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***Health Action Information Network***
***With Support from United Nations***
***Development Programme***

**February 2013**

# *Taking Stock*

## A Survey of AIDS Response for Men who have sex with men (MSM) and Transgender (TG) People in the Philippines

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**ISBN - 978-971-8508-38-1**

## Disclaimer:

The information contained in this report is drawn from multiple sources including key informant interviews, focus group discussion and extensive literature review. The views expressed in this publication are those of the authors and do not necessarily represent those of the United Nations Development Programme.

THE QUOTES USED APPEAR VERBATIM AND WERE VALIDATED BY THE INFORMANTS.

# Table of Contents

# Acronyms

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **AMTP** | AIDS Medium Term Plan |
| **AMTP IV** | Fourth AIDS Medium Term Plan |
| **AMTP V** | Fifth AIDS Medium Term Plan |
| **ART** | Anti-Retroviral Therapy |
| **ASEP** | AIDS Surveillance and Education Project |
| **ASP** | AIDS Society of the Philippines |
| **BHWs** | Barangay Health Workers |
| **CHD** | Center for Health and Development |
| **CSO** | Civil Society Organization |
| **CUP** | Condom Use Program |
| **CEMSHAD** | Centre for Multidisciplinary Studies on Health and Development |
| **DepEd** | Department of Education |
| **DILG** | Department of the Interior and Local Government |
| **DOH** | Department of Health |
| **DSWD** | Department of Social Welfare and Development |
| **FLSW** | Freelance Female Sex Worker |
| **FHI** | Family Health International |
| **GFATM** | Global Fund for AIDS, TB and Malaria |
| **HIV** | Human Immunodeficiency Virus |
| **HDES** | Human Development and Empowerment Services |
| **IEC** | Information, Education and Communication |
| **ICT** | Information Communication Technology |
| **LAC** | Local AIDS Council |
| **LGU** | Local Government Unit |
| **LGBTIQ** | Lesbian, Gay, Bisexual, Transgender, Intersexed,Questioning |
| **M&E** | Monitoring and Evaluation |
| **MARP** | Most-At-Risk Population |
| **MDG** | Millennium Development Goals |
| **MSM** | Men Who Have Sex with Men |
| **MTDP** | Medium Term Development Plan |
| **NEC** | National Epidemiology Center |
| **NDHS** | National Demographic and Health Survey |
| **NGO** | Non-Governmental Organization |
| **OI** | Opportunistic Infections |
| **PIP** | People in Prostitution |
| **PLHIV** | People Living with HIV |
| **PNAC** | Philippine National AIDS Council |
| **PAMA-Q** | Peer Educators Movement for Empowerment – Pasay, Manila, Caloocan and Quezon City |
| **PBSP** | Philippine Business for Social Progress |
| **PHANSuP** | Philippine NGO Support Program Inc. |
| **PNGOC** | Philippine NGO Council on Population, Health and Welfare |
| **PRRM** | Philippine Rural Reconstruction Movement |
| **RA** | Republic Act |
| **RAAT** | Regional AIDS Assistance Teams |
| **RHWC** | Reproductive Health Wellness Center |
| **SHED** | Social Health Environment and Development Foundation, Inc. |
| **SMS** | Short Messaging Service |
| **SPMC** | Southern Philippines Medical Center (Formerly Davao Medical Center) |
| **SHC** | Social Hygiene Clinic |
| **STD** | Sexually Transmitted Disease |
| **STI** | Sexually Transmitted Infection |
| **TCS** | Treatment, Care and Support |
| **TLF-SHARE COLLECTIVE** | TLF Sexuality, Health and Rights Educators Collective Inc. |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **UNFPA** | United Nations Population Fund |
| **UNGASS** | United Nations General Assembly Special Session |
| **VCT** | Voluntary Counseling and Testing |
| **UNICEF** | United Nations Children's Fund |
| **WHO** | World Health Organization |

# Acknowledgements

This survey was conducted by the Health Action Information Network, Inc. (HAIN) in partnership with the United Nations Development Programme.

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**PEER EDUCATORS**

The MSM and transgender participants of the different focus group discussions that were conducted.

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# Executive Summary

*This survey focuses on the learnings and feedback of the proponents involved in the implementation of key national programs and the emerging community initiatives. This survey also includes highlights from PLHIV focus group discussions (FGDs). Three methods were used for the data gathering: desk review of relevant documents, key informant interviews, and FGDs.*

The year 2007 signaled a shift in the Philippine HIV epidemic. The Philippine HIV and AIDS Registry indicates that from 2007, there has been a significant spike in the number of newly infected individuals, and a shift in the dominant trend in sexual transmission of HIV infection from heterosexual contact at 29% to Men who have sex with men (MSM) at 71% (PNAC, 2010). From January to May 2011, new HIV cases registered a 20% increase relative to the same period of the previous year, and 80% of which were MSM.

In March 2012, 313 Filipinos were recorded to have acquired the virus, 82% more compared to the previous year. It was the highest number since 1984 in the history of the Philippine HIV and AIDS registry. According to the report of the National Epidemiology Center, sexual contact remains as the number one mode of transmission, and MSM remain to be the number one trend of transmission at 83%. This seems to belie what has been said as an improving and expanding comprehensive prevention program in the country.

This survey focuses on the learnings and feedback of the proponents involved in the implementation of key national programs and the emerging community initiatives. This survey also includes highlights from PLHIV focus group discussions (FGDs). Three methods were used for the data gathering: desk review of relevant documents, key informant interviews, and FGDs.

Specifically, the survey attempts to:

1. Highlight the strengths and gaps of existing interventions (the current national response and the key HIV programs, and innovative practices being done on the ground); and

2. Guide directions for scaling-up and areas of prioritization in terms of financial and technical support.

**CONCLUSIONS**

- National and local government health institutions are the primary delivery institutions for prevention services. While there have been serious efforts to better systems and deliver a more comprehensive and multidisciplinary prevention package, this is often challenged by the lack of resources – i.e. the lack of commodities, understaffing and the lack of specialized personnel, inadequate and inappropriate infrastructure, and the lack of support programs like psychosocial counseling. Until recently, there have been no specific interventions to address MSM and transgender people sexual health needs, and quality and accessible HIV treatment and care needs improvements, reflecting an overall poor investment in health. Collaborative efforts by public-NGO/community partnerships are strategies for augmenting the lack in services, e.g. NGO volunteers would augment the staffing of government hospitals. The collaborations have become the foundation of a sustained service delivery system.

- There is a lack of consensus and consistency of service delivery throughout the country. Disinterest and lack of political prioritization of HIV and AIDS program by local government units (LGUs) result in conflicting, competing, and at times outright lack of policies in LGUs. Where there are existing programs, snags in the implementation are attributed to unclear and conflicting mandates regarding MSM and TGs, further aggravated by competing policies on resource allocation.

  Documented best practices for service delivery are those characterized by enabling and supportive LGUs, and those implemented by Local AIDS Council (LAC) and the Social Hygiene Clinics (SHC). Existing programs are implemented mostly in the cities where there are already

MSM and TG organizations working. A national program is required to chart the breadth and coverage of the services of these existing groups to ensure that, as much as possible, a geographically comprehensive implementation is conducted for at-risk MSM and TGs all over the country.

A comprehensive national policy is needed to harmonize the conflicts in policies, and address the required investments in MSM and TGs sexual health. There is a need for a comprehensive national program that ensures adequate and appropriate services, as well as monitors services.

- The continuing stigmatization of HIV contributes to the negative uptake of prevention programs. The gaps in information on MSM and TG diversity in terms of identity and vulnerabilities, present a barrier to program planning and implementation. The lack of a systematic mechanism for gathering data on MSM and TG clients remains a setback for adequate monitoring. There is also lack of studies and literature on Filipino MSM and TGs to guide programs, and as bases for more appropriate and sensitive mechanisms. PLHIV are important contributors who could provide important data and help generate data. The challenge in the implementation is to develop a strategic information that goes beyond surveillance.

- Peer educators lack sustained training and capacity development. While most are dedicated and self-motivated, they lack supplementary training and are not adequately compensated. There is a need to standaridize the required knowledge and skills of peer educators. PLHIVs can provide input in the trainings, regarded as active educators who can provide personal knowledge and wisdom, as well as leadership on HIV and AIDS programs.

- Community-based organizations provide innovative interventions that refresh awareness generation and help expand support for MSM and TG health concerns. Their independence allows community-based groups/organizations to innovate and be creative in their projects, enabling them to resonate with and reach out to MSM, TGs and supporters alike. Their use of innovative platforms such as information communication technology (ICTs) and major events (like photoshoots), are new models for generating awareness and information, and service delivery.

  The limited resources of community-based groups, however, limit their service delivery (e.g. treatment). There is also a lack of systematic mentoring and nurturing of the capacities of these community organizations. As mostly informal organizations, their access to resources, e.g. funding and capability-building trainings to improve their delivery of services are also limited. Supportive intervention to develop their organizations, and in some cases formalization of their (legal) existence are required for their sustained growth and development.

- Community-based organizations and individual supporters compose the support for MSM, TG, and Lesbian/Gay/Bisexual/Transgender/Intersexed/Questioning (LBTGIQ) rights, and are the primary movers for HIV initiatives, education awareness, and assertion of rights. They help build, protect, and call attention to the need for a more enabling environment for MSM and TGs.

The 2010 UNGASS Report notes that based on recorded spending for HIV from 2007 to 2009, majority of the Civil Society Organizations (CSOs) externally source their funds through development partners and international NGOs to implement a significant number of AIDS-related activities. Echoing the recommendation forwarded by the 2010 UNGASS Report and by Dr. Mario Taguiwalo in the 2009 AIDS Summit, this survey's results recommend that the government take on a more engaged role in sustaining and scaling up efforts already being conducted by the NGOs and community-based initiatives. This also applies to the incorporation of components of the national plan for LGU planning and implementation for a harmonized policy and implementation. At the same time, there is a need to continuously engage and help create an enabling environment for community efforts for them to easily network with established institutions. For this to be concretized, it should be reflected in an increase in domestic spending on programs on HIV and AIDS, which only has an average pegged at 20% (relative to the 67% input sourced externally) for the 2007 to 2009 period. Monitoring where fund, are allocated (prevention, treatment care and support, strategic information, and supportive interventions) and who the beneficiaries are will similarly provide clearer indicators on what specific key affected populations are being reached, which will ensure the comprehensiveness of the country's response.

At this point of the HIV history in the country, it is even more imperative to promote the MSM Comprehensive Response to address the needs of MSM and TG Filipinos.

# 1. Introduction

*The study shows that among MSM, condom use remains very low, even though the number of those with multiple partners are increasing. Risky behaviors like this are set against a backdrop of latent intolerance of homosexuality and privileging of the masculine ideal, which shape and influence how MSM and TGs view themselves, consequently reinforcing these risk behaviors.*

## 1.1 RATIONALE

The Philippines has been regarded as a low HIV-prevalent country with only 0.1% of its population reported to have HIV. However, since 1984 when the first case of HIV was reported, there has been an increase in the rate of HIV infections. The Department of Health (DOH) reports that from 1984 to February 2011, 6,326 HIV-positive cases were reported in the Philippine HIV and AIDS Registry. Of this number, 863 or 14% of the cases progressed to become AIDS; 324 (or 38%) of whom dying from AIDS-related complications. In the span of three years, the reported HIV cases per year multiplied more than four times, from 324 cases in 2007 to 1,591 cases in 2010. Of the 6,326 total HIV cases reported since 1984 (until February 2011), 79% (4,984) were males and 21% (1,331) were females (with no data available on sex for 11 cases). The median age was 30 years (range 1-73 years), and the age groups with the most number of cases were: 20-24 (18%), 25-29 (25%), and 30-34 (19%). Data from the DOH show that all 17 regions of the country have reported incidence of HIV and, as of May 2010, 72 of the 80 provinces had at least one HIV-positive case. The top three areas with the highest incidence of HIV infections are the highly urbanized areas of Metro Manila, Metro Cebu, and Metro Davao (DOH, 2010).

The year 2007 signaled a shift in the Philippine HIV epidemic. The Philippine HIV and AIDS Registry indicated that from 2007, there has been a significant spike in the number of newly infected individuals and a shift in the dominant trend in sexual transmission of HIV infection from heterosexual contact at 29% to MSM at 71% (PNAC, 2010). From January to May 2011, new HIV cases marked a 20% increase when compared with the same period of the previous year; 80% of the new cases are MSM.

Age disaggregated data indicate that in 2008, younger MSM in the 25-29 age bracket were getting infected. At present, figures show that MSM in the 20-24 age bracket have exceeded their counterparts in the 30-34 age range.

Urban and developed cities currently bear the brunt of the epidemic. Initial findings of the 2011 Integrated HIV Behavioral and Serologic Survey (IHBSS) corroborate the picture being reflected by the AIDS Registry. Prevalence among MSM rose by up to 5% in urban areas, particularly in Metro Manila and Cebu City. Though Davao City's prevalence rate remained stable relative to the 2009 figure, this also remains to be high enough to merit attention.

Summarizing the epidemiological profile of HIV prevalence in the Philippines, reports reflect that more and more are getting infected; those who are infected are young, mostly in their productive years; and that, increasingly, the mode of transmission has been through male-to-male and bisexual contact. [1]

Given these developments, attention has been given to MSM and TGs in recent years. The 2009 IHBSS and the Health Action Information Network's (HAIN) assessment of risks and vulnerabilities of MSM and TGs provide initial evidence to understand and address the growing concern among these groups. The study shows that among MSM, condom use remains very low, even though the number of those with multiple partners are increasing. Risky behaviors like this are set against a backdrop of latent intolerance of homosexuality and privileging of the masculine ideal, which shape and influence how MSM and TGs view themselves, consequently reinforcing these risk behaviors. Awareness of HIV and AIDS, which is high at over 90%, is clearly not translating into diminished risks. The moderately high knowledge in this population also fails to achieve this goal. The low regard for the self and an internalized notion of an insatiable sex drive among MSM and TGs have been found to motivate these risk practices, instead.

## 1.2 OBJECTIVES

As part of the efforts to address the risks faced by MSM and TGs, HAIN implemented a three-year project, the Strategic Information and Community Leadership among Men Who Have Sex with Men (MSM) and Transgenders (TG), Component 4 of the UNDP's Country Project Promoting Leadership and Mitigating the Negative Impacts of HIV and AIDS on Human Development. Taking Stock: A Survey of AIDS Response for Men who have sex with men (MSM) and Transgender (TG) People in the Philippines is an integral part of the project.

This survey looks into the national programs and local initiatives targeting MSM and TGs that have been implemented in the

[1] *Philippine National AIDS Council. 2011. 5th AIDS Medium Term Plan (2011- 2016) The Philippine Strategic Plan on HIV and AIDS.*

Philippines. The recent framework developed at the Southeast Asia and Asia Pacific Regional level [2], the MSM and TG Comprehensive Response, is used to determine a baseline of how far the country has gone in terms of addressing MSM and TG needs as far as HIV is concerned.

**The survey, specifically, attempts to:**

**3.1.** Highlight the strengths and gaps of existing interventions (the current national response and the key HIV programs, and innovative practices being done on the ground); and

**4.2.** Promote discussions to guide directions for scaling-up of these programs, and identify areas of prioritization in terms of financial and technical support.

## 1.3 MSM AND TGS

The definition of MSM used by the Asia Pacific Coalition on Male Sexual Health (APCOM) is adopted for this survey, i.e.:

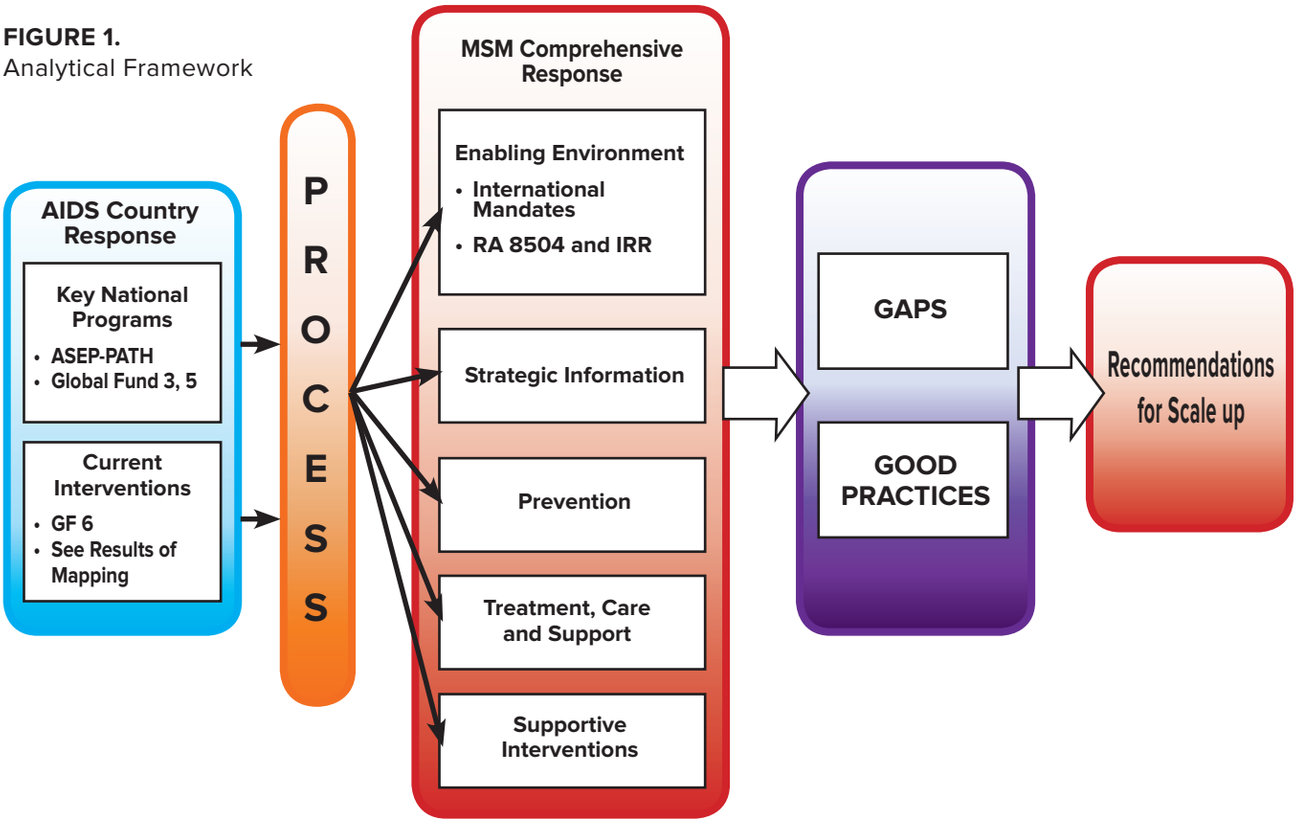
> Men who have sex with men is an inclusive public health term used to define the sexual behaviors of males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular "community". The words "man" and "sex" are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male to male sex takes place. [3]

Transgender persons are individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term transgender persons describes a wide range of identities, roles and experiences which can vary considerably from one culture to another. Transgender persons in Asia often identify themselves in local indigenous terms (for example, *waria* in Indonesia and *kathoey* in Thailand). [4]

## 1.4 ANALYTICAL FRAMEWORK

The survey presents an overview of the intervention programs implemented within the past 20 years that aimed to address the risks and needs of MSM and TGs. The analytical framework charts the flow of survey for the study. The AIDS country response is translated into the key national programs and current interventions, which in turn follow the MSM comprehensive response framework with its components. The assessments are founded on the gaps and good practices in the component-interventions presented by the respondents, and are bases for recommendations.

**FIGURE 1.**
Analytical Framework




[2] *Regional HIV and Development Programme for Asia and the Pacific--United Nations Development Programme. (2009). Developing a comprehensive package of services to reduce HIV among Men who have sex with men (MSM) and Transgender (TG) populations in Asia and the Pacific: Regional Consensus Meeting.*

[3] *U.S. Agency for International Development Regional HIV, Health and Development Programme for Asia and the Pacific UNDP Asia-Pacific Regional Centre. 2010. Men who have sex with Men and Transgender populations: Multi-City Initiative.*

[4] *Ibid.*

*The AIDS country response is translated into the key national programs and current interventions, which in turn follow the MSM comprehensive response framework with its components. The assessments are founded on the gaps and good practices in the component-interventions presented by the respondents, and are bases for recommendations.*

The MSM comprehensive response components are:

## A. PREVENTION

**TABLE 1.** General and specific prevention activities

| MAIN PREVENTION ACTIVITIES | SPECIFIC PREVENTION ACTIVITIES |
|---|---|
| **OUTREACH, PEER EDUCATION, AND DROP-IN CENTERS** | • Support and/or mentoring of local MSM and TG communities<br>• Training and support for peer ed and outreach<br>• Presence of MSM and TG sub-group specific models for service provision<br>• Safe spaces for MSM and TG<br>• Incorporation of other services (VCT)<br>• Linking to other services (HIV, TB and mental health)<br>• Positive prevention |
| **PROMOTION OF AND ACCESS TO COMMODITIES** | • Condoms with lubricants<br>• Ensuring range of access sites<br>• Messaging<br>• Clean needles and syringes |
| **STI PREVENTION AND TREATMENT** | • Sexual health as HIV prevention<br>• STI services within MSM and TG CBOs and NGOs<br>• MSM- and TG-friendly services<br>• Primary care services<br>• Training of health care providers<br>o Sexual history with attention to anal sex even among those who may not appear to be having male-to-male sex<br>o Counselling on safer sex even for those in relationships<br>o Sensitivity<br>o Psychosocial support |
| **HIV COUNSELING AND TESTING** | • For PLHIV: gateway to access to treatment and positive prevention<br>• For MSM who are still HIV-negative, services should reinforce importance of staying healthy and HIV-free |

## B. TREATMENT, CARE AND SUPPORT (TCS)

The voluntary and confidential nature of HIV counseling and testing cannot be underscored enough. Accessibility (time and venue) is of prime importance, particularly when provided alongside prevention counseling and information. As with STI prevention and treatment, this should be linked to psychosocial support and treatment, care and support.

## C. ENABLING ENVIRONMENT

Enabling environment covers three major domains, namely: (1) harmonization of HIV policies and practices with other laws and procedures, particularly policies and laws that may impede the HIV response among MSM; (2) reduction of harassment, violence and stigma; and (3) ensuring the continuity and consistency of the program and services through advocacy and leadership building.

## D. STRATEGIC INFORMATION

Strategic information is data gathered that are relevant in determining the appropriate and strategic prevention programs. Basic data base include population size estimation; biological and behavioral surveillance and social and operational research to contextualize the programs; and program and service monitoring and evaluation, coupled with policy /legislative review in order to ensure that a comprehensive and sustained information is available to guide and improve the interventions.

## E. SUPPORTIVE INTERVENTIONS

Supportive interventions are programs and projects geared toward strengthening organizations that deliver prevention, treatment, care and support services. Often, they come in the form of organizational development and capacity building programs. Supporting interventions are seen as sustaining interventions that are aimed at empowering communities and service providers, as well as providing skills that would allow for a more strategic and effective implementation of HIV prevention, treatment, care and support and rights protection.

