report, 2008 (hereafter Cabigen, Health Sector Response, 2008).

[44] PNAC, 'Mid-Term Review Report: Fourth AMTP 2005-2010', December 2008.

[45] Ibid.

[46] PNAC, AIDS Medium-Term Plan IV Operational Plan 2009-2010.

[47] PNAC, 'Mid-Term Review Report'.

[48] Republic Act 8504, Sec. 4. See Cabigen, Health Sector Response, 2008.

[49] National programmes on STI, HIV and AIDS through the years, http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program.

[50] PNAC, 'UNGASS Country Report', 2010.

[51] http://www.ched.gov.ph/policies/index.html.

[52] Ibid.

[53] Ibid

[54] PNAC, 'UNGASS Country Report', 2010.

[55] 2008 and 2009 Philippine HIV and AIDS Registry.

[56] PNAC, 'UNGASS Country Report', 2010, p. 10.

[57] PNAC, 'UNGASS Country Report', 2010, p. 11.

[58] UNICEF has trained certain schools in life skills education.

[59] 2009 AMTP IV Operational Plan 2009-2010.

[60] Supra, Panadero.

[61] PNAC, AMTP IV Operational Plan, 2009-2010.

[62] AO PMTCT.

[63] Ibid.

[64] CRR and ARROW, WOW—East and Southeast Asia 2005, New York, 2005, pp. 141-142.

[65] Id.

[66] General country information Philippines_UAHealthSector_Report_2009 (Prevention in health setting worksheet).

[67] PNAC, AMTP IV Operational Plan, 2009-2010.

[68] Since 2005 through the 6th Country Programme.

[69] Proceedings of the 1st HIV Summit: Call for Action and Broad-Based Responses to AIDS by Leaders, 2010. The recommendation came from the representative of the Philippine Commission on Women.
[70] Tayag, 'Tracking HIV', 2010.
[71] PNAC, 'UNGASS Country Report', 2010; Center for Reproductive Rights, Gaining Ground: A tool for advancing reproductive rights law reform, New York, 2006; UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights', Geneva, 2006.
[72] 2009 AMTP IV Operational Plan 2009-2010.
[73] Cabigen, Emily Christi, Health Sector Response, 2008.
[74] Ibid.
[75] OFW FGD, Cebu.
[76] Cebu, NCR and Davao FGDs, consultations and KIIs.
[77] Cebu, NCR and Davao FGDs, consultations and KIIs.
[78] Cebu, NCR and Davao FGDs, consultations and KIIs.
[79] Davao FGDs, consultations and KIIs.
[80] Cebu, NCR and Davao FGDs, consultations and KIIs.
[81] Cebu, NCR and Davao FGDs, consultations and KIIs.
[82] Davao FGDs, consultations and KIIs.
[83] Davao FGDs, consultations and KIIs.
[84] Davao FGDs, consultations and KIIs.
[85] Davao FGDs, consultations and KIIs.
[86] Davao FGDs, consultations and KIIs.
[87] Davao FGDs, consultations and KIIs.
[88] Davao FGDs, consultations and KIIs.
[89] Davao FGDs, consultations and KIIs.
[90] Cebu FGDs, consultations and KIIs.
[91] Cebu FGDs, consultations and KIIs.
[92] NCR FGDs, consultations and KIIs.
[93] Davao FGD.
[94] Group working with women in prostitution.
[95] NGO working with women in prostitution.
[96] Davao FGDs, consultations and KIIs.
[97] Davao FGDs, consultations and KIIs.
[98] Davao FGDs, consultations and KIIs.
[99] Davao FGD.
[100] Davao FGD.
[101] Davao FGD.
[102] Cebu FGDs, consultations and KIIs.
[103] Cebu FGDs, consultations and KIIs.
[104] NCR FGDs, consultations and KIIs.
[105] Davao FGDs, consultations and KIIs.
[106] Davao FGDs, consultations and KIIs.
[107] Davao FGDs, consultations and KIIs.
[108] Cebu FGDs, consultations and KIIs.
[109] Davao FGDs, consultations and KIIs.
[110] Cebu FGDs, consultations and KIIs.
[111] NCR FGDs, consultations and KIIs.
[112] NCR FGDs, consultations and KIIs.
[113] Cebu, NCR and Davao FGDs, consultations and KIIs.

