# Situational Analysis on the National Workplace Response on HIV and AIDS

*A Study commissioned by the International Labour Organization*
*In partnership with the Occupational Safety and Health Center of the Department of Labor and Employment and the Inter-Agency Coalition on HIV and AIDS*

*" ...However much the current pace of the HIV response has produced good outcomes, we still need to use this brief five years window to accelerate our response, make the right decisions and the right investments if we are to end AIDS as a public health threat by 2030."*

Guy Ryder
Director-General
International Labour Office

# EXECUTIVE SUMMARY

Globally, new HIV infections have declined by 35% between 2000 and 2014, more people know their HIV status, and more People Living with HIV (PLHIV) are receiving Highly Active Antiretroviral Therapy (HAART). This global decline in the HIV epidemic has inspired a more ambitious scale up strategy within the next six years, the 'window period', as many are putting it, when HIV and AIDS can be averted. The UNAIDS 2016-2021 Strategy articulates these approaches and, combined, these new strategies and targets are projected to result to the aversion of 28 million HIV infections and 21 million AIDS related deaths by 2030.

In Asia and the Pacific, new HIV infections have likewise declined by 31% between 2000 and 2014, although AIDS related deaths have increased by 11%.

The Philippines' performance in coping with the epidemic has been quite dismal, with HIV infections having risen steeply by 48 times between 2000 and 2014, with 74% of all infections registered since 1984 having been recorded only in the past five years (January 2011 to October 2015). Based on a UNAIDS study[1], some Php16.76 billion are required between 2016 and 2021 to scale up the national HIV and AIDS response. In reality, the response can expect much less funding.

The future projections are equally gloomy with more than 300,000 PLHIVs by 2030 and treatment costs reaching as much as Php4 billion yearly. The only way Philippines can cope with the HIV epidemic is by spending Php2.3 billion in average annual investments between 2015 and 2022, and by ensuring that the bulk of this funding goes to programs that increase the prevention, treatment, care and support services for key affected populations (KAP) — men who have sex with men (MSM), Freelance Sex Workers (FSW), and People Who Inject Drugs (PWID).

These recommendations have been reverberating for years in the Philippines HIV movement, and though the call to action was heeded to, the required actions are not quite easy to adopt on the ground. For one, reaching the KAPs have been challenging enough for the national response. Second, there are also difficulties faced in capturing them and making them part of a more holistic, more targeted HIV program.

**The role of the workplace in the national response to HIV**

With the most productive ages of 15 to 34 years old, the peak of productivity, bearing the brunt of new HIV infections and the health, economic and social impact that follow, there is most definitely a role for the workplace to continue taking on a significant role and stepping up workplace interventions to make greater contributions to the national HIV and AIDS response.

The advantages of staging HIV interventions where people work include the following:

- The workplace offers a steady, captive audience that can be easily mobilized and reached by HIV and AIDS interventions.

- A Tripartite mechanism has been in place for years. This structure may be tapped at both the national and local levels to roll out HIV interventions in key sectors and geographies to reach the most vulnerable workers, including young workers and migrant workers.

- Workplace-based interventions have been started, with some of the currently most active programs being driven by non-traditional workplace actors, which include corporate foundations, non-government organizations, and PLHIV groups.

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[1] "Investment Options for Ending AIDS in the Philippines by 2022: Modelling different HIV Investment Scenarios in the Philippines from 2015 to 2030". UNAIDS. Manila: 2015 Accessed on: 11 Dec 15 File Path: http://www.unaids.org.ph/apanel/uploads/2015%20Investment%20Options%20Paper%20LAYOUT.pdf

These advantages offered by the workplace must be viewed in light of the limitations inherent in this captive setting, among which are:

- That the labor sector is beset by a broad spectrum of issues and concerns that span from wage rates, provision of statutory benefits and legal issues around employment arrangements, to occupational safety and health issues where HIV and AIDS is only one of many subjects of concern;

- That workplace actors have to deal with these broad spectrum of issues too; and,

- That most workplace actors do not have a steady representation nor do they regularly participate in HIV and AIDS related fora to keep themselves abreast with HIV news and sustain the organizational momentum to spearhead interventions in their respective workplaces and organizational networks.