# 2. Methodology

## 2.1 DATA SOURCES AND DATA GATHERING

The study builds on previous initiatives conducted by HAIN, such as the qualitative study assessing the risks and vulnerabilities of MSM and TG Populations (2010); the assessment of interventions done among female sex workers and IDUs; and the 6-City Scan Initiative supported by the UNDP, UNAIDS, USAID, USAID Health Pro, Family Health International, and APCOM (2011). The survey focuses on the learnings and feedback of the proponents (i.e. key informants) involved in the implementation. However, only in cases where outcomes are available was this included.

Three methods are used for the data gathering: desk review of relevant documents, key informant interviews, and focus group discussions (FGDs). Findings are reinforced by the interviews conducted with key informants. Among the documents surveyed for this purpose are:

- International agreements and policies
- RA 8504 and its Implementing Rules and Regulations
- AMTP 1-4 and assessment reports, when available
- Grant Performance Reports
- Project reports

In determining the interventions currently being implemented, the survey initially drew from the results of the scoping exercise conducted by HAIN as part of its UNDP Project. The results of the APCOM-supported mapping exercise conducted by the TLF-SHARE Collective is also utilized for this purpose. Information from these two documents serve as springboard in identifying the individuals and groups already working on HIV in the different sites.

The data gathering exercise followed a three-step process. Firstly, an orientation meeting and a workshop were conducted to gather majority of the groups working on HIV across the different sectors, namely from the government, non-government, and private sectors in Cebu City and Davao City. This was followed by discussions focused on efforts currently in place, and identifying of innovations being done. Individual interviews then followed, focusing on these innovations.

## 2.2 STUDY RESPONDENTS AND STUDY SITES

There were 14 key informants interviewed. The interviews were meant to look into the implementation of key national programs. Eight of the interviews were conducted in Manila, and six were conducted in Cebu City and Davao City.

To capture the experiences of frontline service providers, separate FGDs were conducted among community health outreach workers and peer educators in Metro Manila.

As a second step, groups in Davao City were gathered to discuss their different efforts and probe into the details of their implementation of these efforts. Here, the methodology used for the 6-City Scan Initiative developed by Scott Berry for the UNDP was adopted. Metro Manila was part of the 6-City Scan Initiative, and thus provided basis for comparison of results across the two sites. Moreover, the Initiative integrated inputs from the UNAIDS assessment done among sex workers and Injecting Drug Users (IDUs).

Recognizing the importance of the input of the beneficiaries, nine interviews (three for each site), and an FGD with PLHIV were conducted in Metro Manila.

## 2.3 SURVEY INSTRUMENTS

An interview guide was used for the key informants. The interview guide was developed by the research team to capture the historical progress of the interventions, their contexts at inception, and their implementation processes, in order to capture the strengths and gaps of these interventions.

FGD guide. Two discussion guides were developed. One meant to capture the experiences of frontline service providers, conducted among community health outreach workers and peer educators in Metro Manila. The other was developed in order to look at the experiences and insights of those who benefited from these interventions, particularly beneficiary PLHIV (in Metro Manila). The FGDs meant to triangulate the data gathered.

## 2.4 SCOPE AND LIMITATIONS

The initial plan for the survey was for a three-site data gathering, with Metro Manila, Metro Cebu, and Metro Davao meant to represent the three urban centers where the prevalence of risks for MSM and TGs are registered as highest in the country, and where most of the interventions are concentrated. Each key site was also meant as a representative site of each major area of the country.

Due to the limitations of facilitation and time, data from Cebu were not gathered in time. Thus, the results of the FGDs and interviews were conducted only in two sites, i.e. Metro Manila and Davao. The discussions, therefore, that resulted from the interviews and the FGDs are representative only of the identified sites and their interventions.

# 3. Overview:
## Asia-Pacific and Philippine HIV Situation and Survey of Initiatives

*When HIV first appeared in Asia, it manifested first within marginalized communities, including intravenous drug users (IDUs), sex workers, and MSM. From there, it expanded into the general population.*

### 3.1 ASIA-PACIFIC AND THE PHILIPPINES

According to conservative estimates, MSM around the world are 15 times more likely to be infected with HIV. [5] In the Asia-Pacific region, MSM are 19 times more likely to be living with HIV compared with the general population. And while they are more likely to be living with HIV, the proportion of MSM that is reached by HIV program interventions (prevention, care and support) remains low. [6] According to the report *Examples of Municipal HIV Programming for Men who have Sex with Men and Transgender People in Six Asian Cities* (2011) that surveyed HIV interventions in six major Asian cities, namely Bangkok, Thailand; Chengdu, China; Ho Chi Minh City, Viet Nam; Jakarta, Indonesia; Manila, the Philippines; and Yangon, Myanmar, for many MSM and transgender people, highly urbanized and densely populated cities offer spaces of freedoms for expression of sexuality and gender identity. But while these offer spaces for negotiations of identities, there is a great economic and social disparity in these cities, and poverty means a lack of health and social services. The cities do not provide enough economic opportunities, so for many disadvantaged MSM and TGs, cities also create greater vulnerabilities to HIV, discrimination, and other human rights violations.

The report also echoes the Commission on AIDS in Asia (2008) prediction that unless strategic and effective initiatives are identified and scaled-up by the year 2020, 46% of new HIV infections in Asia will be among MSM, marking a 13% increase from 2008 figures. The report notes that this is now the reality in some of the cities. For Metro Manila in the Philippines, the report states that the HIV and AIDS cases among MSM more than quadrupled between 2006 and 2009. Approximately 70% of all new HIV case reported in the Philippines from 2008 to 2009 are, in fact, among MSM.

When HIV first appeared in Asia, it manifested first within marginalized communities, including injecting drug users (IDUs), sex workers, and MSM. From there, it expanded into the general population. Initially, HIV and AIDS moved slowly across the region and was only seen intermittently until 1988, after which it then began to spread among IDUs in the region around the Thai, Myanmar, and Lao borders. It has since expanded to an epidemic level among sex workers, as it continues to spread across the region. [7]

Sexuality is regarded as more fluid in many Asian and Pacific island cultures. Traditionally, there is a recognition of the diversity of sexual orientations. For example, in many communities, transgender people were given roles such as spiritual mediums, healers and artists. There is tacit acceptance of homosexuality that is conditioned on discreetness. This tacit acceptance created a contested assertion of rights and visibility in the region, and created particular vulnerabilities for MSM. [8]

A report on MSM and HIV/AIDS risk in Asia (2006) calls attention to the particular vulnerabilities of MSM. The identification of MSM is said to be problematic because of very strong stigma, discrimination, denial, and ignorance of the identity. The report found the most outstanding characteristic of MSM identities in Asia is their diversity, i.e. "MSM identities include transgender individuals, feminine-acting MSM, their masculine-acting partners,

[5] *WHO,UNICEF, UNAIDS. Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector, 2009; UNAIDS.Global Report on the AIDS Epidemic, 2008.*

[6] *USAID. 2008. HIV Prevention for Hard-to-Reach Men Who Have Sex with Men. AIDSTAR-One. Available at: www. aidstar-one.com*

[7] *Ruxrungtham K, BrownT, Phanuphak P. "HIV/AIDS in Asia." Lancet.July 3, 2004; Vol 364:69-82.*

[8] *Winter S., King M. "Well and truly fucked: transwomen, sex work, stigma and sexual health in South and South East Asia." In Dalla, R. L., Baker, L. M., DeFrain, J. & Williamson, C. (eds.) A Global Perspective of Prostitution with Implications for Research, Policy, Education, and Service. Vol. II: North America, Latin America, and Europe. Landham: Lexington Publishers.*

gay-identified men who have situational sex with each other. All of this diversity is in theory covered by the term MSM, which focuses on behavior rather than identity." Moreover, the report highlights that the broad term has been more often associated with groups that are more visible or that are politically active.

Compared to their Western counterparts, relatively few Asian men were found to adopt a Western gay identity that have allowed men to participate in male-male sex while keeping their sense of masculinity. The report points, for example, that many of the men are married, and stigma and discrimination led many of them to conduct covert sex lives that often involve commercial sex.[9] The ignorance and denial about male-male sex resulted in the lack of strategic MSM programming.[10] HIV/AIDS prevention programming in Asia in the past has often concentrated on heterosexual sex and IDUs. Many of the early government health educators who first ran prevention programs, ill-equipped with the lack of data on MSM and confused by MSM diversity–concentrated their programs on the vulnerable groups initially identified, the epidemic-IDUs and female sex workers. This led many MSM to believe that their own behaviors are not risky. [11]

There are also notions that persist among MSM that contribute to their vulnerabilities. Unsafe sex is perceived by those in relationships as a manifestation of commitment; or those who are not in a relationship as a sign "of longing for love." Informants from multiple countries in an HIV vulnerability study among MSM (2000) noted that MSM "did not use condoms so that they could prove their love to their partners." Thus, condom use failed because of the MSM trying to please a partner. Such traditional programming now need to be challenged to meet the changing contexts of MSM vulnerabilities.

Asian MSM have multiple risk factors to HIV and AIDS, including: misconceptions about risk factors; high levels of unprotected anal intercourse; high levels of transactional sex; high numbers of sex partners; and low perception of self-risk. Stigma creates a fertile ground to these behaviors by negatively affecting self-esteem and fostering a hostile policy environment. [12]

## 3.2 INTERVENTIONS

### 3.2.1 PREVENTION

Testing for HIV became available in 1985. Promotion and access to antiretroviral-therapy or treatment (ART) were the primary modes for forwarding prevention programs. The early process of testing was initiated by a healthcare provider, usually from the government, recommendations for testing were usually forwarded to persons manifesting symptoms. Testing as a preventive program has since evolved into the HIV voluntary counseling and testing (VCT) practice in use today, where testing is now initiated by an individual based on an informed and voluntary consent after an appropriate counseling. The principles of the "3 Cs" became the framework for testing: informed and voluntary consent, counseling, and confidentiality, where the session/s and the results of the testing are kept strictly confidential. [14]

The UNAIDS, WHO and other international agencies took on the global promotion of VCT programs. With the increasing trend of HIV prevalence, urgency was felt to encourage VCT services among high risk populations and vulnerable populations as part of a comprehensive prevention framework.[15] Moreover, in more recent implementation of prevention programs, there has been movement from government-initiated and implemented efforts to a more comprehensive effort that involved communities. In large cities in Asia, community-based organizations and their services were found to be crucial in delivering services to MSM and TGs, especially such services as HIV and STI testing and counseling. [16]

Studies found that the interactive model for VCT is more sustainable and effective. An excellent VCT is characterized by culturally appropriate and sensitive counseling. This has been found to be

[9] *TREAT Asia, AMFAR. 2006. MSM and HIV/AIDS Risk in Asia: What Is Fueling the Epidemic Among MSM and How Can It Be Stopped?*
[10, 11] *Ibid.*
[12] *Hong Kong AIDS Foundation, Jones RH, KwanYK, Candlin CN. 2000. A Preliminary Investigation of HIV Vulnerability and Risk Behavior among Men who have Sex with Men in Hong Kong.*
[13] *Ibid.*
[14] *UNAIDS/WHO Policy Statement on HIV Testing, June 2004; from http://www.who.int/hiv/pub/vct/statement/en/ Accessed January 2012.*
[15] *Ibid.*
[16] *UNDP, USAID-ASIA, UNAIDS, AIDS Project Management Group. 2011. Towards Universal Access: Examples of Municipal HIV programming for Men who have sex with Men and Transgender Persons in Six Asian Cities*

*There have been many initiatives towards prevention of HIV in Asia. Many organizations have led efforts, and institutions have given their funding support through MSM organizations in several countries in Asia and the Pacific.*

effective in increasing the client's awareness and knowledge, as well as openness to testing.[17] An integral component of an effective VCT is the use of peer educators and counselors, found to be more effective to generate more positive responses. In a report on Chinese efforts on VCT and peer counseling, they found that when peer educators who were MSM used their own identity and experiences as gay men/MSM and their knowledge of local MSM gathering places (like saunas, bars, fitness centers, private houses, massage parlors, parks, and public toilets), they become more effective in reaching more individuals. It was regarded that the work of peer educators were largely responsible for the continuing accessing of MSM of VCT and STI testing, as well as in recruiting new members to join the volunteer team of peer educators. [18]
Prevention programs with peer educators as main implementers became a model to reach more vulnerable and hard-to-reach groups.

Among peer-based interventions, the group-based, peer-led services in running workshops, camps, social and cultural events were seen as the more effective methods in engendering a sense of community and family among MSM and TGs, by providing "role modeling" and "positive reinforcement" for many of those who participate in the activities. [19]

Prevention interventions have also moved in step with the evolving ways that MSM and TGs communicate and interact with each other. Studies have reported that more and more MSM and transgender people, including those considered hidden and "hard-to-reach" groups, are turning to the Internet to make new friends, and meet for social and sexual liaisons. [20] In the cities surveyed for MSM and TG programming, MSM and TGs were found to increasingly use mobile phone technologies for "chatting" and "hooking-up". [21] A report surveying Asian cities found that new communication technologies expanded the reach of prevention programs to larger numbers of MSM and TGs. [22]

The service delivery have began to use new information and communications technologies, such as online sites and SMS (text messaging) as part of their outreach efforts for relaying information, awareness for testing, and counseling services. Both in the medical and community services, there are efforts that use mobile technologies such as SMS to reach MSM and transgender people as they relay their services. One common implementation strategy is the online peer education program. Peer educators join social networking sites and engage individual users in "chat" that then becomes an opportunity for the discussion of health concerns and relaying of education for prevention. This mode of intervention is supported by researches that suggest that these communication strategies

[17] *Keane, V., G. Hammond, et al.. 2005. "Quantitative evaluation of counseling associated with HIV testing." SoutheastAsian J Trop Med Public Health 36(1): 228-32.*

[18] *UN Technical Working Group on MSM and HIV/AIDS Beijing, China. 2008. Enabling Effective Voluntary Counseling and Testing for Men who have sex with Men Increasing the Role of Community Based Organizations in Scaling Up VCT Services for MSM in China.*

[19] *UNDP, USAID-ASIA, UNAIDS, AIDS Project Management Group. 2011. Towards Universal Access: Examples of Municipal HIV programming for Men who have sex with Men and Transgender Persons in Six Asian Cities.*

[20] *USAID . 2011. HIV Prevention for hard to reach men who have sex with men. AIDSTAR One. Available at: www. aidstar-one.com; Terrence Higgins Trust. Date unavailable. The HardCell web site: online HIV and sexual health promotion with hard to reach, high risk MSM. Available at: www.tht.org.uk; Magnani, Robert; Sabin, Keith; Saidel, TobieandHeckathorn, Douglas. 2005. Review of Sampling Hard to Reach and hidden populations for HIV surveillance. AIDS 2005 19 (suppl 2): S67-S72.*

[21] *Ibid. Among the popular means for hooking-up are mobile phone application/s that would inform the user when there was someone in close proximity with them. As of the survey none of the participating program implementers reported the use such applications in their service delivery.*

[22] *UNDP, USAID-ASIA, UNAIDS, AIDS Project Management Group. 2011. Towards Universal Access: Examples of Municipal HIV programming for Men who have sex with Men and Transgender Persons in Six Asian Cities.*

are successful in promoting a more sustained health seeking behavior among MSM, especially in increasing the rate for re-testing (e.g. SMS reminders were used to promote return visits of MSM and TGs for testing and counseling, and monitoring visits for PLHIV). [23]

In major Asian cities, large annual community events have generated an increase in awareness and acceptance of MSM and TGs, presenting a viable platform for expanding and promoting HIV health and rights among MSM and transgender people. [24]

An important characteristic of the community events is that these were mostly self-generated. As such, the events provided cultural focal points to raise and promote HIV and other health issues. They engender better understanding and acceptance of MSM and TGs. The events, by their sheer character and flair, are able to generate media and public attention. [25]

All around Asia, especially in the cities, print and online, mainstream and MSM-focused media are the new modes of delivering key messages of prevention to MSM and TGs. In Manila in the Philippines, for example, "gay" media were referred by MSM and TG beneficiaries as important advertising and campaign tool for health promotion and raising awareness of HIV and STIs among MSM and TGs.

There have been many initiatives towards prevention of HIV in Asia. Many organizations have led efforts, and institutions have given their funding support through MSM organizations in several countries in Asia and the Pacific. The initiatives were translated in a variety of efforts, from community VCT through peer education; clinical services within NGOs, community-based organizations and governments; drop-in centers; mobile STI clinics; outreach projects to MSM at sites of sex; to the use of new communication technologies. Most of the programs have had some positive results on the lives of individuals, sectors and communities that were reached. More often, however, these programs have been challenged in their limited reach. [26]

While on its own each effort made progress in promoting preventive messages and behaviors among MSM and TGs, there is still a strong call for a comprehensive package of services and programs to support HIV prevention. It is a package that interlocks with treatment and care among MSM and TGs in a framework that interconnects preventive efforts with continuing contact with MSM and TGs, to continue reaching MSM and TGs, and continue assisting them in the reduction of their risk of infection; and for PLHIV, for their continued access to treatment, care and support. [27]

### 3.2.2 TREATMENT, CARE AND SUPPORT

Traditionally, clinics are the main sites for HIV/AIDS prevention and care, so that their effectivity rests on the knowledge and sensitivity of their healthcare workers. According to some studies, healthcare workers usually lack knowledge and fail to ask about male to male sex, or manifest discriminatory attitudes regarding male to male sexual activity. Very few health workers are attuned and sensitized to the needs and realities of MSM. [28]

According to a 2010 international survey, 56% of people living with or affected by HIV reported experiencing negative attitudes from health workers due to their membership in a stigmatized group, with one in four saying they were afraid to seek services due to the risk of experiencing social disapproval or active discrimination. [29] Community workers echo this sentiment, reporting that many MSM are reluctant to avail of the services of public STI clinics because of fear of being stigmatized and being treated poorly by health workers. Because of this, many MSM decide to self-treat for STIs and seek out community pharmacies and pri-

[23] *Bourne C, Knight V, Guy R, Wand H, Lu H, McNulty A. 2011. Short message service reminder intervention doubles sexually transmitted infection/HIV re-testing rates among men who have sex with men. Sexually Transmitted Infections. Available at: http://sti.bmj.com/.*

[24, 25] *Ibid.*

[26] *Lou McCallum, Scott Berry, Andy Quan, AMFAR. 2009. Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific Determining Operations Research Priorities to Improve HIV Prevention, Treatment, Care, and Support Among Men Who Have Sex With Men.*

[27] *Regional HIV & Development Programme for Asia & the Pacific UNDP Regional Centre for Asia Pacific. 2009. Developing a Comprehensive Package of Services to Reduce HIV among Men have sex with Men (MSM) and Transgender Populations in Asia and the Pacific.*

[28] *UN Technical Working Group on MSM and HIV/AIDS Beijing, China. 2008. Enabling Effective Voluntary Counseling and Testing for Men who have sex with Men Increasing the Role of Community Based Organizations in Scaling Up VCT Services for MSM in China.*

[29] *NGO Delegation to the UNAIDS Board. 2010. Stigma and Discrimination: Hindering Effective HIV Responses. Available at http://unaidspcbngo.org/wp-content/uploads/2010/05/2010_NGO_Report_Final_website.pdf.*

*Community groups would promote counseling and testing in the communities using public settings and "mobile" clinics, while clinics provide ongoing counseling and regular contact. Some clinics were run by community groups, making them more accessible because of the familiarity they provided. To make the clinics more accessible and friendlier, consultations with PLHIV are conducted for getting feedbacks.*

vate providers for HIV testing and treatment.[30] There is also very little appreciation among MSM about how knowledge of their HIV status would benefit them.[31] Often, when they are diagnosed, it is usually in isolated VCT services. Most are then discouraged to follow-up until full-blown symptoms manifest and they develop HIV. Most HIV clinical services play no role in HIV prevention aside from providing knowledge of HIV status. There is often an assumption that prevention interventions are done by the community. [32]

It was found that the lack of coordination between VCT, STI, HIV, TB, and drug treatment services tend to leave little choice to MSM in finding the services they need. This implies that the effectivity of HIV prevention-to-care hinges on the ability of individual MSM to have the means, personal ability and character, and resources to avail one service to another for information, prevention, treatment, care and support. The uncoordinated services result in many MSM and TG unable to avail of proper servicing, as they are often lost when it comes to referrals and follow-up. In the case of some MSM sub-populations in the region [33] , they are unable to access ART because of the lack of required identity papers or fixed residence, or because they are deemed "unreliable" and therefore suggest being unable to comply with treatment by health workers. [34]

The framework for a comprehensive delivery of services emphasizes the strength required in the link between HIV testing and counseling, and ongoing treatment, care and support. Where there was a lack of firm link in place, in many countries, the implementation of VCT services resulted in high rates of loss to follow-up and the late administration of HIV, treatment, care and support for MSM and TGs. This, in turn, led to higher death rates, higher cost for medical treatments of infections, as well as HIV transmissions. [35]

A report scanning Asian city initiatives for MSM and TGs (2010) found that the linking of communities with clinics using "outreach" and "in-reach" activities tended to enrich and expand the promotion of counseling and testing. Community groups would promote counseling and testing in the communities using public settings and "mobile" clinics, while clinics provided ongoing counseling and regular contact. Some clinics were run by community groups, making them more accessible because of the familiarity they provided. To make the clinics more accessible and friendlier, consultations with PLHIV are conducted for getting feedbacks. The report found that good relationships between service providers and community groups allowed for better awareness, and more access by MSM and TGs. [36]

### 3.2.3 ENABLING ENVIRONMENT

By 2005, 191 members of the United Nations (UN) endorsed the goal of universal access to HIV prevention, treatment and care for all who need it. The universal access agenda provided

[30] *Lou McCallum, Scott Berry, Andy Quan, AMFAR. 2009. Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific Determining Operations Research Priorities to Improve HIV Prevention, Treatment, Care, and Support Among Men Who Have Sex With Men.*

[31, 32] *Ibid.*

[33] *Ibid. Particularly transgendered people, migrants, and the homeless.*

[34] *Ibid.*

[35] *Regional HIV & Development Programme for Asia & the Pacific UNDP Regional Centre for Asia Pacific . 2009. Developing a Comprehensive Package of Services to Reduce HIV among Men have sex with Men (MSM) and Transgender Populations in Asia and the Pacific.*

[36] *U.S. Agency for International Development Regional HIV, Health and Development Programme for Asia and the Pacific UNDP Asia-Pacific Regional Centre. 2010. Men who have sex with Men and Transgender populations: Multi-City Initiative.*

a framework for advocating HIV response programs for MSM. Countries were made to describe their progress against their goals set in their reports to the United National General Assembly Special Session on HIV/AIDS (UNGASS). International institutions that also mandated that countries include universal access targets in their national AIDS strategies included the Global Fund, President's Emergency Plan for AIDS Relief (PEPFAR) plans, and other donor-funded programs. This was envisioned to create a framework that inspired HIV response among most-at-risk populations, lending support for the creation of enabling environments for preventing HIV transmission and providing HIV treatment, care, and support for people from marginalized populations. [37] This framework agreed to by States would have created an environment that was safe, enabling and empowering for MSM and TGs.