[114] Davao FGDs, consultations and KIIs.
[115] Davao FGDs, consultations and KIIs.
[116] Davao FGDs, consultations and KIIs.
[117] Cebu, NCR and Davao FGDs, consultations and KIIs.
[118] NCR FGDs, consultations and KIIs.
[119] NCR FGDs, consultations and KIIs.
[120] Davao FGDs, consultations and KIIs.
[121] NCR FGDs, consultations and KIIs.
[122] Davao FGDs, consultations and KIIs.
[123] Cebu FGD.
[124] NCR FGDs, consultations and KIIs.
[125] NCR FGDs, consultations and KIIs.
[126] Cebu FGDs, consultations and KIIs.
[127] Cebu FGDs, consultations and KIIs.
[128] Davao FGDs, consultations and KIIs.
[129] Cebu, NCR and Davao FGDs, consultations and KIIs.
[130] NCR FGDs, consultations and KIIs.
[131] Cebu FGDs, consultations and KIIs.
[132] Cebu/Davao FGDs, consultations and KIIs.
[133] NCR FGDs, consultations and KIIs.
[134] Davao FGDs, consultations and KIIs.
[135] NCR FGDs, consultations and KIIs.
[136] NCR FGDs, consultations and KIIs.
[137] NCR FGDs, consultations and KIIs.
[138] Cebu FGD.
[139] Zamboanga KIIs.
[140] Zamboanga KIIs.
[141] Cebu FGD.
[142] Cebu FGDs, consultations and KIIs.
[143] Davao FGDs, consultations and KIIs.
[144] NCR FGDs, consultations and KIIs.
[145] NCR FGDs, consultations and KIIs.
[146] Davao FGDs.
[147] NCR FGDs, consultations and KIIs.
[148] NCR FGDs, consultations and KIIs.
[149] NCR FGDs, consultations and KIIs.
[150] NCR FGDs, consultations and KIIs.
[151] KII Lorna Garcia.
[152] KII Lorna Garcia.
[153] NCR – PLHIV women.
[154] Davao FGDs, consultations and KIIs.
[155] Cebu FGDs, consultations and KIIs.
[156] Cebu FGD.
[157] NCR – PLHIV women.
[158] NCR – PLHIV women.
[159] NCR – PLHIV women.
[160] KII Lorna Garcia.
[161] KII Lorna Garcia.

[162] Cebu FGDs, consultations and KIIs.
[163] NCR FGDs, consultations and KIIs.
[164] NCR – PLHIV women.
[165] NCR FGDs, consultations and KIIs.
[166] KII Lorna Garcia.
[167] An NGO catering to urban poor families and informal settlers.
[168] ABC stands for abstinence, be faithful, condoms.
[169] Davao regional consultation.
[170] Cebu, NCR and Davo FGDs, consultations and KIIs.
[171] NCR regional consultation.
[172] Davao FGDs, consultations and KIIs.
[173] Reaction of Dr. Caraballo, Council for the Welfare of Children, at the July 16 national consultation.
[174] NCR FGDs, consultations and KIIs.
[175] KII of Dr. Jaime Leal, PNP Baguio.
[176] KII of Dr. Jaime Leal, PNP Baguio.
[177] KII of Dr. Jaime Leal, PNP Baguio.
[178] KII of Dr. Jaime Leal, PNP Baguio.
[179] KII of Dr. Jaime Leal, PNP Baguio.
[180] KII of Dr. Jaime Leal, PNP Baguio.
[181] Cebu FGDs, consultations and KIIs.
[182] Davao FGD.
[183] Davao FGD.
[184] NCR FGD.
[185] Cebu FGDs, consultations and KIIs.
[186] NCR FGD.
[187] Davao FGDs, consultations and KIIs.
[188] NCR FGDs, consultations and KIIs.
[189] KII Lorna Garcia.
[190] NCR regional consultation.
[191] Davao FGDs, consultations and KIIs.
[192] Davao FGDs, consultations and KIIs.
[193] NCR regional consultation.
[194] NCR FGDs, consultations and KIIs.
[195] NCR FGDs, consultations and KIIs.
[196] Cebu/Davao FGDs, consultations and KIIs.
[197] Davao FGDs, consultations and KIIs.
[198] Budats can be briefly described as sexually active female adolescents who are urban poor and mostly out-of-school. Their first sexual initiation is from bodots, their male counterparts.
[199] NCR regional consultation.
[200] Zamboanga KIIs.
[201] Zamboanga KIIs.
[202] Zamboanga KIIs.
[203] Zamboanga KIIs.
[204] Zamboanga KIIs
[205] NCR FGDs, consultations and KIIs.
[206] Dr. Genesis Samonte, poster presentation for Vienna AIDS Conference, 2010.
[207] Open Forum, July 16 national consultation.
[208] Open Forum, July 16 national consultation.