**The current state of the workplace response**

For the reporting period covering January to December 2015, 77.5% of all establishments surveyed were found to have set up workplace policies and programs on HIV and AIDS. Some 44,524 establishments were sampled, representing an estimated 4.7% of the total number of establishments (N=945,000) based on 2013 figures[2].

Based on the report submitted by the Department of Labor and Employment (DOLE) — Occupational Safety and Health Center (OSHC) to the Philippine National AIDS Council (PNAC), covering the period January to October 2015, the workplace response accomplished the following:

- HIV and AIDS in the workplace learning sessions were facilitated, where 135 employers and workers, representing 64 companies, participated.

- The highest training participation rates were registered for the Basic Occupational Safety and Health (BOSH), and Construction Safety Trainings which, together, covered 7,971 participants representing 4,749 companies. Basic information about HIV and AIDS are mainstreamed in both training modules.

- OSH appreciation courses ranked third in yielding the most number of participants (n=2,665) and the most number of companies covered (n=146). This course is offered to companies, students, the informal sector, and business process outsourcing companies (as part of the partnership forged between DOLE and the IT and Business Process Association Philippines).

- The e-BOSH has a modest reach in terms of the number of participants but, was still able to reach out to 115 companies via the OSHC online e-learning platform.

In as far as DOLE's OSHC programs are concerned, this report shows that the most effective channels to disseminate information on HIV and AIDS to the broadest number of participants is through courses where this subject is mainstreamed, particularly through the BOSH, e-BOSH and Construction Safety Trainings, and OSH Appreciation Orientations.

The OSHC website likewise provides a medium by which HIV and AIDS information may be shared and disseminated to the workplace actors, and even to the public per se. However, some of the information may have to be either provided by the Department of Health (DOH) and PNAC on a periodic basis or, visitors will have to be redirected to the DOH and PNAC websites for specific information, such as directories of testing centers and treatment hubs.

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[2] "Summary Report on Compliance in guidelines for the implementation of HIV and AIDS prevention and control in the workplace program" (Generated through LLCS-MIS for the period, 1 Jan 2015 to 31 Dec 2015.

While the reported accomplishments of DOLE represents the bulk of reach in the workplace response, it does not provide an avenue for capturing the accomplishments of the traditional and non-traditional workplace actors in reaching more workers and employers with information on HIV and AIDS.

**Policy and programmatic gaps in the workplace response**

The policies most relevant to the workplace were reviewed. These include:

1. RA 8504 (Philippine AIDS Prevention and Control Act of 1998)
2. PNAC Resolution No. 1 (Rules and Regulations Implementing the Philippine AIDS Prevention and Control Act of 1998, RA 8504)
3. DOLE D.O. 102-10 (Guidelines for the Implementation of HIV and AIDS Prevention and Control in the Workplace Program)
4. DOLE D.O. 56-03 (Rationalizing the Implementation of Family Welfare Program in DOLE)

The gaps were identified and the recommendations were formulated using as a yardstick, the following:

1. ILO Recommendation, 2010 (No. 200), an international labor standard that provides a concrete global policy on treating HIV and AIDS as a workplace concern, and not merely a health problem. More importantly, R. 200 sets the policy tone for the workplace, particularly in defining the workers' rights, as well as the roles and responsibilities of workers and employers in the HIV response.

2. ILO Code of Practice on HIV and AIDS, the forerunner of ILO R. 200, this document clearly outlines the standards, policies and policy elements essential for an effective workplace response on HIV and AIDS.

Based on the policy review conducted, the current local HIV policy context for HIV is highly supportive and reflective of global standards for workplace response. However, the issuance of a departmental level policy instrument is called for to update and provide further, more detailed guidelines as to the scope of workplace policies on HIV and the corresponding breadth of workplace programs on HIV.