However, according to the Legal Environments Report (2010), repressive legal environments for MSM and transgender people exist in the majority of the countries in the Asia Pacific region. In 19 out of 48 counties, male-to-male sex is criminalized. Eight countries in the region have laws pertaining to public order and prostitution that are enforced by police against MSM and TGs. [38] The report also describes how legal environment push MSM and TGs away from seeking HIV services, as they become anxious of being prosecuted and branded as criminals. [39] While there are many regional and national human rights institutions, they remain underutilized in seeking redress and to respond to issues of rights violations affecting MSM and TGs. [40]

In an effort to create an enabling environment for MSM and TGs rights and services, interventions were taken to empower existing institutions to take on the cause of MSM and TGs towards their rights to health, protection, and quality of life. The Asia Pacific Forum of National Human Rights Institutions (APF) became the leading regional human rights organization that promoted and increased its engagement on HIV, sexual orientation and gender identity issue. Its two major efforts paved the way for greater awareness and involvement of institutions with MSM and TG issues. In 2009, APF, in partnership with the Indonesian Human Rights Commission, convened a regional meeting for human rights institutions, focusing on the role of national institutions in promoting the Yogyakarta Principles. In 2010, along with the UN Office of the High Commissioner for Human Rights (UNOHCHR) and the Danish Institute for Human Rights, with the support of UNAIDS, and UNDP, the AFP organized a Regional Workshop on HIV and Human Rights for National Human Rights Institutions. The regional meetings became a way for linking and establishing coordination between national human rights institutions and civil society organizations. [41]

In 2009, Asia and the Pacific saw the establishment of the ASEAN Intergovernmental Commission on Human Rights. This presented an opportunity to emphasize the urgent need to prioritize human rights issues for MSM and TGs at a regional level, and "to explore the relationship between human rights and public health in the context of the escalating regional HIV epidemic, and to identify examples where country-level action (such as recognition of constitutional rights to nondiscrimination on grounds of sexual orientation) provide useful models for consideration by other jurisdictions." [42]

At the onset of the rise of HIV in the region, some countries took on a more focused effort in ensuring that MSM and TG health rights are ensured and protected. In 1998, the Philippine Legislature enacted the Philippine AIDS Prevention and Control Act of 1998 (RA 8504), touted as "one of oldest laws on HIV and AIDS and a model for HIV/AIDS-related human rights legislation."[43] Used as models for the law were the Universal Guidelines on HIV/AIDS and Human Rights, namely: national framework, supporting community partnership, public health legislation, and crim-

[37] *Lou McCallum, Scott Berry, Andy Quan, AMFAR. 2009. Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific Determining Operations Research Priorities to Improve HIV Prevention, Treatment, Care, and Support Among Men Who Have Sex With Men.*

[38] *In the Philippines, while there are no laws that outrightly criminalize male-to-male sex, police harassment of MSM and TGs continue to the application and interpretation of other laws.The Anti-Vagrancy and Anti-Sex Work laws (Revised Penal Code Article 202), Anti-Public scandal Law (Revised Penal Code Article 200), the Anti-Trafficking in Persons Act and laws that pertain to moral turpitude are among those often cited by the police. In most cases the ultimate goal of the police is mainly for extorsion and harassment of MSM and TGs.*

[39] *John Godwin. 2010. Legal Environments, Human Rights, and HIV responses among Men who have sex with Men and Transgender People in Asia and the Pacific: An Agenda for Action*

[40, 41, 42, 44] *Ibid.*

[43] *Alternative Law Research and Development Center (Alterlaw), Inc.. 2003. Where are we now? A Candid Snapshot of Philippine Observance of International Guidelines on HIV/AIDS and Human Rights.Quezon City.*

*A report in HIV/AIDS Risk in Asia (2006) noted that even when prevalence of risk behaviors among MSM populations are existing in their countries, governments allocate very few resources on monitoring or developing prevention and education programs.*

inal and correctional systems. [44] Among the highlights of the law are its provisions for the protection of PLHIVs from any form of discrimination, requiring the State to fully protect their human rights and liberty, with specific provisions related to HIV testing, including prohibition on compulsory testing, and respect for privacy and confidentiality. The law made it an obligation of the State to promote accurate and appropriate public awareness about the prevention and care of HIV and AIDS through a comprehensive nationwide educational and information campaign;[45] The State was also made to respond to barriers that hampered the prevention of the rise of the infection, namely gender inequality and marginalization; just as a proposal was also presented for the State to recognize the role of affected individuals in providing information about HIV, and their experiences to educate and inform the public.[46]

Getting legal representation services and the engagement with local law enforcement bodies have become a source of support for many MSM and TGs in the region. Their effectiveness is given credence by the support given by the international community in the Greater Mekong Region and China. There, initiatives that engaged those tasked with local law enforcement have shown some positive results. In the Philippines, among such engagements with local law enforcement and local government are those focused on the prevention of the police from using condoms as evidence for sex work, the continued lobbying for the amendment of the Anti-trafficking Law, and amendment of police policies to prevent law enforcement agencies from using these as bases for harassing sex workers, MSM and TGs.[47] Cited as one of the best practices in engaging local issues is that of the Action for Health Initiative, Inc. (ACHIEVE), which had an initiative to improve cooperation and dialogue among the police, sex venue owners and city government health officials, with the goal of preventing further harassment against already marginalized groups.[49]

In the creation of an enabling environment, support from communities is very integral, and local government support and commitment to ensure project sustainability at the local level remains just as indispensible.[50]

All over the region, people affected and infected with HIV continue to experience stigma and discrimination. Most are denied access and enjoyment of the services they are entitled to. Because of stigma and discrimination, PLHIV hesitate and are unable to file complaints and seek redress for the discriminatory acts against them.[51] Years after the enactment of the AIDS Law in the Philippines, PLHIV continue to suffer discrimination, especially in healthcare settings. Discrimination was also noted when accessing social services, housing and edu-

[45] *Republic of the Philippines, Philippine AIDS Prevention and Control Act of 1998 (RA 8504), Section 2b.*
[46] *Ibid., Section 3e.*
[47] *Ibid.*
[48] *Action for Health Initiatives (ACHIEVE). 2011. Positive Justice: Utilization of People Living with HIV of the Philippine AIDS Prevention Control Act of 1998 (RA 8504).*
[49] *UNDP, USAID-ASIA, UNAIDS, AIDS Project Management Group. 2011. Towards Universal Access: Examples of Municipal HIV programming for Men who have sex with Men and Transgender Persons in Six Asian Cities.*
[50] *Lou McCallum, Scott Berry, Andy Quan, AMFAR. 2009. Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific Determining Operations Research Priorities to Improve HIV Prevention, Treatment, Care, and Support Among Men Who Have Sex With Men.*
[51] *Action for Health Initiatives (ACHIEVE). 2011. Positive Justice: Utilization of People Living with HIV of the Philippine AIDS Prevention Control Act of 1998 (RA 8504).*

cation, especially for their children. And yet none used the law to seek redress for their complaints. [52, 53] In addressing HIV and AIDS, access to redress mechanisms and assurance of rights are integral to the holistic approach to care and prevention. Access-to-justice issues, and applicability of laws and policies are part and parcel of the realities that serve as either barriers to or enabling environments for MSM and TGs.

Among the arenas that proved fertile ground towards universal access is in the use and promotion of rights and the law. Organizations in major Asian cities that work for health and rights program play a crucial role in encouraging broader government support, coordinating and organizing local advocacy. [54] For intervention programs to be sustained and effective, structural barriers that hamper the HIV prevention, services and care for MSM and TGs have to removed. [55]

### 3.2.4 STRATEGIC INFORMATION

According to a 2007 UNAIDS study of 20 countries in Asia, 60% of national surveillance mechanisms did not include MSM in their data collection. Fifteen percent of the countries did not collect behavioral and HIV infection data on MSM. Only 8% of the countries provided MSM with the means of preventing HIV transmission, and 75% of the countries did not provide any targeted funding for MSM. In terms of national planning, 40% did not mention MSM in their national AIDS plans. [56] Notwithstanding that 5% to 20% of new infections occur among MSM, most countries in Asia still spend less than 1% of their HIV budgets for MSM targeted interventions. [57]

According to some studies, there is a need for more information about what influences and steers the decisions MSM are making regarding sex and HIV risks. The lack of information presents a challenge for the design of prevention messages and services that would work effectively for MSM. [58] The lack of strategic information is one of the most challenged component in addressing HIV prevention. While there have been MSM-specific studies conducted, relative to the vast size and diversity of the population, much remains to be done. For instance, many countries in Asia have yet to conduct epidemiological research among their MSM groups. [59] A report in HIV/AIDS Risk in Asia (2006) similarly noted that even when prevalence of risk behaviors among MSM populations are existing in their countries, governments allocate very few resources on monitoring or developing prevention and education programs. [60]

Where there were strategic information gathered, the surveillance and monitoring programs found to be effective were those that used behavioral surveys. [61] The surveys provided help in identifying the prevalence of the riskiest behaviors (e.g. unprotected anal intercourse with a casual partner) and paved the way for providing of different categories and better targeting of services relative to the extent of risk behavior. [62]

Some efforts have similarly been taken to describe sub-populations of MSM in different parts of the region. However, greater and more in-depth research is still required to inform programs how to better reach these sub-populations, and how to better the messaging and actual service delivery. [63] Research recommendations for surveillance have been presented for risks and vulnerabilities not only of the individual or of MSM subcultures, but contextualizing these in the wider society in which MSM live. This is because each locale would define gender and sexuality differently. As such, this

[52] *PinoyPlus Association (PPA). 2004. Human Rights Peer Documentation Project: A Multi-City Participatory Action Research on Social Stigma, Discrimination and AIDS.*

[53] *According to the ACHIEVE report (page 12): "While no assessment has been done on RA 8504's effectiveness in curbing discrimination against people on account of their actual, perceived or suspected HIV status, the national HIV response appears to not fully address stigma and discrimination and their harmful impact on public health and human rights. Stigma and discrimination remain among the major barriers to HIV prevention, treatment, care and support in the country. To date, no pioneering test cases have been successfully pursued against perpetrators of discriminatory acts."*

[54] *UNDP, USAID-ASIA, UNAIDS, AIDS Project Management Group. 2011. Towards Universal Access: Examples of Municipal HIV programming for Men who have sex with Men and Transgender Persons in Six Asian Cities.*

[55] *Lou McCallum, Scott Berry, Andy Quan, AMFAR. 2009. Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific Determining Operations Research Priorities to Improve HIV Prevention, Treatment, Care, and Support Among Men Who Have Sex With Men.*

[56] *UNAIDS. 2007. Men who have sex with men: The missing piece in national responses to AIDS in Asia and the Pacific. UNAIDS: Bangkok, Thailand. Retrieved from http://www.unescobkk.org/fileadmin/user_upload/hiv_aids/Images/in_house_doc_covers/Recommended_resources/MSM_the_missing_piece__Aug_2007_.pdf*

[57] *Lou McCallum, Scott Berry, Andy Quan, AMFAR. 2009. Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific Determining Operations Research Priorities to Improve HIV Prevention, Treatment, Care, and Support Among Men Who Have Sex With Men.*

[58, 60, 61, 62, 63] *Ibid.*

[59] *TREAT Asia, AMFAR. 2006. MSM and HIV/AIDS Risk in Asia: What Is Fueling the Epidemic Among MSM and How Can It Be Stopped?.*

*Local NGOs and POs have found the institutional support and mentoring to enable them to sharpen their programs and implementation better. Supportive interventions became an integral part of efforts towards delivering a comprehensive package.*

could influence the degree to which MSM are fully accepted, and thus influence their risk behavior, as well as the availability and access of services. [64]

The implementation of a comprehensive package of programs and services require a good basis for planning, ensuring geographical areas and sub-populations of MSM and TGs are identified in order to maximize the impact of the use of resources. To achieve this, an eidetic process of ongoing monitoring and evaluation, and research to assure that the services remain attuned to the changing patterns of HIV risk, and changing needs of MSM, TGs and PLHIVs living with HIV. [65]

### 3.2.5 SUPPORTIVE INTERVENTIONS

Supportive interventions go a long way in strengthening efforts for prevention by strengthening the organizations that deliver prevention services. Institutional support for organization development for NGOs and community-based organizations serve as scaling-up factor for many prevention initiatives. The UN bodies and other regional organizations have initiated supportive interventions through programs geared towards organizational development and instrastructure support for country program implementors. In the Philippines, for example, an NGO-to-NGO Mentoring Program was established to improve and capacitate local NGOs and POs working on the ground. The program meant to transfer "technology" and capacitate interventions on the ground for better efficacy and sustainability. Many of the "transfer" were through trainings and capacity-buildings. Among the specific areas targeted for supportive interventions were through trainings for peer education, organizational development through systems and infrastucture development, constant updates for information, and networking for policy updates and interventions.

Local NGOs and POs have found the institutional support and mentoring to enable them to sharpen their programs and implementation better. Supportive interventions became an integral part of efforts towards delivering a comprehensive package.

[64, 65] *Asia Pacific Coalition on Male Sexual Health. 2008. The Role of Research in Improvi ng Health Seeking Behaviours Among MSM: A Guideline.*

# 4. Survey of Philippine Interventions

Since the enactment of the Philippine AIDS Law in 1998, spearheaded by the Philippine National AIDS Council (PNAC), the Philippine government has implemented four country responses to curtail the spread of HIV in the country. The country's 4th AIDS Medium Term Plan (4th AMTP) ended in 2010 after a six-year period implementation. A mid-term review of the 4th AMTP conducted in 2008 showed how some programs and systems needed further support and strengthening, primarily in the prevention strategy. [66] This was assessed as the result of insufficient budgetary commitments and unsustained support from both the national government and LGUs. The lukewarm uptake of initiatives for HIV and AIDS was viewed as an effect of the realities and influence of opposing religions and political differences that both the national government and LGUs continue to negotiate and navigate. The assessment also pointed to stigma and discrimination as a continuing experience for PLHIV and the absence of redress mechanisms for their grievances. [67]

The 5th AMTP recognizes the challenges that continue to face efforts on HIV prevention in the Philippines, noting that socio-cultural and socio-economic factors affect access and behavior change (especially with condom use) programs; how psycho-social factors such as denial, stigma and discrimination can influence an individual's motivation to know one's HIV status; and how poverty plays a role in an individual's capacity to access comprehensive care (cost of transportation, etc.), and consequently, affect the efficacy of VCT and ART programs. [68] In the inception of the 5th AMTP, these gaps and challenges were noted and considered in the updating of the national response strategies.

The 5th AMTP lists as its strategic objectives the improvement of coverage and quality of prevention programs, treatment, care and support programs for PLHIV, those at risk, and their families; increase coordination among HIV programs at all levels, national and local; providing support interventions by expanding and increasing the capacities of the council, its members, LGUs, partner organizations, the private sector, and communities-at-risk. [69]

Results of studies on the programs already implemented for HIV and AIDS called for a comprehensive framework in the delivery of the various programs. In the Comprehensive Package of HIV Services for MSM and Transgender People in Asia and the Pacific, programs such as peer outreach, peer education and drop-in services as well as promotion of, and access to them, were regarded as some of the best means of HIV prevention. As such, the document emphasized that services had to be provided by a variety of organizations, each with distinct information and knowledge that would take into account the variety of MSM and transgender sub-populations, and take account of their varied needs and vulnerabilities.

## 4.1 KEY NATIONAL PROGRAMS IMPLEMENTED (ASEP TO GFATM ROUND 5)

When the Philippine government first developed its national response to HIV and AIDS, the DOH was its primary implementer. Most government programs focused on prevention by establishing treatment sites, and programs that focused on treatment, research, and surveillance. Support from USAID and Global Fund provided important resources to initiate the programs.

The AIDS Surveillance and Education Project (ASEP), supported by the USAID, began as a national program in 1992. It was meant to support the DOH in the development and

[66] *PNAC. 2011. 5th AIDS Medium Term Plan (2011- 2016) The Philippine Strategic Plan on HIV and AIDS*
[67, 68, 69] *Ibid.*

*Results of studies on the programs already implemented for HIV and AIDS called for a comprehensive framework in the delivery of the various programs*

implementation of its national AIDS prevention and control program. It is the first major program to focus on HIV and AIDS prevention in the country. It was implemented through a framework of collaborative engagement among the DOH and its affiliate institutions, LGUs, and NGOs. In 1995, intervention focusing on MSM became one of its primary objectives.

In the implementation of the ASEP, NGO partners provided the local counterpart in prevention projects. Under the ASEP, PATH Foundation was the initial lead NGO partner. PATH's local NGO implementer was the Kabalikat ng Pamilyang Pilipino Foundation (KABALIKAT), one of the first NGOs in the country to venture into AIDS-related work. Initially focused on providing family planning, nutrition and water sanitation, its work expanded to cover AIDS prevention in 1988. Along with RITM, research efforts were conducted, as well as work with people in prostitution.

To broaden its reach, the ASEP was implemented through partnerships with local-based NGOs throughout the country. Early initiatives at the community level were taken on by: Remedios AIDS Foundation, Reach Out International (Manila and Angeles), University of Southern Philippines Foundation (Cebu), and Hope Foundation (Bacolod).

**1994, through ASEP and other funding support by international organizations, saw the expansion of delivery of services at the local level through cooperative efforts:**

- ❑ Reach Out International provided services to MSM through hotline and clinics
- ❑ KABALIKAT initiated activities such as peer education and establishment of LGU ordinances
- ❑ CEMSHAD conducted Operations Research in areas of Manila and Pasay City
- ❑ TALIKALA ventured in MSM intervention (prostituted men) through peer education
- ❑ DOH and Field Epidemic Training Program handled the surveillance, while KABALIKAT was in charge of the education together with local partners (initially there were three sites: Davao, Cebu, and Quezon Cities, and expanded to eight sites for MSM)
- ❑ Community Outreach Peer Education (COPE) was implemented as a training program for peer educators on basic communication. It also had condom distribution component conducted in partnership with DKT.
- ❑ Philippine-Thailand Exchange program conducted with LGUs and stakeholders
- ❑ International HIV and AIDS Alliance based in UK funded PHANSUP for initiatives on HIV and AIDS youth projects
- ❑ Packard Fountation funded PHANSUP for its Reproductive Health project with components on HIV and AIDS
- ❑ Miserior, a church based organization, provided grant to Iwag Dabaw for its MSM community intervention

Under ASEP, peer education became the intervention thrust for KABALIKAT and PHANSUP national programs. ASEP became the umbrella of the implementation of outreach, educational projects, drop-in centers, and VCT at the local level. PHANSUP followed a framework for partnership and collaboration with its partner NGOs, conducting a monthly forum with local implementing NGOs for the sharing of experiences, and consultation and sharing of expertise. It was a strategy for supportive intervention that emphasized capacity and confidence building among the NGOs. A shift, however, had to be taken in the implementation of the ASEP. It had to consider the devolution of health services from the national government to local government units (LGUs), as mandated by the then enacted Local Government Code of 1991. The delivery of services and the budgetary allocations were devolved to the LGUs, resulting in a substantial change in the health sector delivery of services and priorities. With this, the DOH had to develop a new relationship with LGUs, which now determined their own priorities for health and services. [71] The evolved framework for ASEP called for concerted efforts among LGUs and community based organizations (CBOs). The aim was to capacitate LGUs and CBOs to implement their local surveillance and prevention programs.

In the course of its organizational history, KABALIKAT became PATH Foundation Philippines. PATH Phils. initiated MSM-focused programs, specifically catering to MARPs (initailly termed "risk groups" in the early 1990s).

Nearing the conclusion of the ASEP, the Global Fund 3[72] provided support for HIV interventions in the Philippines. Initial prevention programs were conducted using Behavioral Change Communication (BCC) frameworks and through community outreach interventions. Infrastructure and service delivery were also important program components: These mainly focused on improvement and expansion of clinical services for HIV/AIDS care and treatment in health facilities, establishment of home and community care for PLHIV, as well as educational activities; development of partnership mechanisms for care; treatment and support involving the positive community, service providers and key stakeholders; improvement and expansion of VCT, and strengthening of the monitoring and evaluation mechanism for the tracking of the implementation progress; and leveling up of social mobilization and advocacy campaign. [73]

| ASEP (PHANSUP) sites (1998-2003): | GLOBAL FUND SITES: |
|---|---|
| Luzon: Baguio, Tuguegarao, Palawan<br>Visayas: Cebu, Bohol (Tagbilaran), Iloilo<br>Mindanao: Davao, Zamboanga, Cotabato, Koronadal, General Santos | Luzon:<br>Visayas: Samar, Leyte, Antique, Iloilo, Cebu, Bacolod<br>Mindanao: Davao, General Santos, Marbel, Zamboanga and Cotabato |

In Round 5 of the Global Fund, the Philippines was again given support through the DOH and the Tropical Disease Foundation Inc.[74] The support was meant to enhance interventions in four components: prevention through BCC and community outreach (through condom distribution), counseling and testing, and STI diagnosis and treatment, prevention of TB disease in PLHIV, TB/HIV collaborative activities; treatment (antiretroviral treatment and monitoring, prophylaxis and treatment for opportunistic infections); care and support (the chronically ill and families); supportive environment (human resources and laboratory); and strategic information (information system and operational research).

Within the DOH, the National AIDS/STD Prevention and Control Program (NASPCP) and the Research Institute for Tropical Medicine (RITM) have the distinct functions of initiating HIV national interventions. NASPCP has the distinct role of providing technical leadership in the STI/HIV/AIDS response in the health sector by providing policy guidance, technical assistance, capacity building, and monitoring and evaluation within the health care system. As an instrument of the DOH, NASPCP is mandated to ensure the delivery of DOH and organizations outside the DOH of services specifically for STIs, HIV and AIDS. In 1995, the DOH, through

[71] *PNAC. 2011. 5th AIDS Medium Term Plan (2011-2016). The Philippine Strategic Plan on HIV and AIDS.*
[72] *Global Fund 3 grant for HIV AIDs was "Accelerating STI and HIV prevention and care through intensified delivery of services to vulnerable groups and people living with HIV in strategic areas in the Philippines Principal Recipient" granted to the Tropical Disease Foundation Inc.*
[73] *Accessed from http://portfolio.theglobalfund.org/en/Grant/List/PHL*
[74] *Upscaling the national response to HIV/AIDS through the delivery of services and information to populations at risk and people living with HIV/AIDS.*

its Hospital Management Office and the NASPCP, formulated the policy guidelines for the creation of HIV/AIDS Core Team (HACT), which act as the focal unit for all HIV-related services in the hospital setting. The guideline is currently the framework used for HIV counseling and testing, specifically for the treatment of opportunistic infection, universal precaution and infection control, psychosocial support to PLHIV, and the clinical management of AIDS through provision of antiretroviral drugs. [75] The HACT guideline was assessed in 2009 and is being revised.