[209] Open Forum, July 16 national consultation.
[210] The issue of the acceptability of homosexuality amongst Muslims and the subordinate role of women in Muslim culture was raised as a hindrance in outreach efforts during the open forum of the July 16 national consultation.
[211] PNAC, 'UNGASS Country Report', 2010.
[212] PNAC, 'UNGASS Country Report', 2010.
[213] PNAC, 'UNGASS Country Report', 2010.
[214] Open forum, July 16 national consultation.
[215] Recommendations, July 16 national consultation.
[216] Recommendations, July 16 national consultation.
[217] KII Lorna Garcia.
[218] NCR PLHIV participants' observation in NCR VCTs.
[219] NCR FGD.
[220] NCR FGDs, consultations and KIIs.
[221] KII of Dr. Jaime Leal, PNP Baguio.
[222] Recommendations, July 16 national consultation.
[223] Recommendations, July 16 national consultation.
[224] Recommendations, July 16 national consultation.
[225] Davao FGDs.
[226] Recommendations, July 16 national consultation.
[227] Recommendations, July 16 national consultation.
[228] Recommendations, July 16 national consultation.
[229] Open forum, July 16 national consultation.
[230] Open forum, July 16 national consultation.
[231] NCR FGDs, consultations and KIIs.
[232] NCR regional consultation.
[233] Open forum, July 16 national consultation. UNDP is supporting an initiative to profile MSMs, its sub-populations and characteristics to come up with specific interventions for the sub-groups.
[234] Recommendations, July 16 national consultation.
[235] Open forum, July 16 national consultation.
[236] Recommendations, July 16 national consultation.
[237] Preliminary results of the NSO study on children engaged in commercial sex exploitation in Cebu City presented in January 2010.
[238] Cebu FGDs, consultations and KIIs.
[239] Recommendations, July 16 national consultation.
[240] Recommendations, July 16 national consultation.
[241] Concluding comments, supra note 45, para. 20.
[242] Id.
[243] Id.
[244] Id.
[245] Recommendations, July 16 national consultation.
[246] Recommendations, July 16 national consultation.
[247] Recommendations, July 16 national consultation.
[248] Recommendations, July 16 national consultation.
[249] Open forum, July 16 national consultation.
[250] Recommendations, July 16 National Consultation.

[251] Discriminatory acts punishable under RA 8504 cover discrimination in the workplace, discrimination in schools, restrictions on travel and habitation, inhibition from public service, exclusion from credit and insurance services, discrimination in hospitals and health institutions, and denial of burial services.

[252] Adapted from http://www.ilo.org/public/english/region/asro/mdtmanila/training/unit1/empowfw.htm.

[253] Strategy Framework on Country HIV Response for Children and Young People.

[254] Open forum, July 16 national consultation.

[255] Recommendations, July 16 national consultation.

[256] Recommendations, July 16 national consultation.

PAMBANSANG PANGASIWAAN SA KABUHAYAN AT PAGPAPAUNLAD
REPUBLIKA NG PILIPINAS

UNAIDS

UNDP

unicef
unite for children