The most practical policy instrument that may be issued is a Department Advisory that may emanate from either the Occupational Safety and Health Center (OSHC) or the Bureau of Working Conditions (BWC). This proposed policy will suffice to clarify vague provisions of DOLE Department Order 102-10, and provide workers and employers with practical information on how HIV policies and programs may be set up at the workplace as well.

Among the specific recommendations that should be considered in writing this policy is in integrating HIV in a broader workplace health promotion program, which even the ILO has strongly recommended in its Code of Practice on HIV and AIDS.

While there are gaps in the national policy, most higher level concerns — such as provisions on non-discrimination in employment based on HIV status, confidentiality, instituting a stigma-free environment, and making available information on HIV and AIDS in the workplace — have been thoroughly covered by existing policies.

However, bringing into context, Republic Act No. 7160 (Local Government Code) of 1991, the regulatory gaps become more evident. With the passage of the Local Government Code, the National Government Agencies (NGA) have taken a more developmental and recommendatory approach; the regulatory function has shifted to the Local Government Units (LGU). Department of Interior and Local Government (DILG) Memorandum Circulars 99-233 (HIV and AIDS Education in

Communities and Related Concerns), and 2013-29 (Strengthening Local Responses Toward More Effective and Sustained Responses to HIV and AIDS) in no way requires but rather “enjoins” LGUs to adopt the recommendations contained therein.

The ensuing devolution makes it inevitable for the DOLE, workers and employers to work more closely with the LGUs to ensure that local policies thoroughly capture national policies so as to effectively regulate workplace-based responses to HIV and AIDS. The DOLE, however, is normally not represented in Local AIDS Councils and, as a result, local policies hardly incorporate provisions pertaining to issues and concerns of workplaces in connection with HIV and AIDS nor are these reflective of DOLE DO 102-10.

On a more programmatic level, the DOLE, through the OSHC, has made HIV and AIDS education for workers and employers a steady offering in a number of training programs regularly conducted by the Center, both as a stand alone module or, as part of more holistic occupational safety and health programs. Besides training, the DOLE is also in a prime position to offer care and support services for PLHIVs, through its various bureaus and agencies offering alternative livelihood programs, oversight for statutory coverage including access to PhilHealth benefits, and redress through labor arbitration.

Workers, employers, and non-traditional workplace actors including PLHIV groups, corporate foundations and other non-government organizations also have workplace programs on HIV and AIDS. These include HIV orientations, peer education, traning of trainers, and onsite HIV counselling and testing. However, programs are often not regularly offered and are hardly sustained. Even with currently active programs, there are no evident sustainability mechanisms in place that neither ensures a scale up nor longer-term implementation.

Further complicating the workplace HIV response is the fact that workplace actors are faced with a multitude of issues and concerns that have to be dealt with on an equal footing or even requiring greater and more immediate attention than what is called for by the workplace response to HIV and AIDS. In general, employers and workers are severely resource challenged in dealing with HIV and AIDS at the workplace level — the resources to fund HIV intervention functions on a regular, sustained basis is either limited or not at all available; although employers and workers are mandated by the law to take on several roles and responsibilites in implementing HIV and AIDS in the workplace policies and programs, these are, in reality, overshadowed by other more pressing or perceived to be more pressing concerns than the issues surrounding HIV and AIDS. In the end, the workplace response is unnecessarily sidelined and delayed.

LGU-level interventions are more promising and have better potential for both scale up and promoting a more sustained workplace response. Given the stronger regulatory capacity of LGUs, particurly in relation to the issuance of business permits and licenses to operate, and even the issuance of sanitary certificates for people employed in certain professions and specific types of entertainment establishments, the workplace response is already being supported and promoted by LGUs, albeit unknowingly and unintentionally in most cases. This potential can be furthered and realized with the greater involvement of DOLE and other workplace actors, both traditional and non-traditional, in workplace policy-making and program implementation activities led by the LGUs.