RITM was established in 1989 as the research arm of the DOH through the mandate of Executive Order (EO) 67. Its functions are mainly to conduct and implement research programs to prevent and to control prevailing infectious and tropical diseases in the Philippines. Support from the Japan International Cooperation Agency (JICA) provided for the initial construction of the RITM facility.

Social Hygiene Clinics (SHCs) were constituted to serve as local-based service providers for STI and HIV prevention programs. The SHCs are LGU-supported establishments that serve as the local governments' arm in addressing community health concerns. SHCs provide the community an access to STI and HIV prevention programs. First established to address the health concerns of people in prostitution, SHCs has since broadened their programs to include HIV prevention.

The following presentation of interventions, their highlights and challenges, is based on the results of desk review of previous program evaluations, focused group discussions and key informant interviews.

### 4.1.1 PREVENTION

Government health institutions evolved to include multi-disciplinary care that includes various provisions of commodities, counseling methods, patient education, and livelihood in order to address the myriad needs of clients. They endeavored to deliver a more comprehensive package by including prevention in their programs.

The recognition of the increasing number of MSM clients have led to the realization that previously there was no specific intervention that addressed MSM sexual health needs, i.e. there are no specific clinics that MSM could turn to for information, counseling or treatment. The implementers cite understaffing and the lack of specialized personnel to run prevention programs. For instance, psychological counseling is recognized as an emerging concern among PLHIVs. However, there are often no professional counselors to handle the patients' and their families' counseling needs. This is often traced to the lack of resources, specifically to budget allocation for *plantilla* (regular) positions in hospitals. There is also a lack of clinical protocol specific for MSM and TGs. Aside from a generic orientation on sensitivity and discretion given to new doctors, it is the assumed clinical training of the new doctors that are relied on to enable them and the staff to be sensitive in handling psychosocial counseling for MSM and TGs.

*"Identity issues, stigma issues, etc. na walang kinalaman sa HIV and AIDS, kaya nag-co-contribute sa risky behaviors."*

*"Person-centric versus diseases-centric (support)."*

*"(Post-test counseling) yan yung kailangan mo after mo malaman na positive ka. Kasi kailangan mo na may magsasabi sa yo na hindi pa tapos ang buhay mo. It is very crucial."*

**- PHLIV, FGD**

*"Punta sila (MSM) sa urologist na hindi naman oriented sa mga social problem ng MSM; pupunta ba sila sa OB na hindi naman trained for men? Wala talaga silang pupuntahan, kung saan talaga. Sa mga STD clinic, it's either babae na may STD or lalaking straight na may STD. Tapos yung mga doctors ng STD clinics, hindi din naman sila oriented sa mga social problems ng MSM, di ba? Wala talaga silang mapupuntahan. Kaya naisip namin sa RITM na mag set-up ng ganito. Ano ba ang ideal clinic for MSM na magiging MSM-friendly, at the same time viable?"*

**- Dr. Rossana Ditangco, RITM**

[75] *http://www.doh.gov.ph/naspcp/about_us.htm*

According to implementers, their efforts to follow the administrative order for positive prevention, interpreted to mean condom distribution, is very sporadic and dependent on the availability of the condoms that the units receive, more often as donations and not as budgeted line items. In most instances, they do not have enough funding to sustain their prevention programs. Implementers are thus forced to find innovative ways to augment their program resources.

To this end, to augment the lack of staff, prevention programs are often conducted with the critical support of volunteer organizations. These collaborative undertakings highlight both the good practice of complementing efforts of the institutions and support organizations, on the one hand; and the lack of personnel to adequately implement all of the prevention programs, on the other hand. These efforts highlight that it is through cooperative and creative means that government treatment facilities have been able to implement their prevention programs with some success.

***Research Institute for Tropical Medicine (RITM):***

**SELF-EMPOWERMENT TRAINING.** *The institute provides training for PLHIVs though their Self-Empowerment Training. Through the services of a professional trainer, PLHIVs are able to learn some skills and gain motivation in handling their life situations better. While an effective program for the PLHIVs who are able to participate, it has a very limited reach. The cost and the time required for each training pose constraints on the program's resources.*

***MSM Clinic.*** *After seeking feedback from MSM clients, certain mechanism were implemented in the clinic to enhance the friendly environment. Among such innovations are that most of the staff and doctors in the clinic are female, since MSM clients report feeling more at ease consulting with a female doctor (i.e. there was less discomfort during physical check-ups). Also, to avoid stigmatization, the sublet clinics will be generally labeled (e.g. internal medicine, OB Gyn, infectious diseases). An internal confidential system will then direct the MSM client to the designated MSM-friendly clinic. The crafting of the clinic program was closely coordinated with the NASPCP and the DOH.*

*They expect that by word of mouth and through the clinic's MSM network, this service will be made well-known among MSM and TGs. In the 1980s and 1990s, patients who eventually became volunteers in RITM organized a group that provided social support to other PLHIVs. The volunteer organization became the Positive Action Foundation Philippines Inc. (PAFPI). Pinoy Plus was also an identified pioneering group and partner that provided care and support for PLHIV. Currently, services provided by the institute are given for free. The group gets its funding from the DOH, though only as a start-up fund, as well as from its research resources.*

***San Lazaro Hospital:***

**VOLUNTEERS.** *Pinoy Plus and PAFPI are regular volunteers of the H4 (HIV Ward). Under the direction of the ward director, the volunteers have their set of assignments in assisting patients. The volunteers provide different forms of assistance, from providing patients and their caretakers with hot meals; assisting in the facilitation of their medical processing, including PhilHealth; subsequent follow-up (home visits and home care); and referral (e.g. insurance).*

*Other organizations also provide the hospital with support, some through psychosocial counseling conducted by faith-based organizations, PLHIV groups, and by volunteer HACT members. Counseling vary. Depending on the situation of the patient, it can be conducted one on one, as a couple, as a family, pastoral, or for discordant couples. Other activities include facilitation of hospital-based support activities for PLHIVs and their families (e.g. treatment partner's meeting, activity based-family day, children's walk, etc.). ARV adherence treatment (Directly Observed Treatment) counseling is also conducted by pharmaceutical personnel for clients, their families, and caregiver/treatment partners. Most of the cooperative work are in the form of informal partnerships.*

Peer educators point to the inconsistent uptake of messages of prevention among MSM and TG. While noticing an increase in the demand for more information and referrals, they also find inconsistent condom use and testing practices among their clients.

*"Sa akin, mas ok na hindi ka bumili para hindi ka matukso. Hindi din ako mahilig dyan. Mas ok sa akin ang passion, kissing; pero penetration, hindi ko gusto."*
*"Bumibili ako, pero pag wala halimbawa, tapos andun ka na, go nang wala."*
**- PLHIV, FGD**

*"Yung phone ko hindi na tumitigil sa pag-ring, at nagpapa-schedule na sila na magpa-screen ASAP."*
*"Yung open minded, mapipilit mo. Yung iba, hindi talaga."*
*"Karamihan sa mga friends ko, negative naman. So sila naiisip nila bakit ako magpapa-ganyan (magpapa-test) e hindi naman ako malandi, hindi naman ako nakikipag-sex kung kani-kanino."*
*"Hindi daw sila papalit-palit. Secure daw sila sa boyfriend nila... Sabi lang nila safe daw sila."*
**- Peer Educators' FGD responses**

*"The attitude of MSM towards condom is still very, very poor at the moment. Ang daming biases, myths, beliefs on the pleasure of not using condoms..."*
**- Dr. Gerard Belimac, Program Director, NASPCP**

*Pop shops have been perceived to have matured over the years, becoming more adapted to local issues. Initially intended only for family planning commodities, with the involvement of peer educators, it has become a mechanism for providing commodities to MSM.*

At another front of the prevention program, implementers point that there are now some efforts in looking at increasing the role of Pop shops and the national social marketing of condoms as potential areas for expanding the reach of prevention programs. The plan is to complement this with creating messages aimed at increasing the acceptability of condoms. Pop shops have been perceived to have matured over the years becoming more adapted to local issues. Initially intended only for family planning commodities, with the involvement of peer educators, it has become a mechanism for providing commodities to MSM. It is recognized that the uptake of commodities and accessibility will greatly enhance the reach and breadth of prevention programs. According to the ICAAP (2009), if the Philippines could raise condom use among MSM to 80%, the impending epidemic in the country could be controlled.

To respond to the lack of MSM-specific and appropriate approach to providing prevention services, RITM has propelled the pilot-testing of an MSM-specific clinic. Taking note of the increasing number of MSM clients and the gaps in their implementation, RITM is in the process of pilot testing a clinic that offers free and friendly services specifically to MSM clients. This has led to the redesigning of its approach to providing services, one of which is by designing a clinic environment that is more conducive to MSM clients, and by providing support programs. The new scheme is aimed to better address the psychological concerns of both the clients and their families primarily through counseling. The crafting of the clinic program was closely coordinated with the NASPC and the DOH.

Social Hygiene Clinics (SHC) provide the community an access to STI and HIV prevention programs. Primarily LGU-supported, most of the prevention programs initiated by LGUs are through the SHC. In the city of Manila, for example, the Manila Social Hygiene Clinic (MSHC) is the designated arm of the Manila Health Department (MHD) to provide education, advocacy, referral, treatment, care and support to most at-risk populations, and to provide the general public with education and/or testing for STIs.

Each SHC is independent in the running of prevention programs. This independence allows them leeway to innovate or to be conservative in their interventions. For most SHC, however, there are no specific programs for MSM and TGs; it is mostly general public services that are offered, only with some special package for sex workers and MSM.

SHC officers point out that while SHCs as arms of LGUs can innovate in their prevention programs, the strength and support for these programs are dependent on the HIV policy of their local government. It is not always the case that LGUs would prioritize HIV, much less target MSM and TGs in their programs. SHC representatives across LGUs report that there would often be an inconsistent servicing for HIV prevention. SHCs under an LGU that do not prioritize health and do not recognize the critical condition of HIV can suffer from low budget allocation, consequently resulting in the lack of staffing and lack of commodities. Under these LGUs, the SHC can only do a limited coverage for their prevention program.

**Common SHC services include:**

- Information dissemination
- Diagnosis and Treatment (STI)
- Peer education
- HIV and AIDS Counselling and Testing (HCT)
- Outreach
- Condom distribution
- Networking

Those with supportive LGUs can progress and expand their services. Quezon City is a well-cited LGU that provides a good environment for HIV prevention, since there is a strong political support from the city officials. This support is concretely translated in budget allocations that have allowed Quezon City SHCs to increase their staff and expand their clinics, e.g. the establishment of the Sun-Down Clinic in Novaliches, which provides services after office hours. They also point to the functioning LAC of the city, which meets every month with CSO partners in attendance.

> *"...Not only for MSM, holistic yung approach namin, since the close down of the red light district in year 1992, yung Social Hygience Clinic of Manila became a referral center catering to walk-in clients with signs and symptons of STI and as a VCT center not only for Manilans but also to nearby cities and provinces who access the services through the Internet."*
>
> **– Dr. Diane Mendoza, Physician, Manila Social Hygiene Clinic**

Among the cited good practices for SHC include the conduct of mandatory HIV seminar for clients, inclusion of bathhouses for their target establishments, availability of free HCT, and a round of health lectures covering HIV among the SHCs in the city.

Particularly unique to Quezon City is the Teen Health Quarters Program, where health officers of the city conduct regular lectures to public high school students on HIV/AIDS and reproductive health. Another is the initiative for referral for care and supportive services for PLHIVs and their families.

***Manila Social Hygiene Clinic***

*The SHC participated in the "Take the Test" event in Malate in 2010. The event was under the directive of the Manila City Health Office (CHO). The SHC provided free testing. Popular media covered the event, providing an opportunity to generate awareness and information.*

*"Na-feature pala kami sa newspaper at sa TV, yun pa pala yung nakatulong sa akin. Na-feature yung efforts on HIV awareness and candle lighting ceremony." - Dr. Diane Mendoza, Physician, Manila Social Hygiene Clinic*

***Pasay Social Hygiene Clinic***

*The SHC changed their name to Social Hygiene Clinic from their previous "STD Clinic." In order to encourage more clients to visit the clinic, they also took effort to clarify that not everyone who visits the clinic has STI, and that there are other services they can avail.*

*The clinic has also encouraged the involvement and support of stakeholders in the community.*

*"Yung support ng mga stakeholders, for instance yung support ng mga entertainment managers, yung owners ng clubs; sa community naman yung support ng Barangay Captain, yung Kagawad for Health natatap din namin yun. And also yung mga BHWs namin, malaki rin yung function nila. Kasi sila yung frontliners sa barangay so alam nila kung sino yung-dapat naming puntahan..." - Dr. Joanne Carlota Raneses, Physician, Pasay Social Hygiene Clinic*

Another challenge pointed out by implementers is in infrastructure. Clinics can be problematic since they provide very little privacy. In most SHCs, there are no separate counseling rooms, and the clinics themselves are located in high-traffic areas, e.g. clients are often discouraged to visit SHCs that are located at the City Halls. In most SHCs, there are no feedback mechanisms for clients. There is also limited opportunity for consultation at different times of the day when clients may wish to access services with some discretion.

SHC personnel also point to the conflicting LGU policies that run counter to each other and hamper SHC programs for HIV. For instance, condom use is encouraged as a prevention mechanism by many of the SHCs. However, the use of condoms is construed as evidence of criminal acts, e.g. prostitution, by local police enforcers, and so discourages clients to use or be in possession of condoms.

SHC personnel also lament that in some cities, police raids continue to target cruising sites and establishments, specifically targeting MSM and people in prostitution, driving the MSM and people

*Those with supportive LGUs can progress and expand their services. Quezon City is a well-cited LGU that provides a good environment for HIV prevention, since there is a strong political support from the city officials. This support is concretely translated in budget allocations that have allowed Quezon City SHCs to increase their staff and expand their clinics.*

in prostitution underground and more difficult to access. This makes it harder for them to be reached. A peer educator (PE) explained that in the local government where he was working, the mayor was "pro-life", so that while they (as peer educators) could distribute condoms, if they were caught by the police, the City Health Office will not step in and claim the distribution as part of their prevention programs. The condom distribution is tacitly allowed but not officially supported.

Personnel attribute the continued stigmatization of HIV as cause for the prevailing negative perception of SHCs, with their clients almost always thought to have STI or HIV. SHC personnel have found that clients do not usually use their real names when they avail of services.

There are reported self-medication practices among clients who would rather not visit the SHC for their follow-up consultation. Follow-up check-up, especially among MSM, is highly irregular. In general, SHCs have difficulty in establishing baseline data (total population of MSM and TG, where they are, their accessibility) on MSM and TGs. Most SHC still need to develop a working monitoring and evaluation mechanism specific to MSM and TGs.

SHC officials note that while there is little support from the LGU, prevention programs via the SHCs will continue to be challenged. There is a general acknowledgement that there are no MSM and TG specific programs in most SHCs, conveying, they say, a lack of recognition in LGU health policies for HIV. STI

*"Pero ayaw nila pumunta lalo na kung MSM ka, kasi may stigma talaga."*
*"Akala nila may bayad sa SHCs, pero libre naman talaga."*
*"Sa ibang lugar, may client ako nag-walk out kasi nakakita siya ng mga sex worker, sabi niya 'I don't belong here'."*

**-Peer Educators, FGD**

*"Ako personally, I didn't have any problem accessing the SHC information. Sometimes nga masyado nang madami, overwhelming na."*
*"When I went to the SHC hindi naman pumasok sa akin na baka ma-brand ako. Ok naman yung experience ko, sa Caloocan ito."*

*"Si Tita Malou* is perfect. Ang nangyari sa akin, nung I found out na I was positive, tinawagan ko yung friend ko na positive din. Sinabi niya sa akin na tawagan ko si Tita Malou. Tinawagan ko siya, kinausap niya ako kahit hindi niya ako kilala."*
*"Maganda kung ang dating ay medyo motherly, nurturing... Cool mom – medyo stern pero approachable"*
*"Hindi kailangan MSM, basta MSM-friendly."*

**– PLHIV, FGD**

**SHC nurse in Manila*

and HIV are commonly perceived to be more common among female sex workers, and not a health issue among the general sexually active population.

Moreover, they add, budget allocation for HIV compete with perceived to be more common and prevalent health problems, such us dengue, malaria and TB. In some SHCs, there is limited supply of testing kits for STIs and their required medications. Prevention programs for HIV at the level of SHCs is sustainably challenged, they point out, especially when there are no support from other funding sources other than the LGU. Some SHC prevention programs are sustained by resources from the Global Fund. Both the support for medicines and peer educators hinge on continued allocation of resources. They point out that inactive LACs will lose the opportunity to develop mechanisms and devote resources to better the delivery of services.

**National NGOs** such as PHANSUP, and later KABALIKAT, were the community-based coordination institutions for the implementation of ASEP. Tapping community-based NGOs for programs were Cebu, Zamboanga, General Santos, Cotabato, and Cagayan de Oro. Each organization employed different strategies for their prevention programs for MSM. Partnerships and collaboration between the national organizations and the local organizations for transfer of knowledge and skills through an active mentoring program helped facilitate the implementation of projects. LGU support played an important part in the propagation of prevention programs initiated at the national level.

One of the early efforts toward providing prevention programs was the establishment of drop-in centers for people in prostitution who are also PLHIV. This was provided by civil society organizations. The drop-in centers served as an important shelter for marginalized PLHIVs, very often their only means of protection. The centers, however, were often placed under the vicissitudes of changing local government attitudes toward people in prostitution and PLHIVs, and in some instances having to move from one city to another, and heavily dependent on financial support for its services. It would be through the efforts of similar community-based NGOs that drop-in centers primarily for MSM were established. The community-based NGOs would provide prevention services to MSM and TGs at the local level.

Lead implementers point out that while there are a number of innovative projects conducted throughout the country, these are implemented mostly in the cities where there are already functioning MSM organizations. Their reach and continuity is challenged since most of these projects run under donor support. There is also little documentation on the actual reach and progress of the interventions. There are also barriers to the actual implementation, including: police raids are constant in the "hot spots" where peer educators are targeting MSM; high stigma and discrimination, making access to respondents more difficult; and the fast transition among peer educators, so that continuation of capacity-building is hampered.

According to the proponents, what challenged the partnership is the lack of real framework for cooperative work that could foster a more categorized partnership, specifically for MSM and TG organizations and the LGUs. There is also the limited coverage of SHCs for intervention, targeting mostly sex workers, so that MSM are not accessing them. The limited experience on the part of LGUs on MSM and TG interventions presents a challenge to the implementation.

***Cebu Youth Zone (CYZ), Cebu City***

*Early prevention interventions in Cebu was for a drop-in center for PLHIVs, started by the Cebu Youth Zone (CYZ). The Center's involvement was mainly with MSM.*

*Cebu's innovative program was through beauty parlors, the gathering places for MSM. The space was utilized for Learning Group Sessions, with the parlors becoming satellites of the Cebu Youth Zone. Identified parlors have shelves with IEC materials on HIV/AIDS and gave out free condoms. A referral system was also available for testing and treatment of STIs.*

***Mindanao***

*The NGOs Neighbors, Higala, and Ang Kaugmaon targeted young MSM in schools, as well as out of school youths. Adolescent Sexual Reproductive Health (ARH) program was introduced in schools, and teachers and school counselors were trained in ARH, including such topics as HIV/AIDS and "identity crisis counseling."*

*IwagDabaw ran a drop-in center for MSM. The drop-in center served both as shelter (for runaways) and as a hang-out place for young bayots. Iwag Davao designed the drop-in center also as an education center. Parents are invited to*

*Volunteer peer educators from CSOs provide their time and expertise in the VCT services of the SHCs, as well as resources for trainings. They conduct mapping for better targeting of their primary clients, and they offer information on STI and HIV, referral information, and distribute condom in establishments and cruising sites focusing on MSM.*

*attend seminars to better understand their child. Education sessions, especially on the Anti-Child Abuse Law (RA 7610), are conducted for parents and the young bayots. Increasingly, there was growing concern for discrimination and violence inflicted on young MSM. PHANSUP and IwagDabaw saw the importance of injecting human rights into their education sessions. This was also the entry point of IwagDabaw's cooperative work with the barangays. Learning groups are conducted in the Barangay Centers. Iwag Dabaw expanded its project to General Santos City. The Ginoong Pilipinas project, a "beau-con" (beauty contest) was conducted to generate awareness among MSMs. The question and answer portion consisted of information on STI and HIV prevention.*

*Tingog in Cagayan de Oro received support for the establishment of C+ Shop, where condoms were made accessible and targeted to MSM, as well as providing a venue for educational outreach for HIV and STI prevention. Condoms were sold in establishments that were known to be MSM spots. United Gays Association of Surigao ran its own condom and education project, and not only in Cagayan de Oro, but also in Bacolod and General Santos.*

> *"...GenSan, Davao, Cotabato at Zamboanga, nagkaroon ng turnover ceremony between the NGO, PHANSuP and DepEd, division of schools, with the understanding na ipagpapatuloy ng division of public schools ang (ARH) program."*
>
> **- Ruthy Libatique, Former Executive Director, KABALIKAT and PHANSUP**

***Luzon***
*PNGOC tapped RocK Ed to organize concerts in malls (SM Batangas, SM Baguio) and commercials about AIDS in gay bars.*

**Peer educators** implement prevention programs on site and on the ground, and are considered the pro-active interveners for prevention. An important component of the services provided by the CSO and local health prevention programs is the training and deployment of peer educators. Volunteer peer educators from CSOs provide their time and expertise in the VCT services of the SHCs, as well as resources for trainings. They conduct mapping for better targeting of their primary clients, and they offer information on STI and HIV, referral information, and distribute condom in establishments and cruising sites focusing on MSM.

Among those that have active peer education programs are: Reach Out, TLF-SHARE COLLECTIVE, ASP, QCSHC and PAMACQ. There are differences in the work coverage of NGO-based and SHC-based peer educators. While employing similar methods of outreach, SHC-based and CSO-based peer educators have distinct functions. Only those based in the SHC are given authority to visit establishments and conduct checks whether the establishments have permits; as well as to follow-up the clients' yellow cards (SHC compliance cards). Peer educators in SHC also get their directive from the LGU physician.

According to the respondent-participating peer educators, it is mostly MSM and PIP that are given emphasis in interventions. Most PE seek out clients in known hubs, cruising sites, and online communities. However, they report that

there are establishments that are not cooperative, and are even hostile to their interventions.

As MSM themselves, most of the peer educators observe that they often use their network to access their targets. They point out that as peers, they are accepted as members of the community they work at and for. This has contributed to the increase in the reach of both CSO-based and SHC-based peer educator-led prevention programs.

Most interactions between PE and clients start with the initial introductory information. The clients are then invited to the more formal Learning Group Sessions. These sessions offer more in-depth discussions on HIV and STIs. Peer educators also refer clients to SHCs and other treatment hubs. The PEs emphasize that it is in the forging of a good relationship with the SHC/treatment hub, and the quality of their services that are integral in the success of the referral. Most clients would have a repeat visit when the facilities and staff are friendly and sensitive.

In extending outreach efforts to MSM and TGs, peer educators use new communication technologies, specifically SMS and online social networking sites, to provide health and referral information. One of the online efforts was initiated by the AIDS Society of the Philippines (ASP), under the program peer educators focused their efforts on interacting online with MSM in Metro Manila. The online peer educators join chat and social networking sites, keying in terms such as "orgy", "party and play" and "bareback" to identify those most at risk and then engage MSM in discussion, provide education and support, promote HIV and STI testing. Successful online engagement usually results in a face-to-face meeting to accompany the individual to HIV and STI testing and avail of counseling services.

*"Target namin ay 50 MSM unique chat encounters. five to seven referrals per month para magkaroon ng stipend 11k, kasama ang internet connection fee."* **- ASP**

*"Meron kami sa araw sa malls at sinehan. Sa gabi, sa Malate. Nagdagdag lang kami ng online. Nung 2009, nag-advertise lang na you can get tested. Tapos gumawa ako ng blogspot. Maganda yung feedback. Naka link yun sa Facebook account ko na for testing. May questionnaire din kasi ako, sa exposure, self-assessment ng risk. After nun, text na o tatawagan. Or email, mag-cha-chat."*
**- Manila SHC**

*"Sa QC na target din namin yung mga TG, pag may mga Miss Gay nandun kami, nagbibigay ng information. Pag gusto nila magpa-test, nagbibigay kami ng info. Habang nagme-make-up yung mga bakla, nakikipag-usap kami, nagbibigay ng condom. Kung saan may Miss Gay, andon din kami.*

*Meron kaming pyramiding, hahanap ka ng 10 na peer partners, na gagalaw din para maghanap din sila. Para madagdagan. Tapos i-train ulit."* **– PRRM**

*"May mapping, saan ba makikita ang target natin? Ang hawak namin sa TLF, Pasig, Marikina, Mandaluyong. Ang ginagawa, pupunta kami sa area, titingnan saan ba makikita ang mga MSM. Maghahanap kami ng MSM. Sa barangay, sa parlor, sa plaza. Ang makikita mo sa barangay, yung pa-girl tapos malalaman mo yung mga lalaking MSM ang nagiging client nila."* **– TLF**

*"Outreach din sa freelancer sex worker at MSM. Maghanap ng bagong establishment, i-follow up ang yellow card nila. Mag-lecture ng STI sa establishment, para mapa-comply ang-mga bagong establishment. Tapos i-check na makapag-VD sila at least once a week, then i-follow-up."* **– QC SHC**

*The number of young MSM and TGs is on the rise, they observe, so they emphasize the need for programs that would specially cater to the needs of MSM and TGs. Most feel they are unprepared to handle adolescent sexual and identity issues.*

PEs note that they are aware that they are mostly in the cities and are still not not able to penetrate certain MSM and TG subpopulations. They have less presence in rural areas. A respondent in the PLHIV FGD affirmed that in his case, it was through his personal efforts that he was able to come by any information on HIV. Many of the respondents in the FGD similarly said it was only after their diagnosis that they were able to meet and interact with a peer educator. They made a distinction, however, with localities, claiming that there are more proactive peer education programs in some LGUs, more than in others. They acknowledged, too, that there are groups of MSM that keep to themselves, since stigma is a barrier for coming out and for getting tested. They commented that conducting educational sessions in offices may be convenient, but still prove ineffective, since many hesitated getting involved because of the stigma attributed to testing. They, nonetheless, emphasized how ICT is giving them more access to information and counseling. They also cited the anonymity provided by ICT as an important factor for their use.

The peer educators note the great need to provide training and better motivation among their existing ranks. They report the different levels of knowledge (e.g. lack of knowledge of existing referral system in their locality, information on STIs and HIV) and skills among peer educators (inadequate counseling, facilitating, organizing skills, *etc*.), as well as the propriety of conduct (they emphasize the need to be respected). Some peer educators lament the unprofessional and sometimes unethical practice of their peers.

For training needs, they particularly mention the distinct and varied psychosocial needs of MSM and TGs, often in relation to issues of identity and sexuality. While there are identified expert trainers in these areas, if there is an intention to reach more MSM and TGs, the educators suggest greater specialization in these issues.

There are different types of MSM communities and TG communities, they report, with some harder to tap than others, so that each present unique challenges and opportunities. The number of young MSM and TGs is on the rise, they observe, so they emphasize the need for programs that would specially cater to the needs of MSM and TGs. Most feel they are unprepared to handle adolescent sexual and identity issues.

Pilot programs were designed and implemented to promote peer education trainings to appropriately meet the needs and reach out to the most-at-risk youth and adolescents. One-on-one sessions and small group discussions were among the peer education strategies, which were meant to respond to the needs of each target group. Following the

*"May mga NGO na nag re-refer na iiwanan ka sa ere pagkatapos ng testing. Kinuha lang ako as number sa report nila. Na hindi na ako makabalik sa SHC kasi yung kakilala ko, iniwan na ako."*
*"Yung mga peer eds na may mga clients na bagong 'posit,' nagkakaroon sila ng affair. As peer educator, hindi maganda na tine-take advantage. Nawawala yung ethics."*

**- PLHIV, FGD**

VCT framework, peer education was not only designed for awareness and education, but also to assist beneficiaries in meeting their particular needs, especially in obtaining services for testing, counseling or referral, and condom use. Great lengths were taken in the design of the training courses for the peer educators so that they could appropriately respond to the risks and vulnerabilities of the target groups. One of the projected indicator for the success of the program is the increase of knowledge and access of condom use. Evaluation of the program, however, report that many of the respondents-beneficiaries stated that while they had intended to use condoms, this was often unfulfilled, citing insistence of their partner not to use condoms, the need for them to purchase condoms, and the discomfort and inconvenience of using condoms as reasons. Despite the prevention initiatives, the evaluation found the targeted young populations were still vulnerable to HIV and other STIs.

Moreover, a study also showed that while the focus on community-based interventions and campaigns for lower income bracket target populations remains important and necessary, the interventions have rendered the young MSM professionals in the middle to high income brackets invisible, with little information and access to services.

*"Ang TG na nasa community, madali i-tap. Pero ang TG na nasa Burgos sa Makati, mahirap i-tap, yung magagandang TG. Ang TG na taga-community, masa kasi sila, kalog, madali kausapin. Pero yung magaganda, yung nag-ja-Japan, nag-a-abroad, mahirap i-tap. Sinasabi nila, 'Wala kaming sakit', hindi kami ganyan'***." - Emer**

*"Sa akin, madami akong na-experience na discreet. Sa outreach ko pa lang, malalaman mo na. Halimbawa bago yung ginagamit na Facebook account, kasi ayaw nila makita yung totoo nilang itsura. Tapos minsan sinasabi nila, 'Straight ka ba? Kasi ayaw ko makipag-usap sa long hair.' Sila yung umiiwas sa testing. Kaya dapat sakyan mo yung gusto nila. Ang tagal ma-kombinsi yung ganon eh, yung discreet. Sakyan mo lang, kasi unti-unti mapapalagay yung loob niya. Mas problem ang discreet."***– Ryan***

*"May class A, class B, tapos yung lower classes. Iba din kasi. Sa Manila kasi namimili kami ng groups na lalapitan. Ang nagbibigay ng time sa amin yung hindi matatataas ang level. Yung matatataas kasi sasabihin 'I'm clean, I'm done with it'."***– PLHIV, FGD**

The evaluation also found that there may be other conditions that continue to challenge the efforts of peer educators when their work is not contextualized in a program geared towards a comprehensive change in environment and perception for vulnerable groups. An evaluation of HIV and STI prevention interventions for vulnerable and most-at-risk adolescents and young people in the country, covering four pilot prevention projects implemented by NGOs in the cities of Pasay, Iloilo, Davao, and Zamboanga between 2007 and 2009, saw that while the beneficiary respondents became very knowledgeable about condoms, there remained a gap between their condom knowledge and actual condom use.

*Worth highlighting here is the call for the need to increase the numbers, at the same time to ensure that those who will undergo training are positively motivated. They suggest continued and standardized training, and national coordination for peer educators.*

Respondents also point that many sex workers continue to be misinformed, and they attribute this to the constant mobility of the workers and their PEs' failure to maintain contact and sustain the education; as well as to the lack of information and training of the peer educators themselves. Worth highlighting here is their call for the need to increase their numbers, at the same time to ensure that those who will undergo training are positively motivated. They suggest continued and standardized training, and national coordination for peer educators. Very often, they point out, only less than half of those who attend peer education trainings continue on to become actual peer educators. The issues that cause this often involve finances or the lack of appropriate motivation for the work.

**TLF-SHARE COLLECTIVE** started as a socio-civic, informal peer group among regular customers of the Library Bar in the late 1980s. As an informal peer group, its initial efforts for prevention was to conduct community medical and dental missions for MSM and TGs. Recognized for its efforts targeting MSM, it was granted support by then AIDSCOM, now USAID, to conduct trainings for MSM on HIV awareness and prevention.

Later registering as a formal organization, TLF-SHARE COLLECTIVE ventured into more focused HIV/AIDS work in response to the clamor among MSM, by providing education and condom distribution services. The group became an NGO member of the PNAC. Later, TLF geared towards community service through organizing, advocacy and support for the LGBT community, at the same time continuing efforts for prevention programs, particularly addressing MSM and TG concerns. It broadened its involvement to include the human rights framework in its engagement for health rights for MSM and TGs. TLF-SHARE COLLECTIVE continues to be membership-based.

TLF-SHARE COLLECTIVE has good practices and expertise in training and development of peer education modules, mostly conducted in the form of HIV workshops. The workshops become the jump-off point for the creation of support groups that provide a sense of belongingness and camaraderie among the participants. According to the proponents, the strength of the workshops was not only in addressing issues related to HIV, but also the personal issues of the participants in relating to sexual and sexuality issues. It was from these workshops that the proponents were able to develop their peer education assistance (PEERETA) and organizing programs. They developed the concept of "paying forward" the skills and information learned from the workshops by passing these on to other community organizations that, in turn, will pass on the training to other MSM and TG community-based organizations. TLF-SHARE

> *"Ang legacy ng The Library Foundation na take-up ng PEERETA. Pero yung PEERETA we do it by paying it forward, we do it for others now because we benefitted from it. Kaya kami advocates, we're not just educators. We are advocates because of that kind of idea. With the better management system, we want to prove that PEERETA program really works."*
> - **Glenn Cruz, TLF-Share**

COLLECTIVE developed its advocacy projects using the framework of rights based approach.

As a continually growing organization, TLF-SHARE COLLECTIVE is challenged by its still developing structure and human resource limitations. As an organization, it has yet to develop a program for its membership development. Its efforts are greatly dependent on external funding support. Often, the financial support is not enough to sustain programs and their deliverables. Trained and skilled staff make do with low salary, resulting in the fast turn-over of staff. As for its network organizations, many of its local peer educators based in the provinces move to Manila because of economic opportunities. Consequently, the continuity of skills among staff members is slowed down, which in turn impact on the implementation of programs. As a membership-based organization, officers recognize that they may only be reaching a particular type of demographics in the programs and may be missing out on more marginalized populations.

Stigmatization and antagonism from religious groups hamper the reach of many of the programs. Issues that involve MSM and TG concerns continue to be regarded as controversial. TLF-SHARE COLLECTIVE instituted programs for MSM and TGs to gain respect and improve self-esteem as part of their community services.

Since it is mainly dependent on external support to run its programs, the group's programmatic goals have not always been in total harmony with required deliverables. Funding is also limited in the deliverables of the projects and does not provide for a holistic approach in prevention (either training or service delivery). Most of the funding sources do not include sustainability mechanisms for the projects that are supported.

> *"Projects have their own deliverables and those are not necessarily your programmatic interest... but they may get in the way of organizing. Kasi halimbawa, you have to deliver a number of condoms... ano ba ang mauuna? Makapag-distribute ako ng condoms? O ma-assess ko kung ilan talaga ang kaya ng komunidad(?) So nagiging potential barrier yan, kasi hindi lang ikaw ang nagde-define ng mga interes ng iyong programa."*
> – ***Ferdie Buenviaje, TLF SHARE***

What has kept the organization in step with other efforts for prevention is the members' sense of volunteerism. Community-based organizations that TLF-SHARE COLLECTIVE came in contact with have initiated community activities that contributed to the greater awareness of MSM and TGs (e.g. Loop party, Ms. U Bowling pageant, beauty contests).

Communities of MSM and TGs have begun to organize local response for HIV and AIDS. There is now greater awareness in involving the government in delivering services outside of the usual modes (e.g. beauty contests) to more concrete mechanisms of redress (e.g. accessing to grievance committee, creating/establishing human rights desk in ***barangay***). Community groups have also developed organizationally and have established themselves as NGOs (e.g. SHINE in General Santos, COLORS in Cebu); as well as more organized informal groups of MSM and TGs in Makati, Pasig, Mandaluyong, Marikina and Batangas. Here, a good example is the self-help group like Barako.

### 4.1.2 TREATMENT, CARE AND SUPPORT

Government hospitals serve as the initial and remain the primary source of treatment for HIV in the country. From January 2008 to December 2009, the Philippine government implemented a multi-disciplinary approach of intervention geared towards providing complementary medical care and psychosocial support to PLHIV. HIV and AIDS Core Teams (HACTs) were formed at selected treatment facilities to deliver these medical and psychosocial services. Thirteen treatment hubs and 68 hospitals across the country had HACTs (PNAC, 2010), with the medical services including the provision of ART, pediatric AIDS treatment, and HIV testing for TB and AIDS (PNAC, 2010; UNAIDS, 2010).

Among the identified barriers to the implementation of treatment programs was the cost of ARVs. Through the Global Fund, public hospitals were given opportunities to expand their retroviral treatment with the expanded purchase of ARVs. The support from Global Fund also allowed for some enhancement of personnel capacity, and renovation of facilities. Succeeding grants (3, 5, and 6) provided support for the purchase of medicines for treatment of opportunistic infections (OIs), as well as the hiring of coordinators specifically for ARV treatments, and treatment, care, and support officers.

Program implementers point to budget allocation and sometimes misappreciation of government financial process as constraints in the proper implementation of treatment, care and support programs. Budget allocation within government institutions are generally applied without specifying actual program designation (i.e. from the DBM to DOH allocated for

*Treatment, care and support are challenged by the lack of personnel. In some hospitals, the personnel are contract-based, challenging the sustainability of care. In some treatment hubs there have been no in-house psychiatrist to provide adequate counseling to patients because there is no budget allocated for the position.*

infectious diseases), so that other infectious diseases are marked as having an epidemic status (e.g. leptospirosis). This results in competition for the budget intended for HIV prevention. There is also still a gap in resources to respond to OIs. In the Philippine national plan, only 2.6% of the budget is allocated for treatment, care and support.

Expenditures monitoring and forecasting of ARV purchase require further refining. There is a limited number of personnel adequately trained in forecasting who can ensure the monitoring and logistics of the ARVs. Corrollary, ARV expiration is a real concern, complicating the management of the infection (i.e. PLHIV developing allergies, other reactions, *etc.*).

The lack of commodities is also a constant challenge to implementers. Often, hospitals needed to augment patient needs through donations. Implementers also report to the increasing number of surgical cases required for patients. Many of the institutions catering to HIV treatment do not have the medical facility to address surgical requirements of patients. According to the respondents, this situation further highlights the need for a more systematic referral system. In most cases, only clients who are able to pay for additional treatment are referred to private hospitals. Treatment hubs also follow different protocols for patient treatment, resulting in confusion in the regimen of care and also hamper the access for treatment of PLHIV.

*"Bawat treatment hub kasi iba-iba ang protocol. Meron kasi na hindi maka-access ng lab hangga't hindi ma-admit; magbabayad kapag outpatient. Yung iba, hindi maka-afford, kaya ang gagawin nila magpapa-admit sila."*
*"Sa amin libre ang lab, kaya sa amin sila nagpupunta for lab. Pero trabaho yun ng treatment hubs."*
*"Sa amin malaking issue yung nag-a-ARV ka o hindi. Makaka-access ka lang gamit ang PhilHealth ng libre pag ARV ka na. Pag hindi ka nag-a-ARV magbabayad ka ng lahat labs, CD4, etc., kahit pa may PhilHealth ka."*

***- PLHIV, FGD***

The lack of livelihood and financial support of PLHIV and their families are reported to have a direct impact on the effectivity of the patients' treatment.

Treatment, care and support are challenged by the lack of personnel. In some hospitals, the personnel are contract-based, challenging the sustainability of care. In other treatment hubs there have been no in-house psychiatrists to provide adequate counseling to patients because there is no budget allocated for this position. The patient to health care provider ratio remains a challenge. On the average, a clinic with only three personnel attend to an average of approximately 800 patients per month. The lack of staffing affects the unit's monitoring and evaluation process as well. Data is often also managed by the treatment, care and support officers, on top of their other tasks. Not surprisingly, there is no system in place for grievance or feedback mechanisms. Counseling is also conducted by the same staff. While multitasking mechanisms highlight collaborative efforts, it mainly highlights the lack of personnel to adequately implement programs. Many of the identified good practices in treatment hubs are often conducted with the help of volunteer organizations.

*"...Yung discrepancy sa patient and caregiver, patient-doctor, or patient-healthcare worker ratio, hindi talaga kakayanin with the increase in the number of patients. Peer support groups like Pinoy Plus and PAFPI play relevant roles in the care, support and treatment of PLHIVs. They are the ones encouraging patients who were lost to follow-up to come back for treatment."*

***- Dr. Rosario Tactacan-Abrenica, San Lazaro Hospital***

***San Lazaro Hospital***
*San Lazaro Hospital is identified by the DOH as one of the special tertiary hospitals in the country. It specializes in treating communicable diseases. As part of its mandate and the government's initial answer to the presence of HIV in the country, it was tasked to provide treatment services for PLHIVs. It has since become the primary treatment hub in the country.*

*The hospital's mandate for HIV prevention is primarily on treatment, care and support. The laboratory of the hospital has been conducting research specifically on the expanding genetic diversity of HIV 1 on molecular diagnosis, HIV resistant determination, and the role of CD4/CD8 for the prognosis of infection cases due to HIV patients. The SACCL of San Lazaro serves as the country's reference laboratory for the confirmatory test for HIV. The hospital has a specialized ward for PLHIVs, popularly referred to as the H4.*

*The hospital's treatment program follows the voluntary counseling and treatment framework, based on the module on Voluntary Confidential Counseling and Testing developed by the WHO, UNICEF, FHI and Kathleen Casey. This is applied for every patient, including MSM and TGs. Care and support comes in the form of counseling; after ARV adherence, counseling is conducted involving the health care worker, affected family, and treatment partners. As part of its holistic approach, care and support is conducted through counseling that prepares the patient and family with the possibility of death of the patient. Presently, all services and treatment for PLHIVs are free of charge, upon voluntary enrolment in the ART.*

*The holistic approach on treatment, care and support offered by treatment hubs are done with efforts from private support organizations. These include spiritual support from faith-based organizations; support of PLHIVs' hospital and home care, subsequent follow-up (home visits), and referral (e.g. insurance) conducted by MSM and TG volunteers, also in counseling and facilitation of hospital-based support activities for PLHIVs and their families (e.g. treatment), partner's meeting, activity based-family day, children's walk, etc.). Volunteers also help in the facilitation of the patients' PhilHealth enrolment – taken as a measure in anticipation of the stopping of funding for medication and other hospital services. This highlights the general insecurity of support for treatment in the health care system.*

***Research Institute for Tropical Medicine (RITM)***

*RITM is another government institution that has evolved to offer prevention and treatment support for PLHIVs. Its mandate focuses on medical intervention and the collection of data. The RITM provides services through its clinic. Equipped with a mini-laboratory, it offers screening and treatment of STI, HIV and Hepatitis B. Many PLHIVs are referred to RITM upon confirmation of their positive status.*

*RITM also provides institutional trainings for HIV Support Teams on Anti-Retroviral Therapy for other hospitals and NGOs in the country, e.g. Western Visayas Medical Center in Iloilo. These become treatment hubs and satellites of RITM. The institute also trains the HACT in government hospitals, and have tried to establish a network to facilitate interventions.*

***SPMC-HACT - Davao***

*SPMC-HACT is the only agency that dispenses ARVs in Davao City. The test and the ARVs are given for free. The hospital developed its own protocol on management of clients to address: "1. how to approach a patient suspected (to be) positive; and 2. (come up with a) flowchart, may flowchart 'yun saan siya pupunta; mag-pa-pretest counseling, mag-te-test, magpo-post-test counseling, depende sa result babalik siya. "(1. How to approach a patient suspected of being positive; and 2. come up with a flowchart where to go next: pretest counseling, post-test counseling; depending on the result the client will come back). – Dr. Alicia Layug*

*The hospital implements an adherence counseling program in collaboration with ALAGAD-Mindanao for the newly diagnosed positive individuals required to take ARVs. Disclosure is encouraged to aid clients in their adherence. Adherence counseling is done during the 14-day trial period. ALAGAD has established a temporary shelter for indigent patients and for those who live far from the city.*

*Aside from the counseling during pretests and post-tests, SPMC-HACT also conducts VCT. Clients are given a choice for their treatment, whether at the hospital or if they would prefer ALAGAD or MAAA, NGO service-providers. The institution has also signed a Memorandum of Agreement with PAFPI, a national organization of PLHIV, to give support on patient care; this is instituted as part of the hospital's clinical management system.*

*Global Fund funding for ARVs will end in 2012. SPMC-HACT is encouraging clients to enrol in PhilHealth in preparation for the suspension of the free ARVs.*

The respondents acknowledge the important role volunteers play in the transition of patients from hospital care to home-based care. Those who may be lost to follow-up are often "found" by the volunteers through their support service of providing home visits. This highlights the lack of capacity of the hospitals to provide a continuum of care, especially for OPDs. In most cases, when it comes to the provision of care and support, it is the personal network rather than institutional network that are availed by patients.

***On ART Adherence:***

*"Madalas akong malungkot ngayon, kaya hindi muna ako nag-i-inom."*
*"Mas malalim ang problema, na nakakaapekto sa adherence."*
*"Minsan pag lumalabas ka, di mo nadadala, hindi mo akalain na mag-e-stay ka sa labas ng matagal."*
*"Hindi pa kasama sa routine, hindi pa ganon ka-automatic."*
*"Pag bumibyahe ako, hindi ako nagdadala ng gamot."*
*"Pag nakikita mo yung gamot, parang nakakasawa na, nakakaumay."*
*"...Pero alam ko yung importance at ang repercussions."*

***- PLHIV, FGD***

*There is some optimism on PhilHealth's expansion of health benefit package to include HIV-related coverage. This is, however, still limited by the membership of PLHIV with PhilHealth, as well as if particular treatments or certain packages are allowed by a treatment hub.*

In an effort to improve HIV and AIDS treatments, the DOH established trainings for HACT surgeons for treatment hubs, as well as institute HACT guidelines. However, there has been feedback that in some instances, the core team could not mobilize because they are not supported by their hospital officials. There is, for instance, no Memorandum of Agreement to provide support for HACT-trained personnel.