**Recommendations**

The workplace continues to be a vital component of the national HIV and AIDS response. With at least 39 million people employed, half of whom work in the Services Sector, it is only prudent that this leg of the response is given more attention and revitalized.

This study recommends the following actions to better coordinate, and improve the sustainability and impact of the workplace response:

1. Set the right tone. Policy remediation is inevitable given the current local HIV situation, changing context of the workplace response, and the renewed perception of the importance of linking back the workplace response to the community, particularly in tapping on the strengths and resources available at the level of the LGUs which can be accessed from both national and local health delivery systems.

   A Departmental Advisory will have to be issued by the DOLE to define further and clarify the practical implications and requirements of DOLE DO 102-10.

2. Strengthen existing mechanisms to better orchestrate the workplace response to HIV and AIDS. The DOLE has to drive the workplace response more aggressively, in consultation with the Inter-Agency Committee (IAC) on HIV and AIDS and in close coordination with the DOH.

   Although the DOLE and the IAC have collaboratively been pushing the national workplace response, better coordination of resources towards achieving very specific targets are called for to cause a significant positive impact in the workplace response, whether geographically or in specific sectors, particularly where the most vulnerable workers, including migrant and young workers, are employed. The new national workplace response strategy must emphasize how it links back workplace-based HIV interventions to other national and community responses, particularly on tapping the health systems delivery mechanisms already in place, and the support systems already instituted to cater to the special needs of KAPs and PLHIVs.

3. Learn from experiences and focus on achieving impact. The tripartite partners have conducted many HIV interventions in the past which have shown that trainings conducted for workers and employers to facilitate workplace-based HIV education programs, most especially on peer education and trainers' training, can be time consuming, costly and unsustainable, partly due to the unavailability of resources to sustain such interventions, but also due to staff turnover.

   The DOLE may have to look into engaging tripartite partners to focus more on networking with employers and workers rather than implementing workplace programs on their own all the time. While the tripartite partners, workers and employers more specifically, can make significant contributions in education and information dissemination with affiliate employers and workers, more of these activities will have to be referred to organizations that have the dedicated staff and regular resources to run and sustain such workplace-based interventions, including PLHIV groups, volunteer organizations and LGUs.

   The DOLE, through the OSHC, is uniquely positioned in reaching more employers with HIV education and information dissemination activities. OSHC, through its regular and specialized program offerings, including its sectoral partnerships, has the capability to reach a significant mass of employers directly and an even larger volume of workers indirectly. It should continue and strengthen its HIV module offerings, whether these are stand alone or integrated with other OSH concerns. More importantly, referral mechanisms will have to be put in place to touch on the non-educational services called for by an effective national response on HIV, particularly those involving testing, treatment, and care and support.

   Accredited OSH service providers may also be tapped to help scale up the response.

4. Strategize to win the war against HIV and AIDS. Only 1% of workers are employed by medium and large scale enterprises (employing 100 and up employees) while 99% are employed by micro and small establishments (employing 1 to 99 employees). Services Sector employ 71.6% of workers; Manufacturing, which is not under the Services Sector, is the second largest employer. A large majority of HIV infections are being recorded in the National Capital Region, followed by Regions 4A, 3, 7, 6 and 11, including major cities nationwide. All of these information are important in determining the course of the workplace response — which sectors and geographies to prioritize.

The workplace response has to focus on two primary objectives:

Objective 1: To conduct general population HIV and AIDS intervention strategies in key sectors / industries / geographies, taking advantage of the workplace's captive population in capturing KAPs for further, more targeted interventions to be made. The approaches will have to be adjusted based on the demographics and preferences of targeted audience, that is face-to-face interventions will work for some, while online information will work more effectively for others.

Objective 2: To promote the creation of stigma-free workplace environments, and uphold the employment-related rights of workers infected and affected by HIV and AIDS.