Towards improving the provision of care and support, proponents point out that coordination through referral to the DSWD as service provider is seen as key to sustaining the intervention efforts. However, they report that personal networks rather than institutional networks are accessed and are accessible to PLHIVs and individuals at risk.

There is some optimism on PhilHealth's expansion of health benefit package to include HIV-related coverage. This is, however, still limited by the membership of PLHIV with PhilHealth, as well as if particular treatments or certain packages are allowed by a treatment hub.

In local implementation of treatment, care and support programs, partnerships between a number of primary health clinics and community organizations are formed out of necessity in order to maximize their resources for servicing. The primary clinics, suffering from underfunding by some city governments, had to seek recourse and for assistance from community organizations for pre- and post-test counseling, referral for treatment and care for those diagnosed with HIV. These partnerships have allowed the increase intake of patients by community organizations, and has at the same time strengthened the partnerships.

### 4.1.3 ENABLING ENVIRONMENT

As a complementary mandate to RA 8504, the AIDS Medium Term Plan (AMTP) was developed by the government to serve as a "blueprint for action in accelerating the country's response to STI/HIV/AIDS." Among its strategy was to "integrate stigma reduction measures in preventive, treatment, care and support services and in the design and installation of management support systems." This was geared towards creating an enabling environment for MSM and TGs through the assurance of non-discriminatory policies, guidelines and systems that are developed and enforced at the national, sub-national and local levels; the education of service providers, key stakeholders and the general public regarding stigma and discrimination; and that PLHIV are empowered to be effective advocates and educators.

The framework for collaborative work among LGUs and CBOs, where LGUs and CBOs were supposed to be capacitated to implement their own surveillance and prevention programs, was envisioned to create an enabling environment to foster wider reach for HIV efforts. In the early days of the prevention programs, the implementors' recognition of the inadequacy of surveillance as a main form of intervention, and appreciating the importance of an enabling environment, expanded the prevention program under ASEP to include education for LGU officials. This was mainly through study trips abroad, targeting local stakeholders (e.g SHC physicians, City Health Office) and Local Chief Executives to showcase best practices in other countries. At the same time, KABALIKAT and PHANSUP supported local efforts for lobbying for LGU ordinances. This became one of the primary interventions for prevention in the early days of engaging LGUs.

> *"We fostered the partnerships between the two, the LGUs and CBOs. So that dahan-dahan they can (be) capacitate(d) for any health program, so they just partner para madagdag lang yung HIV sa kanilang activity. And in fact, there are CBOs that included HIV in their intervention..."*
>
> **- Dr. Gerard Belimac, Program Manager, NASPCP**

Despite efforts to involve LGUs in the implementation of prevention programs, however, former implementers point to the limited experience of LGUs in implementing interventions for MSM and TGs as barriers to an effective implementation. The LGU had little experience then, possessed little knowledge about HIV and on how to implement a prevention program. Moreover, the implementors also point to the lack of information dissemination on current and parallel initiatives happening. The lack of coordination was a barrier to expanding the reach of the programs, as well as maximizing existing programs.

According to the implementers, what ultimately challenged the partnership then was the lack of real framework for cooperative work that could have fostered a more pronounced partnership specific for MSM and TG organizations and the LGUs. This is attributed to the "disconnection

relationship" due to lack of communication and coordination, or what was perceived to be a more vertical approach of intervention, among CBOs, MSM groups, and LGUs, rather than a more consultative, horizontal relationship. Often, service providers did not know that such an organization existed, or there were some discomfort with working with the organizations. There was a lack of information dissemination about the initiatives being conducted. There was also the limited coverage of SHC for intervention, targeting mostly sex workers, so that MSM were not accessing them.

Support from LGU includes salary and sustaining facilities, e.g. SHC. Their availability, however, is greatly dependent on the policy of the incumbent officials, with selected services provided dependent on the leadership (e.g. Manila City considered itself pro-choice, so it does not have an allocation for condoms in its health facilities).

> *"Suportado naman kami ng city health officer, yung QCSAC, very supportive naman sila (Quezon City AIDS Council, LGUs). Kung ano namang kailangan namin binibigay naman. Halimbawa, sa outreach kailangan namin yung health center on wheels, available yun lagi sa amin. Yung mga for transportation syempre magdadala ka lagi ng gamit, kailangan namin ng van, available sa amin yan including the driver. Tapos yung ano naman, halimbawa gabi yung aming outreach, ang ASP naman very generous na mag-provide ng snacks. Actually okay naman sila eh, okay naman yung ano namin."*
>
> **- Dr. Ma. Suzette B. Encisa, Bernado Social Hygiene Clinic Physician, Quezon City**

To remedy this situation, local health workers innovate by identifying local communities that are welcoming of the interventions. This way, the success of interventions is greatly dependent on the enabling environment. The policy of the local government regarding HIV, MSM and TGs, and their political will to enact the programs could mean the success and failure of a program. As an example, proponents in Davao report the direct involvement and representation of MSM in the Barangays Development Councils (BDC), which oversee the function and implementation of the whole program of the *barangays*, to signify community success. The MSM representative in the BDC ensures that MSM and TG in the *barangay* are included in the programs and activities, and that HIV and AIDS programs are included. There is also a strong support for HIV and AIDS, and sexuality issues from the community. There are, however, no alliances or networks formed of and for MSM and TGs. In Davao, while there is a local ordinance relating to HIV and AIDS, the ordinance has no MSM and TG-specific provisions. There is, nonetheless, an ongoing advocacy for the modification of the Anti-Discrimination Bill, originally designed for the protection of the indigenous peoples, to also include the LGBT community.

In an effort to address unequal, inconsistent, or outright lack of LGU prevention programs, the UNDP worked with PNAC and UNAIDS "to increase leadership and improve local commitment to HIV and AIDS," with a goal of bridging the gap between national and local institutions, as well as local government units, to implement effective responses at the local level and ensure there was adequate technical support, under the UNDP program "Leadership for Effective and Sustained Responses to HIV and AIDS in the Philippines." The program is meant to address the identified barriers to implementation: lack of sub-national mechanism for advocacy and technical support, the lack of local champions, and the lack of local awareness and inactivity of LACs. In 2009, two workshops were conducted to clarify and solidify the roles that Regional AIDS Assistance Teams (RAATs) would conduct. This was a precursor to the operationalization of 17 RAATs all over the country, meant to ensure cooperation on interventions in and among LGUs. At the same time, the UNDP and Local Government Academy instituted HIV courses in the orientation that elected officials were required to attend.

Implementers look at the lack of a national policy to address rights of MSM and TGs as a great hindrance. They emphasize how most local efforts still have to contend with local resistance and unacceptance of programs addressing MSM and TG concerns. TLF-SHARE COLLECTIVE report in some of the communities where they render service, one of the serious barriers is LGU refusal to partner with them. Moreover, while the creation of an enabling environment was the focus of larger programs, e.g. AMTP, in their operational plan usually a greater part of the budget would be allocated for prevention. In actual implementation, the paradigm of treatment, care and support for MSM, TGs, and PLHIVs are usually defined in terms of addressing their medical, physiological and psychosocial aspects of their needs, without complementing and basing these on their human rights.

Ang Ladlad, in seeking a more political arena to ensure recognition as a legitimate political party championioning the rights of the marginalized MSM and TGs in the Philippine Congress sought election in the 2009 national election. It was, however, initially disallowed by the Commission on Elections (COMELEC) to run on the ground that it was "immoral." On its appeal to the Supreme Court, the decision of COMELEC was overturned and the court approved the petition of Ang Ladlad group to represent lesbians, gays, bisexuals, and transgenders (LGBT) as a party-list group in the national elections, basing its decision on the equal protection clause of the Constitution of the Philippines, guaranteeing that no person or class of persons shall be deprived of the same protection of laws which is enjoyed by other persons or other classes in the same place and in like circumstances. The Court also regarded COMELEC's decision as a violation of the rights of members of Ang Ladlad to freedom of expression and association. In this case, the Supreme Court recognized that the principle of non-discrimination, as it relates to the right to electoral participation established under international human rights law, applies in the Philippines.

The Ang Ladlad decision notwithstanding, there are no specific laws against discrimination on the grounds of sexual orientation or gender identity in areas such as health care, education and private sector employment. There are very limited applications of civil rights granted to TGs in the Philippines, and

*There are often concerted and coordinated efforts by organizations. For instance, TLF-SHARE COLLECTIVE works with LAGABLAB in joint efforts with Amnesty International-Pilipinas in campaigns, with their most recent effort, the "Stop Discrimination Now!", aimed to raise awareness on the issues faced by the LGBT community, and to encourage popular support for the crafting and enactment of policies and legislation against discrimination and to protect the human rights of LGBTs.*

TGs do not have a legal right to officially change their gender. Respondents cite schools, for instance, that continue to exercise discretion to exclude homosexual or transgender students, ban the promotion of condoms, and exclude HIV prevention or sexual and reproductive health issues from the curriculum. In 2008, the Anti-Discrimination Bill (House Bill 956) was filed in the Philippine Legislature seeking to make unlawful and penalize practices and policies that discriminate individuals on the basis of their of sexual orientation and gender identity. It remains filed in the legislature and has yet to be deliberated. While there are rights that guarantee non-discrimination, these are embodied in separate laws – for instance, the Magna Carta of Social Workers (RA 9432), enacted in 2007 to provide protection for public social workers from discrimination based on sexual orientation. Earlier in 1998, there was the prohibition against discrimination based on gender or sexual orientation in the Philippine National Police.

Given this general lack of categorical protection and promotion of LGBT rights, LGBT organizations engage and participate in advocacy movements. The Anti-discrimination Bill filed in the present Philippine Congress (having failed to pass in the previous Congress) continues to be championed by the LGBT community in the country.

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Local advocacy efforts are provided by Progay-Philippines, LAGABLAB (the Lesbian and Gay Legislative Advocacy Network), STRAP (Society of Transsexual Women of the Philippines), Philippine Forum on Sports, Culture, Sexuality and Human Rights (TEAM PILIPINAS), and TLF-SHARE COLLECTIVE. Advocacy efforts are focused on lobbying, campaigns through media mobilization and raising public awareness on discrimination, the need for sexual health programs, and to secure a more enabling environment for MSM and TGs.

### 4.1.4 STRATEGIC INFORMATION

Surveillance was the DOH's initial efforts on generating strategic information. Research Institute for Tropical Medicine (RITM), and later San Lazaro, was tasked to conduct survey initiatives. The first ones were designed to capture infected populations to generate demographic information. The NASPCP (program) was then established, along with the ASEP, to develop a more integrated strategic information project. What followed under this tandem was primarily a population-based surveillance program more than a prevention program. The project had two main components: surveillance and education. Surveillance consisted of the HIV Serologic Surveillance System (HSS), which provided periodic estimates of HIV prevalence rates among high-risk groups; and the HIV Behavioral Surveillance System (BSS) which monitored high-risk practices among identified target groups in 10 major cities in the country. The surveillance then complemented the Education Component by engaging government agencies, both at the national and local levels, along with NGOs to provide information towards promotion of low-risk behavioral practices, and providing information of services to individuals recognized with high risk behaviors. The intervention sites were selected on the basis of rapid assessment and resources (budget allocation). In the initial conduct, budget was a serious constraint such that the assessment relied on previously conducted studies, e.g. the vulnerability index study of PNAC. Identification of sites of coverage was also based on data based on the presence of high STI rates and convergence sites (i.e. major tourist destinations).

The NGO prevention efforts for MSM were mostly on research initiatives. There was a lack of information and data that was necessary to establish better informed programs. Early partnerships were conducted by KABALIKAT with TLF-SHARE COLLECTIVE and Reach Out International. They initially covered four areas: Quezon City, Pasay City, Angeles City and Cebu City. Among the early research efforts were:

- Male Sexual Risk Behavior and HIV/AIDS:A Survey in Three Philippine Cities (2000)
- Formative Research on the Seafaring Population: Philippines (1996)
- Environmental scanning with local part-

ners with support from the Ramon Aboitz Foundation

With the end of the support from USAID came the Global Fund 3. Global Fund sustained the ASEP efforts in targeting mainly the same priority populations. The Global Fund 5 support saw the expansion of the area of coverage to include MARPs. There was an assumption that the ASEP sites would have already established their own programs and systems. The Global Fund 6 supported 50% of former ASEP sites, and provided mentoring programs to new sites.

Proponents recall that the early surveillance program, being population-based, mainly targeted sex workers and gay men. They point that the early categorization of "gay" was problematic. Implementers explained the concept of "gay" as a term used among MSM as a simple adaptation of a Western terminology and concept. Respondents also considered as openly gay/"out" only those who work in beauty parlors, and "gay boys" and "gay" male sex workers in cruising sites. The limited categorization may have to do with the lack of literature on TG. MSM and TGs mostly remained invisible until the mid-2000 in HIV literature. The implementers report that programs were not able to properly capture diverse identities and their diverse vulnerabilities. In the implementation of Round 6, for instance, while it covered MARPs, it did not require MARP-specific coverage so that MARP-specific interventions were not part of the reporting. Due to this, there was no accounting of their actual coverage. Also touching on the difficulty of identification, a qualitative study conducted by HAIN (2012) noted that TG is still an emerging identity. The study results noted that those who self-identifiy as TG were mostly residents of Metro Manila, and were still a minority. The results of the study highlighted the existence of diverse identities across sites and varied across time, presenting varying risks and vulnerabilities.

*"I think the Filipino community ... is able to tolerate discussions about being gay, about sexuality. ... Isang indication na nga yan.....what the country might have been doing in the past for MSM may no longer be effective - we have an entirely different scenario now. . . The demographic (profile) we're dealing with (have also changed)."*
***- Dr. Gerard Belimac, Program Director, NASPCP***

*"Yung segmentation...hindi pa masyadong pa nage-evolve yun. Pero alam na, meron nang notion ng mga discreet, 'pa-mhin', mga 'closeted'. Ang ano lang noon yung closeted and the overt."*
***- Ruthy Libatique, Former Executive Director, KABALIKAT and PHANSUP***

The early and initial crafting of programs was not based on proper needs assessment. Proponents recall that the organizing, identification of needs, and designing of programs were mostly based on the assumed needs of the communities.

*"Wala'y needs-assessment nga gihimo.Basta gitabangan mi sa TALIKALA pag-organize, pag-identify og programs, pagpangita og funding... nagabase mi sa panginah-anglan sa mga bayot" (There was no needs assessment conducted. TALIKALA helped us in organizing, idenfitying programs and look for funding...we based it on the MSM needs)."*

***- IWAG Davao***

In terms of improving data gathering, RITM reports that it has started the consolidation of data of its patients' adherence to treatment from 2010. These data have yet to become public. As part of their contribution to enhancing initiatives for strategic information, the institute also provided the guidelines for the DOH national adherence monitoring program. The monitoring program targets both the patients and service providers to enhance the adherence of patients. Data consolidation still has to be undertaken.

Implementors in SHC report that there are no feedback mechanisms for clients, there are no formal systems in place for this. While some SHCs would have patients' data filed in their systems, the system for the database is not uniform for all SHCs. Each SHC would have its own reporting mechanism, i.e. monthly reporting of peer educators and of reporting to City Health Office and NASPCP. Where there are mechanisms in place, these are mostly in the forms of referral directory and filled-up forms, as well as data for confirmation of test results.

According to the implementers, case data for clients are updated constantly and assured of discretion, i.e. check-up results are usually coded. They, however, note that as they accept a variety of clients, their reports would not necessarily include classification for MSM or TG clients. In some SHCs, the collection of data would be very rudimentary, i.e. only with the use of a logbook to list referral of clients with very little details indicated. Still, for some SHCs, there would be no strict reporting mechanisms. This non-specific reporting is also reflected in the AIDS Registry and IHBSS, where TGs have been invisible until 2011. Nonetheless, proponents note that the inclusion of TG-specific questions in the IHBSS beginning 2011 as a progress in strategic information.

Proponents note some highlights. In Davao, for example, an informal collaboration between the local SPMC-HACT, RHWC and Alliance Against AIDS in Mindanao (ALAGAD-Mindanao), a direct-service provider NGO,

*In the area of complementing strategic information for advocacy, rights-based NGOs provide assistance in the documentation of violations of human rights against MSM and TGs. The data is part of the concerted effort of the community to inform and influence lobbying and drafting of legislation, e.g. Anti-Discrimination Bill.*

was instituted as a way to ensure that data is compiled and used to develop programs that are attuned to the needs of the population. The data were sourced from the SHC and treatment hubs (for those who avail of VCT and beneficiaries of ARVS, and referrals). To avoid duplication of data and ensure privacy, ALAGAD was designated to encode the data. As an offshoot of its data gathering efforts and as a result of its needs assessment, ALAGAD was able to identify PLHIV requirement and need of close monitoring when undergoing treatment. ALAGAD established a halfway shelter for PLHIV from distant localities for the duration of their fourteen-day assessment of their compliance, as well as provide proximity to the hospital in case of adverse reactions.

A recent effort was conducted by HAIN and TLF-SHARE COLLECTIVE under a UNDP grant to expand knowledge about MSM and TG. The data analysis was specific to an assessment of MSM and transgender persons data from the 2009 IHBSS. As a supplement component to the quantitative data from the 2009 IHBSS, a qualitative survey of behavior and motivations of MSM and TG was also conducted. The results from the studies may have contributed to the inclusion of TG-specific questions in the 2011 IHBSS. These studies take off from the previously conducted work by HAIN with the National Epidemiology Center (NEC) to assess MSM and transgender persons by disaggregating the IHBSS data. The results also provided relevant contribution to the design and development of the 5th AIDS Medium Term Plan.

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### 4.1.5 SUPPORTIVE INTERVENTIONS

Implementers recall that it was KABALIKAT that initially provided capacity building and support programs for the early Pinoy Plus members. The NGO-to-NGO Mentoring Program was established to improve and capacitate local NGOs and POs working on the ground. This was under the "technology transfer" scheme, which was also the initial efforts for delivering a comprehensive package that began to include supportive interventions to intervention proponents and implementers.

One of the early organizations to include institutional support was TLF-SHARE COLLECTIVE when it expanded its services to include strengthening of existing local MSM groups. TLF-SHARE COLLECTIVE did this by providing organizational development support to some of the local MSM communities, initially with the Independent and Diverse Gay Organization (INDIGO) of San Jose del Monte City in Bulacan, Tabak Sangre in Tabaco City and Albay Gay, Bisexual, and Transgender Organization (GAYON) in Daraga, Albay. According to the TLF-SHARE COLLECTIVE implementers, capacity building activities were their main intervention to enhance the ability of MSM and TG community-based organizations. Most of the capacity building trainings were designed to enable the community organizations to participate in local government coordinating bodies. HAIN was also one of the early proponents to conduct AIDS capacity building activities among medical and allied profession students, MSM, male sex workers, PLHIV and health workers.

The UNDP and Global Fund rounds are cited by implementors to have helped in the provision of much needed support in the implementation of a better surveillance system, and allowed for an increase and expansion of coverage for counseling and testing services specifically targeting MSM and TG organizations. The support not only sustained but established services on the ground,by improving LGU coverage and service performance of clients, especially sex workers. This resulted in the stabilization of HIV among female sex workers. While data still requires validation, the expansion of coverage has also increased the involvement of smaller MSM groups at the community level in the country. The discovery and recognition of informal groups, and community-based MSM groups remain the highlights of the program.

## 4.2 CURRENT COMMUNITY INTERVENTIONS

Current community interventions are those conducted by community-based organizations. Most are initiated by concerned individuals or group of individuals who want to contribute to the HIV and AIDS effort in the country. Many of the initiatives were started, unlike the national programs, without formal funding from institutions, and are characterized by innovation and community support.

### 4.2.1 PREVENTION

**Project Headshot Clinic and The Red Whistle Campaign.** The Headshot Clinic was started in 2007 by Niccolo Cosme, a professional photographer. Accommodating his friends' requests for their profile pictures in social networking sites such as Facebook and Multiply, he had an idea of taking profile pictures of people then used to advocate for HIV awareness and prevention. The initial outcome generated interest owing to the campaign's new and unique strategy. The campaign continues to be self-supporting, with each headshot costing two thousand pesos. The campaign now enjoys some support from partner organizations.

After a year of its initiation, the Headshot Clinic campaign led to an awareness project, inspired by Wango Gallaga, an HIV-positive friend of Cosme. This campaign was called "AWARE", aimed to generate awareness to the fact and issues about HIV and AIDS. It was followed in 2008 with "MOVE", to commemorate the celebration of 20th year of World AIDS Day. Move's campaign meant to take off from the efforts of "AWARE", and this slogan meant to generate response and action from awareness.

> *"It (Project Headshot) started there and UNAIDS really liked it because it was young... it uses the social network online, and it engaged a lot of people who weren't really advocates (but) who eventually became advocates by participating. So that was the start, and we've been doing it for three years...awakening that it's (HIV) very near. So parang it was an eye-opener. And I think, with him (Wango Gallaga) coming out kasi, brought a lot of people to assess themselves also. Kasi nag-come out siya eh. And not a lot of people does that, coming out."*
>
> **- Niccolo Cosme, Founder, Project Headshot Clinic Campaign; Co-founder, Red Whistle Campaign**

Eventually, the Headshot Clinic team caught the attention of HIV prevention implementers in the country, and has partnered with UNAIDS for the past three years. In 2010, the "ACT" campaign was launched by the Project Headshot team in collaboration with Take the Test and ASP. During the event, voluntary screening and counseling was provided and encouraged. To expand the reach of the campaign, the proponents collaborated with the national television network GMA7 with its artists modeling for headshots, and launching the campaign "One World". Corporate sponsorship for the campaign was also increased through the support of Globe Telecom, which took the campaign as part of its product promotion in parts of the country.

The Red Whistle campaign was initiated as another campaign to generate awareness towards prevention of HIV. It consisted of distributing red whistles to supporters and advocates in various activities as a reminder of five key messages: "1. There is an ALARMING situation on HIV and AIDS; 2. We should know our STATUS and we need to take the test; 3. Value life, LOVE life, love yourself; 4. That we are all VULNERABLE, all of us can be at risk; and 5. We need to make our COMMITMENT now."

The Red Whistle is meant to symbolize the sounding of alarm of the critical situation of HIV infection in the country. As part of the campaign, safety kits were given to popular bloggers in the MSM community, by way of expanding the reach of the campaign. Each kit contained three condoms, a tube of lubricant, promotional materials, three red whistles, and a "risk" card, which serves as a reminder for when the last HIV test was taken.

*For both Project Headshot Clinic and The Red Whistle, the campaigns were generated mostly through online networks, i.e.with the help ofsupporters from various social networking sites, and bloggers. Utilizing "cost-free" platforms allowed them to launch and conduct the campaigns without much cost.*

> *"...it started out of curiosity when I encountered a friend wearing a whistle for a disaster preparedness campaign... Realization that it (HIV) was not so far from a disaster preparedness, except the part where we were actually taking the disaster to bed..."*
>
> **- Niccolo Cosme, Co-founder, The Red Whistle Campaign**

While the campaign activities targeted MSM, according to the proponents, they did not want to highlight MSM-specific campaigns to avoid "discomfort" for those who were not yet ready to come out. They began with 20 whistles, eventually reaching 2,500 through the corporate sponsorship of an international television network. According to the proponents, their challenge is now how to sustain and expand the campaign.