The strategy should centralize and standardize the response but, it should simultaneously simplify rather than complicate how the workplace HIV interventions are conducted and coordinated whether through the DOLE or the IAC.

5. Set the record straight. By far, the achievements of the workplace response are unconsolidated and incomparable across review periods. Certain measurement standards, including indicators and tools, will have to be set, and all workplace actors implementing any form of HIV intervention must be required to measure and submit the same to the DOLE. It is important to capture experiences so that implementers can discern which interventions are making the most impact with the least amount of resources.

6. Keep building strategic partnerships. Forge stronger partnerships with the DOH and LGUs to better set the targets and strategies for the workplace response. The tripartite partners and the non-traditional workplace actors alike must work with key LGUs to ensure that the provisions of DOLE DO 102-10, and the planned Advisory issuance, are duly reflected in local ordinances or similar LGU policy instruments.

   With the quick wins gained from previous and existing partnerships forged by DOLE with key sectors, the DOLE and the IAC may have to look more closely into the benefits of forging similar partnerships to fast-track the achievement of impacts in the workplace response to HIV and AIDS. Partnerships with key industry and professional associations, chambers of commerce and industry in key locations, and Philippine Economic Zone Authority (PEZA), particularly where key affected populations may be reached more easily in a workplace setting, may have to be explored further.

# INTRODUCTION

HIV and AIDS should be everybody's responsibility — and, by everybody, it includes employers and workers alike. It has been stressed countless number of times and for so long how the workplace can provide opportunities in contributing significantly to any country's response to HIV and AIDS.

A standardized, stronger and more unified workplace response can certainly help change an impending crisis in the Philippines where HIV infections are rising exponentially and are not expected to show any signs of slowing down any time soon. This is an opportune time for both traditional and non-traditional workplace actors to look more closely at the potentials of the workplace that are waiting to be seized in favor of the HIV response. However, real and practical solutions need to be determined while the barriers — policies and programs alike — will have to be overcome with full force so as to eliminate the factors that are hindering scale and impact to result from the workplace response.

## Background

The workplace is vast, and the workplace response to HIV, varied.

This Study was conducted to:

1. Document experiences of workplace actors — DOLE, workers, employers and non-traditional workplace actors.
2. Identify gaps in workplace HIV and AIDS policies and programs.
3. Recommend possible policy and programmatic actions for consideration of the Department of Labor and Employment (DOLE), as the agency mandated to head the workplace response to HIV and AIDS.

## Scope and Limitations

This study will only cover the effect and implications of relevant HIV and AIDS policies on private sector workplaces operating locally in the Philippines. This review then excludes workplace actors in Government, the Armed Forces of the Philippines, and the Philippine National Police.

This review also deliberately excludes the implications of HIV and AIDS policies and programs on Overseas Filipino Workers which, although also under the purview of the DOLE, is affected differently, slightly, or not at all by the policies and programs that are subject for review in this study.

The analysis framework for this study involves both local and global policies and programs on HIV and AIDS. All of which are understood in light of the current HIV and AIDS situation in the Philippines.

**Research and Analysis Framework**

The policies most relevant to the workplace were reviewed. These include:

1. RA 8504 (Philippine AIDS Prevention and Control Act of 1998)
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The gaps were identified and the recommendations were formulated using as a yardstick, the following:

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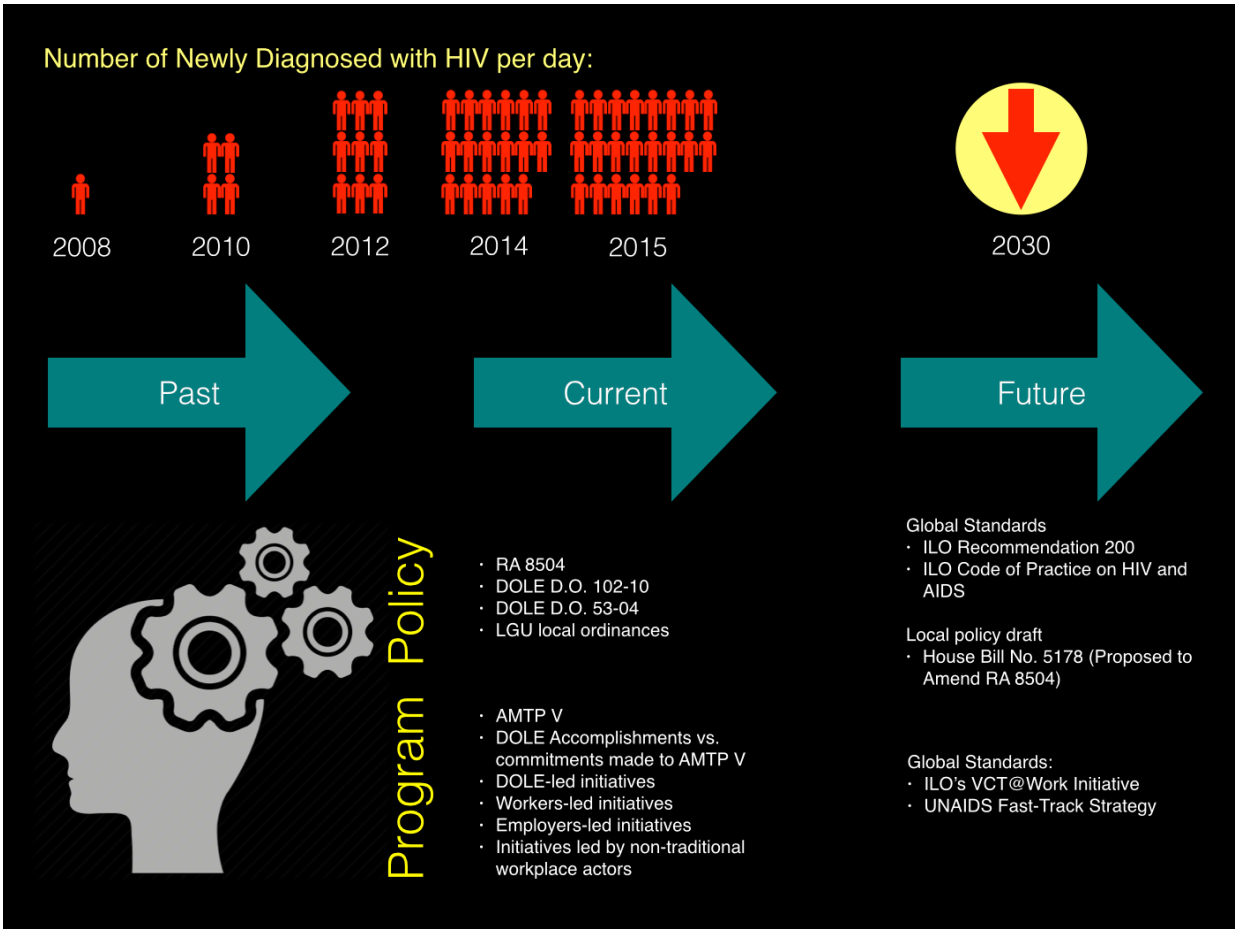
2. ILO Code of Practice on HIV and AIDS, the forerunner of ILO R. 200, this document clearly outlines the standards, policies and policy elements essential for an effective workplace response on HIV and AIDS.

In analyzing programmatic gaps and recommending actions to enhance implementation of workplace programs, this paper took the following into consideration:

1. Review of DOLE reports to PNAC on its commitments and accomplishments relative to the workplace response
2. Case studies of workplace programs on HIV and AIDS that were led by DOLE, workers, employers, organizations of PLHIVs, and three LGUs (i.e., cities heavily burdened by the growing HIV and AIDS epidemic)
3. ILO's VCT@Work Initiative
4. UNAIDS 2016-2021 Strategy (Fast-Track Strategy)

To summarize, the research and analysis framework for this study is illustrated below:




**The Research and Analysis Framework for this study.** Future policies and programs must be informed by the experiences of policymakers and program implementers. The "fast and furious" state of HIV and AIDS infection must be taken into consideration in drawing up future strategies, plans and programs.