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**SMS for MSM - Health Promotion and Communication Project.** The community project SMS for MSM was initiated byHealthPRO, an NGO with funding support from the USAID. Their projects are geared towards supporting health-related behavior change communication (BCC) activities in the country by providing health promotion and communication technical assistance to the DOH and the LGUs. The intervention was born from the work with the Quezon City Health office. In one of the MSM Round Forum initiated with the LGU, the existence of MSM clans, groups of MSM bonding together as "clans" and communicating via SMS, was highlighted. Because the clans used technology-based aproaches, specifically SMS, to network among themselves, the proponents thought it would be an effective means to disseminate information on prevention and testing. The project was designed around peer educators becoming part of the clans and providing information and encouraging testing. Messages about testing are regularly sent out to clans.And for those who are interested to meet in person for more information, a "grand eyeball" (i.e. real time meeting of participants) is organized for awareness and information sharing, as well as to provide testing.

> *"We stumbled upon it... we had Mikael, we commissioned one person who can help us develop (a project)...tapos we invited MSM groups. And that's where we heard of the phenomenon of the MSM clan. The clan...(is) text-based. And we learned more about them, then we decided to have this roundtable discussion."*
>
> *"Well, it is innovative ICT... using text messages to disseminate HIV prevention messages... we just have to evolve with the technology. Kasi we knew that peer education still works. There are just other ways of doing it, of disseminating information."*
>
> **– Dr. Carmina Aquino, Deputy Chief of Party, Health Promo, USAID**

The proponents regard ICT use for interventions as part of the evolving capacities towards effective reach. The messages they send undergo pretesting. Peer educators and counselors send key messages to the leaders of the clans. The leaders then disseminate to their members. The reach is validated by responses, feedback and further inquiries, from the members of the clans. The peer educators provide services by providing further information, counseling and referral to SHCs. After the initial step of the peer educators, the information dissemination, information on HIV and for VCT, was initiated by the clans themselves. The expenses incurred for the cost of the mobile phone credits are now covered by the clan leaders themselves, they do not get financial support from partners. According to the proponents, the sending of the HIV messages was considered by the clan leaders to be a part of their roles as leaders, to monitor and check on their members. The messages were considered as "novelty" because there was something new to discuss for the clans.

*"We were not really a major mover, more like catalyst who put pieces together. Actually this is more an intervention by the MSM clans, by Quezon City, our LGU partner, Quezon City Health Office...and by the HIV positive group."*

**– Dr. Carmina Aquino, Deputy Chief of Party, Health Promo, USAID**

As to the actual efficacy of the project, proponents are not exactly sure of the reach of their impact. Evaluation has yet to be conducted. While there has been some feedback from clients in SHCs, actual numbers are not yet recorded. The reach of the text messaging is difficult because of the mode and flow of the medium of information. The proponents are also uncertain as to the sustainabiity of the project, with funding support for the peer educators ending soon. There is some optimism that the LGU will continue the initiative. According to the proponents, another challenge is the limited geographical reach, covering only Quezon City, where there are already SHCs that the clan members can be referred to. The proponents also suspect that the reach of the initiative may also be nearing a saturation point. They anticipate that replicating the intervention in other areas where close coordination with the LGU is absent, and where the use of technology is also limited will be challenging.

**Love Yourself Campaign (formerly VINN Advocacy for the Youth and MSM).** Nurse Ronivin "Vinn" Garcia Pagtakhan's interest in ICT as a means to give out health information won him the *Twitter Shorty Awards Nurse of the Year*. After winning the award, he thought he could "give something more to the community" by way of providing information, referral for testing, and counseling by using social media. This was also to respond to what he noticed was an increase in questions posted by LGBTs, including MSM on matters relating to STIs and HIV. The initiatives offered by the group has since expanded to include counseling, among others.

*"Nag-rerespond yung mga tao sa internet blog. Yun nga, sa internet, social media. And we find it effective kasi dalawang buwan pa lang kami at napansin ka na ng mga tao sa ginagawa mo. The other day I was interviewed by Brigada, Channel 7. Tapos yesterday we were featured in Manila Bulletin, dun sa front page... nakakatuwa kasi parang wow, nakakatuwa. Yung ginagawa mong tulong na-appreciate ng mga tao... Hindi ko inexpect na ganitong magrerespond yung mga tao.. I thought na parang, kasi gusto ko grassroots lang muna eh, e malay ko ba yung grassroots ang dami. I mean, nakaka-overwhelm, yung mga tao, nakakatuwa lang."*

**– Ronivin Pagtakhan, Co-Founder, Loveyourself**

With colleagues James Garcia Bon and James Warrasaran, he started Venereal Infection Nuisance Nursing (VINN) as a prevention advocacy project targeting the youth and MSM. The Loveyourself blogsite became the primary platform for the campaign, providing its readers with information on how to get tested, livelihood ideas, and invitation to become volunteer-members to its projects.

According to the proponents, the campaign sought individual support rather than funding support from its members and followers. Many of their members have specific skills that contributed to building of the blog. Most of the support come from the LBTGIQ community, e.g. Ian Felix Alquiros, the proponent of the "Loveyourself" Photoshoot campaign. Loveyourself campaign provided supporters, for a fee, a t-shirt and their photograph taken in support of "Love Yourself." Love Yourself is mainly an awareness generation campaign.

*"Ah sa amin, lahat kami ay mga Energizer bunnies...Ang belief naming lahat if you want to do something, move. Hindi porke't president ka utos ka lang ng utos. Ako mismo naghahandle ng SEC namin, as in everything. Lahat ng paperwork, I did it, ako lang. Passionate, commitment, talagang integrity na you want to do it without asking anything in return for the continuity of care."*

**- Ronivin Pagtakhan**

*The initiative also has expanded to include a counseling component where counselors, through chatting online, disseminate information. The proponents say their counseling approach incorporates personal approach based on the FAQs referenced from DOH. They currently have six trained counselors. These "contribution of talents" help make the initiative self-sustaining.*

Another support came by way of "Manila Gay Guy" or MGG, a blogger popularly known among the MSM blogging community, who wrote about the events of the initiative and helped generate awareness and media coverage. As a professional life coach, MGG also provides information and awareness through the conduct of life coaching sessions. Yet another supporter is an anonymous volunteer with expertise in marketing who took charge of organizing the events side of the campaigns. An event in Manila Peninsula and a movie premiere at a mall sponsored by Vfactor Inc. were conducted to generate support to sustain efforts.

> *"Pilot test pa lang yung Life Coach..so three months pa lang muna. Susunod na dyan yung mga schools. Actually Migs is invited sa Philippine Normal University... a talk sa 500 students, HIV awareness, Nagscale up na yan. Dati 10-10 lang kami."*
>
> **- Ronivin Pagtakhan**

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The group has formally registered with the SEC and is looking at expanding their programs. The efforts continue to be generated from personal contributions of members-for instance, a member has volunteered the free use of his office, including computer facilities and utilities as base for the group's online counseling. They are looking at responding to the increasing demand for information and counseling, at the same time scaling up in the reach of their Health and Life Coaching, as well to contribute to LGU SHC's post-test counseling. To this end, initial partnership has been forged with Quezon City. It is the aim of the group to provide an alternative counseling option. They have received feedback that many of those who go for testing no longer return for their results, or for succeeding after-care, citing lack of privacy, business of the facilities, and the lack of personal care in the provision of services.

Among the challenges faced by the proponents is to scale up the capacities of their volunteers for counseling, as well as to further scale up their campaigns for greater reach. While volunteer support is very active, the group does not have enough financial resources to mount all their planned activities.

### 4.2.2 SUPPORT

**Yoga for Life: Living Positively + Living Well.** Yoga practitioners Charmaine Cu-Unjieng and Paolo Leonido initiated Yoga for Life as a program designed to address the needs of PLHIV. A core group was organized composed of their friends to make up the Yoga for Life. The first class was started in June 2001, conducted for free, with 14 students. Funding of the initiative came mostly from the personal contributions of the proponents. They point to the support of the yoga community that helped them start–yoga mats were provided by different yoga studios, and instructors conducted their classes for free.

The aim of the group was to conduct yoga sessions to enable PLHIV achieve wellness, inner peace, and to offer yoga as their complementary therapy. It was also meant by the organizers to provide an avenue to those who were interested and affected by HIV, including relatives and friends of PLHIV. Yoga for Life was formally registered with the Securities and Exchange Commission (SEC) in April 2011, and continues to provide yoga classes with the support of private and personal donations from supporters.

*"Word of mouth, like when people found out about it. And then you know people (who) invited people from different organizations...Media has really helped... as in Manila Bulletin, Star, Inquirer... yung bloggers..."*
**- Paolo Leonido, Co-Founder, Yoga for Life**

*"The reason why these groups are common and there are so many, because there is an innate need for us, meron talagang lungkot especially with what we have to go through, you need to be with people who understand you and go through the experiences that you have."*
**- PLHIV, FGD**

The strength of the initiative, according to the proponents, lies in the application of the principles of yoga, since the sessions provide a venue for PLHIV students to feel safe. They do not force their students to come out to declare their positive status, so that yoga and the anonymity provide a safe haven. The proponents also stress that instead of HIV education that is based on fear, they focus on gaining self-love and respect as a practice to instil behavior change.

The proponents envision scaling-up their services but are challenged by the cost of scaling-up. The proponents cite the cost of training more yoga instructors. The increasing number of students, PLHIV who enrol, are indicators of the effectivity of their program. There has been, however, no corresponding increase in the number of qualified teachers to respond to their increasing need. The proponents also cite the challenge of their status as an "informal" organization. According to them, as a "non-formal NGO," they have not been as well regarded and given due credibility as other more established organizations. Recently, registered with SEC, the proponents believe they are at a juncture in their organization's development.

*"...if we should become (like) a more formal organization, taking (on) bigger problems... For me yun yung question. Do we keep the intimacy of it? Or become like any other organization out there, yung may employees ka na, meron ka nang deliverables?"*

**– Charmaine Cu-Unjieng**

### 4.2.3 ENABLING ENVIRONMENT

Many of the proponents of community initiatives are members of the larger LGBT community that support the more political advocacy of the community, i.e. to pass legislation that would create a more enabling environment for MSM and TGs.

*"Before, nung hindi pa ako totally involved sa advocacy, iwas ako sa maiingay na MSM. Ako sa sarili ko hindi ko tanggap na tawagin akong MSM. Pero may partner ako. Kilala nila ako, na hindi ako sanay na gamitin yung language nila. Akala nila straight ako. Natanggap ko din na ang MSM community, hindi mo pwede na i-stigmatize sila, kasi sila ang makakasama mo sa journey mo. Kasama na dun yung pagiging HIV positive, at pagiging MSM. Natanggap ko, at nasasabi ko na siya ngayon. "*
**- PLHIV, FGD**

In most of their projects, the proponents cite a supportive LGU as an important component to the success of their campaigns. In most of the initiatives of The Red Whistle, SMS for MSM, and Loveyourself, an integral part of their service delivery is the support of SHCs of LGUs. Their partnerships with LGUs have enabled them to expand their reach.

# 5. Discussion

*Many of the more successful intervention programs are implemented in the cities where there are already MSM and TG organizations. A national program is required that will chart the breadth and coverage of services to ensure that, as much as possible, a geographically comprehensive implementation is conducted for at-risk MSM and TGs all over the country.*

National and local government health institutions are the primary delivery institutions for prevention services. While there have been serious efforts to better systems and deliver a more comprehensive and multi-disciplinary prevention package, this is often challenged by the lack of resources, i.e. the lack of commodities, understaffing and the lack of specialized personnel, inadequate and inappropriate infrastructure, and the lack of support programs such as psychosocial counseling. Until recently, there have been no specific interventions that address MSM and TG sexual health needs. The still limited quality and accessibility of HIV treatment and care reflects an overall poor investment in health.

The limitations and challenges, however, are often augmented by public-NGO/community partnerships, where volunteers provide staff support to government hospitals, and other support resources. In many aspects of the various interventions, national and local governments, NGO and community partnerships often supplement the servicing they each provide. These collaborations have been the foundation of what has made service delivery tenable and innovative.

For national, local and community interventions, the continued stigmatization of HIV is viewed as contributing to the low uptake of prevention programs. The gaps in information to better understand MSM and TG diversity in terms of identity and vulnerabilities present a barrier to program planning and implementation. This is a challenge to the development of strategic information that goes beyond surveillance.

The lack of an identical and systematic mechanism for gathering data on MSM and TG clients remain a challenge for monitoring. There is a lack of studies and literature on Filipino MSM and TGs to guide programs and to incorporate more appropriate and sensitive mechanisms. PLHIV are important players that could provide and/or help generate important data.

Community-based interventions provide innovative ideas that refresh awareness-generation, and help expand support for MSM and TG health concerns. Their independence allows them to innovate and be creative in their projects, so that they are able to resonate with and reach out to MSM, TG and supporters alike. Their use of innovative platforms (ICTs, major events, photoshoots) are new models for generating awareness and information, as well as for service delivery. Their limited resources, however, do not actually allow them to provide many of the services (e.g. treatment) required, nor access the capability-building and trainings to improve their delivery. Many of the community-based interventions are not formal organizations and require supportive interventions in the development of their organizations, and in some cases formalize their (legal) existence. There is a lack of systematic mentoring and nurturing of the capacities of community organizations.

Community-based organizations and individual supporters compose the support for MSM, TG, and LGBT rights, and are the primary movers for HIV initiatives, education awareness, and assertion of rights. They help build, protect, and call attention to the need for an enabling environment of MSM and TG.

Peer educators are very important actors in the prevention of HIV and AIDS. While most are dedicated and personally motivated, they lack supplementary training and adequate compensation. There may be a need to standardize required knowledge and skills of those in the frontlines. Here, PLHIV who are active educators can provide personal knowledge and wisdom, as well as leadership.

Disinterest and lack of political prioritization of HIV and AIDS program by LGUs influence local health politics that often result in conflicting, competing, or outright lack of policies. Snags in the implementation are attributed to competing resource allocation policies and unclear and conflicting mandates regarding MSM and TG.

Many of the more successful intervention programs are implemented in the cities where there are already MSM and TG organizations. A national program is required that will chart the breadth and coverage of services to ensure that, as much as possible, a geographically comprehensive implementation is conducted for at-risk MSM and TGs all over the country.

The best practices for prevention programs are those implemented by LGUs through their Local AIDS Council and the SHCs. An enabling climate directly affects service delivery. This climate, however, is not consistent throughout the country. The general state of local policies reflect an environment that is not wholly conducive to the provision of services and support for MSM and TG sexual health needs. A comprehensive national policy is needed to harmonize conflicting local policies, and to address the required investment in MSM and TG sexual health. This emphasizes the need for greater push for a more comprehensive national program that involves, monitors, and ensures adequate services in each local unit.

# 6. Recommendations

**Finely tuned targetting of programs.**
With the increasing focus on service delivery for MARPs in the national programs, an even more targeted and specialized allocation of funding and service delivery should be undertaken for MSM and TGs. These should pay particular attention to their unique vulnerabilities and needs (translated into availability of ARVs, appropriate facilities, and well-trained and capable staff).

**Enhancing capacities.**
The network of HIV practitioners, CSOs and community organizations need to be expanded and systematized, so that expertise and referral can be better complemented and coordinated. The knowledge of LGUs, CSOs and community organizations, as well as their capacities, require scaling-up. Greater monitoring and evaluation of their implementation would complement and improve their mechanisms and systems of servicing.

**Improving information.**
Generating further researches can guide implementers in the evolving and nuanced definition of MSM and TG, and consequently better frame the responses for their unique vulnerabilities. It is also important that in generating and developing tools for strategic information, MSM and TG communities play an important role. Especially nuanced by their personal knowledge, MSM and TGs are indispensible in assisting in the gathering of data, as well as in the translation of the data into program designs and services. Nuanced appreciation of data, sensitive to the particularities of emerging needs of MSM and TGs, require special attention. An exchange of information generated from researches on MSM and TG will enhance service deliveries towards eradicating stigma, and developing more appropriate prevention programs.

**Monitoring and evaluation.**
A systematic monitoring and evaluation mechanism that is replicable and practicable would be helpful in constantly appropriating intervention programs. Surveillance results would be helpful in assessing needs, planning a response, and evaluating programs and project outcomes. As an evaluation tool, surveillance results can be used to validate successful programs and promote their continuation. As part of strategic information, it is essential in engaging other stakeholders and sustaining support for programs. It becomes a tool to help answer questions and uncertainties that policy makers, program implementers and service providers may have about the effectiveness of the policies, programs and services.

**Specific and adequate support allocation.**
The 2010 UNGASS Report notes that based on recorded spending for HIV from 2007 to 2009, majority of the CSOs externally source their funds through development partners and international NGOs to implement a significant number of AIDS-related activities. Echoing the recommendation forwarded by the 2010 UNGASS Report and Dr. Mario Taguiwalo in the 2009 AIDS Summit, the survey results recommend that the government take on a more engaged role in sustaining and scaling up efforts already being conducted by these NGOs. Concretely, this should be reflected in an increase in domestic spending for HIV and AIDS. Average spending was pegged at 20% (relative to the 67% input sourced externally) for the 2007 to 2009 period. Correspondingly, the monitoring of fund allocation (prevention, treatment, care and support, strategic information, and supportive interventions) and who will benefit from them will provide clearer indicators for specific key affected populations. This would help ensure comprehensiveness of the country response.

**Comprehensive response.**
There is an urgent need to promote the MSM Comprehensive Response, and incorporate its components to national and LGU planning and implementation. An integrated, comprehensive, multidisciplinary and complementing partnerships between the public and community sectors that makes the best use of innovative and strategic programming in implementing HIV programs for MSM and TG is necessary to address limited resources and to scale-up much needed services. This underscores the requirements for greater and more inclusive reach. As cooperative interventions already show effective reach through complementing service delivery, it is important that they are sustained by moving towards instituting these partnerships and developing concrete mechanisms towards fostering more cooperative interventions, that should include supportive interventions, continuing capacity development and resource support. Government should initiate the lead in organizing, coordinating, and formalizing ties with various support organizations.

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# 7. Annex

| MSM AND TG MILESTONE INITIATIVES | | | | | |
|---|---|---|---|---|---|
| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1988** | Medium Term Plan I drafted and approved | Department of Health | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| | National AIDS Prevention and Control Program created | | | | |
| **1989** | Birth of The Library Foundation (TLF) | The Library Foundation (TLF) | | http://www.qrd.org/qrd/world/asia/phillipines/the.library.foundation-AIDS | The Library Foundation (TLF) began in 1989 as an informal group of friends who organized fellowship activities for the regular patrons of the Library Pub, a sing-along (karaoke) bar on Adriatico St. near Remedios Circle in the tourist district of Malate in Manila. |
| | Policy Guidelines of HIV Infection/AIDS Prevention and Control drafted and ratified | Department of Health | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| **1990** | TLF as a socio-civic organization was formally organized | The Library Foundation (TLF) | | http://www.qrd.org/qrd/world/asia/phillipines/the.library.foundation-AIDS | This group of friends formed themselves into a socio-civic organization. In addition to its usual fellowship activities, TLF then began to organize small-scale charitable outreach projects for Malate streetchildren and victims of natural disasters. |
| **1991** | TLF started working on HIV and AIDS services and registered as non-government organization. | The Library Foundation (TLF) | | http://www.qrd.org/qrd/world/asia/phillipines/the.library.foundation-AIDS | TLF redirected its vision to work as an AIDS service organization. It became a duly registered non-governmental organization (NGO). Only TLF has Filipino men who have sex with men (MSM) as its community base. TLF's programs and activities arise from and directly serve the concerns of Filipino gay and bisexual men, many of whom do not identify as such. |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
|---|---|---|---|---|---|
| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1991 - 1992** | National HIV Sentinel Surveillance formulated | Department of Health | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| | HIV (Health Interaction and Values) workshops among MSM among MSM (pilot training project) | The Library Foundation (TLF) | Funded by AIDSCOM (now USAID), followed by AusAID | http://www.qrd.org/qrd/world/asia/phillipines/the.library.foundation-AIDS | The "Healthy Interaction and Values" (HIV) Workshops constitute TLF's centerpiece project. From October 1991 to July 1992, TLF has held 10 workshops. About 250 men have participated in these workshops |
| | | | | KII Matrix-TLF (Joel de Mesa)<br>KII Matrix-TLF (FerdieBuenviaje | Note: According to Tan's case study, between 1991-1992, TLF spent 12 weekends, for HIV workshops with 328 participants. |
| | | | | (Tan, 1995, *Tita Aida and Emerging Communities of Gay Men: Two Case Studies from Metro Manila, the Philippines*). | |
| **1992** | Male to Male Helpline | The Library Foundation (TLF) | | (Tan, 1995, *Tita Aida and Emerging Communities of Gay Men: Two Case Studies from Metro Manila, the Philippines*). | It was introduced in November 1992 and suspended in April 1993 |
| | Daily newspaper column (Sexy, Saucy and Spicy) in *Manila Times* | TLF and Dr. Margarita Holmes | | (Tan, 1995, *Tita Aida and Emerging Communities of Gay Men: Two Case Studies from Metro Manila, the Philippines*). | The columns offered advices on matters related to sexuality. TLF's contribution to Holmes' column evolved into a more active position of advocacy and eventually expanded into a media watch activity. |
| | Creation of the Philippine National AIDS Council through Executive Order No. 39 | Department of Health | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| | Designation of TLF as the MSM sectoral representative to Philippine National AIDS Council (PNAC) | PNAC | | www. pnac.gov.ph | TLF is the first and the only MSM sectoral representative up to the present. |
| | Bilateral agreements for AIDS Surveillance and Education Project (ASEP) was signed between the Philippines and the USA | Department of Health Path International | USAID | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program<br><br>http://www.path.org/publications/files/CP_phil_best_practices.pdf | Aimed to help prevent the rapid increase of HIV and AIDS by instituting mechanisms to monitor HIV prevalence and risk behaviors through surveillance activities and by encouraging behaviors that reduce individual risk through education activities.<br><br>ASEP promoted public-private partnerships between city health departments and NGOs, between government social hygiene clinics (SHCs) and private pharmacies and their professional associations, and between local AIDS councils (LACs) and private media concerns.<br><br>(Continue next page) |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
|---|---|---|---|---|---|
| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1992** | | | | | Although initially focused solely on surveillance and education, over the course of the program the scope and coverage of ASEP was expanded to include other high-impact prevention strategies that were brought to scale in the Philippines' eight largest cities.<br><br>The complementary science-based interventions used by ASEP include community outreach peer education (COPE), condom access, STD case management, harm reduction programs for injecting drug users, public service advertising (PSA), and STD social marketing. In addition to supporting the delivery of targeted and combined interventions, ASEP provided extensive additional support to develop long-term human capacity and infrastructure in the public and private sector in ASEP's eight urban sites ( Angeles City, Quezon City, Pasay City, Cebu City, Iloilo City, Davao City, General Santos City and Zamboanga City) |
| **1993** | HIV workshops | The Library Foundation (TLF) | | http://www.qrd.org/qrd/world/asia/phillipines/the.library.foundation-AIDS | |
| | MSM Drop-in Center | The Library Foundation (TLF) | | http://www.qrd.org/qrd/world/asia/phillipines/the.library.foundation-AIDS<br><br>KII Matrix-TLF (Ferdie Buenviaje)<br>KII Matrix-TLF (Glenn Cruz)<br><br>(Tan, 1995, *Tita Aida and Emerging Communities of Gay Men: Two Case Studies from Metro Manila, the Philippines*). | In cooperation with Health Action Information Network (HAIN), a health resource NGO also doing AIDS work, TLF maintains a community drop-in center at 956 Malvar corner Agoncillo, behind the Philippine Women's University in Malate, Manila. It is open to the public from Tuesday to Saturday. At the center, TLF holds continuing short HIV/AIDS workshops, individual face-to-face activities, anonymous telephone hotline activities, and further activities such as plays, film showings, discussion groups, and other gatherings.<br><br>Note: According to Tan's case study, it was noted that April 1992, TLF set up a community drop-in center and was closed in April 2003. |
| | HIV Knowledge and Attitudes among MSM in Metro Manila. (1993-1994), an unpublished HIV training needs assessment results | Dr. Michael Tan | | KII Matrix-TLF (Joel de Mesa) | Dr. Tan collated and analyzed pre-test and post test training results of batch 0-22 participants regarding knowledge, attitudes and skills on HIV and AIDS. Through the unpublished document, it helped TLF recognize the trend/needs of the training participants. |
| | STD Control program integrated to the AIDS control program, now called National AIDS/STD Prevention and Control Program (NASPCP) | Department of Health | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
|---|---|---|---|---|---|
| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1993 - 1995** | AIDS Surveillance and Education Project (ASEP) | • Department of Health<br>• Philippine National AIDS Council<br>• PATH International<br>• KABALIKAT<br>• LGUs<br>• Local NGO Partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | ASEP's targeted intervention program focused primarily on registered sex workers and MSM, although other sentinel groups such as IDUs were prioritized for prevention education in some sites. NGO partners accessed individuals from these groups mainly by going to their place of employment, where project staff would deliver basic HIV and AIDS presentations and condom demonstrations to the employees, owners and managers of establishments registered with the local government.<br><br>Note: According to PATH publication, in September 2003, a Cooperative Agreement was signed between USAID and PATH for HIV and AIDS prevention education |
| | | | | KII Matrix-National Response (Dr. Gerard Belimac) | Emphasized that ASEP is a surveillance and not a prevention project but with a provision on education for the purpose of involving the respondents in the surveillance. |
| | | | | KII Matrix-National Response (Dr. Carmina Aquino) | ASEP is the first major project that focuses on HIV and AIDS prevention. It was the first collaboration engagement among LGU, NGOs and DOH. In 1995, MSM intervention became one of its thrusts.<br><br>DOH and Field Epidemic Training Program handled the surveillance, while KABALIKAT was in charge of the education together with local partners<br><br>Initially there were three sites: Davao and Cebu, Quezon City, and expanded to eight sites for MSM |
| **1994** | MSM hotline and clinic | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• KABALIKAT<br>• Reachout International | USAID | KII Matrix-National Response (Ms. Ruthy Libatique) | This was under the ASEP initiative of which Reachout was one of their grantees. Most of their clients were MSM. (Based on KII transcript as interviewed by E. Magharing) |
| | | | | | Reach Out International project was catering fully for MSM in Quezon City and Pasay (Based on KII transcript as interviewed by M. Navarro) |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
|---|---|---|---|---|---|
| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1994** | Creation of LGU ordinances | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• KABALIKAT<br>• Center for Multi-disciplinary Studies on Health and Development (CEMSHAD) | USAID | KII Matrix-National Response (Ruthy Libatique) | Under ASEP |
| **1995** | Philippine National HIV/ AIDS Strategy developed and endorsed by President Fidel V. Ramos | Department of Health-Philippine National AIDS Council | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| | STD Treatment Guidelines formulated | | | | |
| | Policy Guidelines on HIV/ AIDS Prevention and Control revised | | | | |
| | Mid-Term Evaluation of ASEP (Feb) | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• LGUs<br>• KABALIKAT<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |
| | Phil-Thai Technical Exchange and STD Management (May) | | | KII Matrix-National Program(NASPCP-Gerard Belimac | LGUs, study tours in red light districts<br><br>With the study tours in Thailand, Dr. Belimac noted that LGUs" adopted the concept of red light districts where all entertainment establishments were placed in the same district. |
| | | | | KII Matrix-National Response (Carmina Aquino) | Study tour with government officials (e.g Social Hygiene Clinic physician, City Health Office). |
| **1995 - 1997** | TLF included advocacy and right based approach in the program | The Library Foundation (TLF) | | KII Matrix-TLF (Joel de Mesa) | |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
|---|---|---|---|---|---|
| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1996** | National STD Case Management Guidelines formulated Presidential Proclamation No. 888 signed – declaring 1997 as National AIDS Prevention Year | Department of Health-Philippine National AIDS Council | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| | Model Community Health/ STD Facilities in Commercial Sex Areas in the Philippines | | AUSAID | | |
| | Japan International Cooperation Agency Project for the Prevention and Control of STD | | JICA | | |
| | SEAMEO – GTZ Control of HIV/AIDS/ STD Partnership Project in the Asian Region (CHASPPAR) Monitoring STD/AIDS Service Delivery Through Information System | | GTZ | | |
| | Community Outreach Peer Education (COPE) | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• LGUs<br>• KABALIKAT<br>• DKT<br>• Local NGO partners | USAID | KII Matrix-National Response (Carmina Aquino) | Training peer educators for basic communication. It also had condom distribution in partnership with DKT |
| **1997** | TLF ventured into outreach services including education and condom demonstration and distribution | The Library Foundation (TLF) | | KII Matrix-TLF (Ferdie Buenviaje) | |
| | Policy and Strategies for STD/HIV/AIDS Intervention in the Workplace launched by the Department of Labor and Employment (DOLE) | Department of Health-Philippine National AIDS Council | | http://www.pnac.org.ph/index.php?page=evolution-of-the-national-aids-sti-prevention-and-control-program | |
| | Implementation of Memorandum Order No. 495 s. 1996 Integrating HIV/AIDS education in all schools nationwide by the Department of Education Culture and Sports Guidelines on the Entry of People with HIV/ AIDS to the Philippines endorsed by the Department of Foreign Affairs through Circular No. 214-97 | | | | |
| | ASEP Assessment (Feb) | • Department of Health<br>• Philippine National AIDS Council<br>• Path Foundation Philippines<br>• LGUs<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |
| | | | | Almario, Lyn, Chin, James, Hermann, Chris [et. al]. (1997) *Assessment Report Special Objective: Rapid Increase of HIV/AIDS prevented*. [Philippines:USAID]. | Identified that surveillance was the first response in relation to MSM and TG intervention. |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **1997 - 1999** | TLF directed towards the framework of Human rights with initiatives for Lagablab and Anti-Discrimination Bill campaign | The Library Foundation (TLF | | KII Matrix-TLF (Ferdie Buenviaje) | |
| **1998** | TLF geared towards community service through organizing, advocacy and support to LGBT community | The Library Foundation (TLF) | | KII Matrix-TLF (Ferdie Buenviaje) | |
| | TLF was appointed as a PNAC member | The Library Foundation (TLF) | | KII Matrix-TLF (Joel de Mesa) | |
| | Social Mobilization for Creation of Multi-sectoral Local AIDS Council (March) | • Department of Health<br>• Philippine National AIDS Council<br>• Path Foundation Philippines<br>• LGUs<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |
| **1998 - 1999** | Loop party as fundraising activity related to safer sex in Puerto Galera. | The Library Foundation (TLF) | Private sector | KII Matrix (Tacing Marasigan) | Engagement with private sectors/business groups |
| **Late 90s -2000** | HIV training with *parlorista* salon workers in Manila, Quezon City and Parañaque | The Library Foundation (TLF) | | KII Matrix-TLF (Joel de Mesa) | |
| **Late 90s** | Youth projects<br>a) Training among Guidance Counselor on Adolescent Sexual and Reproductive Health<br>b) Other activities under ARH program: peer education convocation, events | • PHANSUP<br>• Cebu Youth Zone<br>• Baguio Youth Center<br>• Neighbors (Zamboanga)<br>• HDES (Zamboanga)<br>• Davao (site)<br>• General Santos City (site)<br>• Koronadal, South Cotobato<br>• Bohol (site)<br>• Palawan (site)<br>• Iloilo (site)<br>• Antique (site)<br>• Bacolod (site)<br>• Tuguegarao (site)<br>• Kasiglahan (Cotabato City) | • International HIV and AIDS Alliance<br>• David and Lucile Packard Foundation | KII Matrix-National Response (Ruthy Libatique) | • 2 Youth programs in schools were initiated in Koronadal, South Cotabato (formerly known as Marbel). One focused on HIV and AIDS under the framework of Reproductive Health, while the other on Adolescent Reproductive Health (ARH)<br>• In Cotabato, they had an ARH newsletter<br>• International HIV and AIDS Alliance (UK based) supported the HIV and AIDS program while David and Lucille Packard Foundation funded the ARH initiative<br>• Kasiglahan Pakikibahagi Program is a foundation established in Cotabato City that provides street education and drop-in and residential services for street children (http://danilozuno.tripod.com/ngos.htm)<br><br>**(Continue next page)** |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **Late 90s** | | | | | • Trained guidance counselors on Adolescent Reproductive health with emphasis on identity crisis counselling among high school students.<br>• In GenSan, Davao, Cotabato and Zamboanga, there were turnover ceremonies held among NGO, PHANSUP and DepEd with the understanding to continue this program in public schools |
| **2000** | Policy Advocacy and Community-level Interventions (August) | • Department of Health<br>• Philippine National AIDS Council<br>• Path Foundation Philippines<br>• LGUs<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |
| **2000 - 2001** | Positive Light with support from PBSP and Levis Strauss Foundation. | • The Library Foundation (TLF)<br>• Philippine Business for Social Progress (PBSP) | Levis Strauss Foundation | KII Matrix-TLF (Glenn Cruz) | An AIDS awareness project through documentary photographs |
| **2001** | ASEP Final Evaluation (March) | • Department of Health<br>• Philippine National AIDS Council<br>• Path Foundation Philippines<br>• LGUs<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |
| **2001 - 2002** | Training among Guidance Counselors on Adolescent Sexual and Reproductive Health | • Cebu Youth Zone<br>• Baguio Youth Center<br>• Neighbors ( Zamboanga)<br>• HDES ( Zamboanga) | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | Parents took initiative as peer educators among the youth in Zamboanga |
| **2000 to present** | Technical support (HIV Communication, HIV Education) to Babaylan | The Library Foundation (TLF) | | KII Matrix-TLF (Ferdie Buenviaje) | |
| **2002** | PEERETA project (Peer educators and advocates)- one day intensive HIV/AIDS prevention workshop | • The Library Foundation (TLF)<br>• Philippine NGO Support Program, Inc (PHANSUP | International AIDS Alliance | KII Matrix-TLF (Glenn Cruz) | |
| | ASEP Sustainability and Phase Out (August) | • Department of Health<br>• Philippine National AIDS Council<br>• Path Foundation Philippines<br>• LGUs<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **2003** | ASEP End of Project (September) | • Department of Health<br>• Philippine National AIDS Council<br>• Path Foundation Philippines<br>• LGUs<br>• Local NGO partners | USAID | http://www.path.org/publications/files/CP_phil_best_practices.pdf | |
| **2004 - 2007** | TLF undertook community organizing | The Library Foundation (TLF) | Global Fund | KII Matrix-TLF (Ferdie Buenviaje) | Sites: Gumaca, Quezon; San Pablo City, Laguna; Batangas City; and Legaspi, Albay, Daraga, Tobacco in Bicol |
| | MSM organized groups created/established | The Library Foundation (TLF) TLF SHARE Collective | | KII Matrix-TLF (FerdieBuenviaje)<br>KII Matrix (Glenn Cruz)<br>KII Matrix (Tacing Marasigan) | Through HIV, Human Rights and Governance workshops, the following groups were organized: GAYON in Bicol, BARAKO in Batangas City and INDIGO (Independent and Diverse Gay Organization) in Brgy. Kaypian, San Jose Del Monte, Bulacan<br><br>Accomplishments:<br>• GAYON lobbying for Anti-discrimination ordinance in Legaspi City<br>• GAYON active participation in Albay HIV/AIDS provincial plan<br>• Legaspi LGU supportive in HIV/AIDS awareness program and condom procurement and distribution<br>• BARAKO and Batangas City working relationship in exchanges of information on HIV/AIDS<br>• Provincial and local government of Batangay City waived hospitalization bill (including check-up) of MSM referred by BARAKO or member of BARAKO<br>• INDIGO individual members offered support to politicians during election campaign<br>• INDIGO provide IEC materials (flipcharts) to CHO |
| **2005** | TLF was incorporated in September 2005 as a non-profit membership organization duly registered with the Securities and Exchange Commission. | TLF SHARE (Sexuality, Health and Rights Educators) Collective | | http://tlfshare.webs.com/aboutus.htm | Formally changed the name to TLF SHARE (Sexuality, Health and Rights Educators) Collective. |
| **2006** | Voluntary Confidential Counselling and Testing (VCCT) Training | SHC Manila | UNICEF | KII Matrix SHC Manila | |
| **2007** | The Headshot Clinic began | Niccolo Cosme | UNAIDS Donation from Supporters | KII Matrix Community Initiatives (Niccolo Cosme) | First campaign was called "AWARE", a call of spreading the issues and facts about HIV and AIDS. |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **2008** | "MOVE" Headshot Clinic | | UNAIDS Donation from Supporters | KII Matrix Community Initiatives (Niccolo Cosme) | In commemoration of the celebration of 20th year of World AIDS day which aimed to move people from awareness to readiness to respond and act on this specific issue |
| **2009** | Peer educators and IEC materials | SHC Manila | • UNICEF<br>• Pinoy Plus<br>• YAFFA | KII Matrix SHC Manila | |
| **2010** | Take the Test Campaign in Malate | Take the Test | | KII Matrix SHC Manila | |
| | "ACT" Headshot Clinic | • Take the Test<br>• AIDS Society of the Philippines | UNAIDS Donation from Supporters | KII Matrix Community Initiatives (Niccolo Cosme-Project Headshot) | Voluntary screening and counseling was provided |
| | SMS for MSM | • Health Promotion and Communication Project<br>• MSM Clans<br>• City Government of Quezon | UNAIDS | KII Matrix Community Initiatives (Carmina Aquino-HealthPro) | Innovative strategy of disseminating HIV prevention messages through SMS. Identified Quezon City Health Office as their partner because of the highest prevalence of MSM population. |
| **2011** | MSM Friendly Clinic | • Department of Health<br>• Research Institute for Tropical Medicine (RITM)<br>• National AIDS and STD Prevention and Control Program (NASPCP) | Department of Health | KII Matrix-National Program (RITM - Dr. Rossana Ditangco) | • Clinic that will address the sexual health needs of MSM<br>• Mini-lab, for screening of sexually transmitted infections, like syphilis, HIV, Hepa B.<br>• STI diagnosis and treatment, clinical management, counseling. |
| | Red Whistle Campaign | Niccolo Cosme | Donation from Supporters | KII Matrix Community Initiatives (Niccolo Cosme-Red Whistle) | This was an experiment of Cosme and his friends that created a fad (whistle as an accessory) and draw curiosity and attention from other people. It hopes to engage individuals and groups to HELP SOUND THE ALARM in their respective communities that HIV is here and it must be stopped. |
| | Yoga for Life | • Charmaine Cu-Unjieng<br>• Paolo Leonido | Donation from Supporters | KII Matrix Community Initiatives (Yoga for Life) | • Aside from their passion, both yoga instructors wanted to offer a support group to PLHIV at the same time promote the benefits of yoga as a stress reduction practice.<br>• It also provides a venue where students feel safe of being anonymous as HIV positive as compared to other support groups. In addition, both respondents emphasized that instead of educating people on the realities of HIV with fear on its effect/or no cure, but rather focus on gaining self-love and respect for them to change their behaviors. |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **2011** | Love Yourself Campaign (VINN Advocacy for the Youth and MSM | Ronivin G. Pagtakhan | Donation from Supporters | KII Matrix Community Initiatives Love Yourself | • A non-stock, non-profit organization registered with Securities and Exchange Commission last July 15, 2011.<br>• An organization focused on counseling and education to improve awareness and in the prevention of HIV among the youth and the at-risk population. By at-risk population, meaning men having sex with men and freelance sex workers. |
| | | | | http://theloveyourselfproject.blogspot.com/2011/07/mission-vision-and-goals.html | • The acronym V.I.N.N. stands for Venereal Infection Nuisance Nursing, wherein the word NURSING has an operational definition that does not implicate nor has any relation to the nursing profession, but instead the verb connoting care or nurturing.<br>• This organization aims to help the Filipino youth and LGBT giving priority to the high risk MSM (men having sex with men) sector to prevent, detect, treat and control the spread of sexually transmitted infections. |
| **2011** | Concerts in malls (SM Batangas, SM Baguio) and commercials in gay bars about AIDS | • Philippine NGO Council on Population, Health and Welfare (PNGOC)<br>• Department of Health<br>• Rocking Society through Alternative Education (RockEd) | Global Fund Round5 | KII Matrix-National Response (Ruthy Libatique) | |
| **No Year** | Access to retroviral treatment, capacity building, renovation of facilities | • Department of Health<br>• San Lazaro Hospital-HIV Pavilion | Global Fund (GF) | KII Matrix-National Response (Dr. Rosario Tactacan-Abrenica) | |
| | Sustain efforts done by ASEP projects (the same priority populations) | Department of Health | Global Fund3 | KII Matrix-National Program (Gerard Belimac) | |
| | Access to anti-fungal creams and antibiotics | • Department of Health<br>• San Lazaro Hospital-HIV Pavilion | GF Round 3, 5, 6 | KII Matrix-National Response (Dr. Rosario Tactacan-Abrenica) | |
| | Provision of ARV coordinators and computer<br>involvement with proposal negotiations, expanded area among MARPs (contigous area) | • Department of Health<br>• San Lazaro Hospital-HIV Pavilion | GF Round5 | KII Matrix-National Response (Dr. Rosario Tactacan-Abrenica) | |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **No Year** | C+ shop or condom shop (condoms, lubricants etc) | • PHANSUP<br>• United Gays Association of Surigao (Surigao)<br>• Bacolod (site)<br>• Tingog Cagayan de Oro)<br>• HDES (Zamboanga)<br>• SHED (General Santos City)<br>• LGU (Social Hygiene Clinic)<br>• DKT | | KII Matrix-National Response (Ruthy Libatique) | Institutionalization of measures through social marketing run by community organizations to sustain peer education and salary of peer educators<br><br>Located in lodging houses in Cagayan de Oro |
| | Treatment Care and Support Officer, Pneumonia and Hepatitis vaccines (100 people | • Department of Health<br>• San Lazaro Hospital-HIV Pavilion | Global Fund6 | KII Matrix-National Response (Dr. Rosario Tactacan-Abrenica) | |
| | Implementation, 50% former ASEP sites, mentor to the other sites | Department of Health | | KII Matrix-National Program (Gerard Belimac) | |
| | Initiated activities such as peer education and establishment of LGU ordinances | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• LGUs<br>• KABALIKAT<br>• Local NGO partners | USAID | KII Matrix-National Response (Ruthy Libatique) | Under ASEP |
| | Conducted Operations Research in areas of Manila and Pasay City | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• LGUs<br>• KABALIKAT<br>• Local NGO partners<br>• CEMSHAD | USAID | KII Matrix-National Response (Ruthy Libatique) | Under ASEP |
| | Peer education as an intervention to MSM (prostituted men) | • Department of Health<br>• Philippine National AIDS Council<br>• Path International<br>• LGUs<br>• KABALIKAT<br>• Local NGO partners<br>• TANIKALA | USAID | KII Matrix-National Response (Ruthy Libatique) | Under ASEP |
| | MSM community intervention | IwagDabaw | Miserior | KII Matrix-National Response (Ruthy Libatique) | |
| | Drop in Center | • IwagDabaw (Davao)<br>• Cebu Youth Zone (Cebu) | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | IwagDabaw Drop in Center provided refuge among MSM esp. young *bayots* who were mostly victims of abuse |

| MSM AND TG MILESTONE INITIATIVES | | | | | |
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| **YEAR** | **ACTIVITY/ INTERVENTION** | **IMPLEMENTORS** | **DONORS** | **SOURCE** | **REMARKS** |
| **2011** | NGO to NGO Mentoring Program | PHANSUP | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | • Recipients were: Cebu Youth Center, IwagDabaw (Davao and General Santos City), Neighbors (Zamboanga), Human Development and Empowerment Services (HDES) (Zamboanga)<br>• Mentoring includes planning, program implementation, outreach and peer education<br>• IwagDabaw trained Cebu Youth Zone on how to outreach and engage with MSM<br>• Neighbors and HDES, both community based organizations in Zamboanga, exchange mentoring program<br>• As an output of this mentoring program, IwagDabaw was able to produce a training module for planning and implementing programs for MSM |
| | Local Referral Mechanism | • Higala (Davao)<br>• IwagDabaw (Davao)<br>• Kaugmaon (Davaon) | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | Davao active referral support system: Higala Foundation, a youth NGO, overseas who handles, HIV programs in schools while Kaugmaon serves out of school youth. Both organizations referred young *bayots* to IwagDabaw.<br><br>Kaugmaon accomodates and rescues street children and OSY were mostly taken as service boys |
| | Learning Group Session in a parlor on HIV and AIDS with IEC materials and condoms distribution and referral to SHC | • PHANSUP<br>• Ms. Carmi Martin (not real name) | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | In Cebu, Ms. Martin, owner of a parlor tapped during outreach, offered her parlor as venue for peer education. This also provided a space to refer cases to Social Hygiene Clinic |
| | Male Involvement Seminar | • SHED (project holder)<br>• IwagDabaw (General Santos City branch collaborated)<br>• Dr. Dela Merced (Organizer of Ginoong Pilipinas)<br>• Benson Ang (Organizer of Ginoong Pilipinas) | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | Middle class MSM were targeted<br><br>Applicants were required to attend HIV 101 as part of their audition<br><br>Ginoong Pilipinas tied up with SHED for the Ginoong Gen San |
| | HIV 101 and Peer education among malls and canneries applicants and employees | • Mall HR Department<br>• Canneries HR Department<br>• GenSan LGU AIDS Coodinator | PHANSUP | KII Matrix-National Response (Ruthy Libatique) | In General Santos City, applicants of establishments were required to have an HIV 101 orientation as part of their recruitment process |

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