**Study Approach and Methodology**

This Study was conducted over a three-week period.

Given the limited time available, only informants based in the National Capital Region have been considered and involved in this study. Nevertheless, the insights and opinions of informants from Cebu City and Davao City, as per consultations conducted by the ILO and DOLE in 2012 involving some of the topics of this study then for a planned Joint ILO-WHO Programme on Workplace Health Promotion, were revisited and used as references in formulating the recommendations in this study.

This Study utilized qualitative research techniques, as follows:

1. Desk review. The desk review covered:

    1.1. All information available to establish the current state of HIV and AIDS in the Philippines and the extent by which the workplace actors are affected and how the workplace response is coping.

    1.2. Policy and program review. The national policies and programs on HIV and AIDS were taken as the base documents to determine how extensively these are translated into workplace policies and programs on HIV and AIDS. These have been organized into policy and program matrices that summarize the similarities and differences across these policies.

    In the narrative of the policy and program implementation reviews, the gaps are identified. To identify the gaps, global standards and workplace program implementation experiences, and recent publicly reviewed policy drafts were taken and contrasted with the current policies and programs.

    1.2.1. The primary policies covered include: RA 8504, PNAC Resolution No. 1 (IRR of RA 8504), DOLE D.O. 102-10, and DOLE D.O. 56-03. The gaps and potential opportunities were identified using as reference documents: ILO Recommendation, 2010 (No. 200), ILO Code of Practice on HIV and AIDS and the World of Work), and draft DOLE Department Order reconstituting the IAC composition.

    1.2.2. The primary program documents reviewed include: AIDS Medium-Term Plan (AMTP) V, DOLE accomplishment reports vís-a-vís commitments to AMTP V.

2. Case Studies. The gaps and potential opportunities were identified by drawing up case studies on workplace responses to HIV and AIDS that are Government-led (1), Employer-led (1), worker-led (1), corporate foundation led (1), and led by a PLHIV group (1).

3. Focused Group Discussions. Two (2) FGDs were arranged to gather information and ideas from key discussants on the following:
    3.1. Experiences of traditional and non-traditional workplace actors in advocating for enterprise level policy on HIV and AIDS;
    3.2. Practical experiences from conducting HIV programs in the workplace;
    3.3. Insights and good practices; and,
    3.4. Recommendations on integrating the workplace response better with those being led by the PNAC, DOH, DILG and key LGUs.

4. Focused Interviews. To obtain more in-depth information towards fulfilling the objectives of this Study, focus interviews were arranged with the following key informants:

| Key Informant | Nature of information (to be) obtained | Completed / Not |
|---|---|---|
| **Anna dela Torre<br>Corporate Affairs Manager<br>Standard Chartered Bank** | For case study. | Completed. |
| **Julius Elopre<br>HIV Program Coordinator<br>Pilipinas Shell Foundation, Inc.** | For case study. | Completed. |
| **Dang Buenaventura-Snyder<br>Corporate Social Responsibility Manager<br>Employers' Confederation of the Philippines** | For case study. | No response. |
| **Mr. Alan Tanjusay<br>Policy Advocacy Officer<br>Associated Labor Unions** | For case study. | Completed. |
| **Mr. Alex Rutagines<br>Jollibee Workers Union** | For case study. | Responded but no information was provided. |
| **Rommel Legwes<br>President<br>Pinoy Plus Association, Inc.** | For case study. | Completed. |
| **Atty. Alvin Curada<br>OIC<br>Bureau of Working Conditions** | HIV and labor inspection; previous partnerships with LGUs | Completed.<br>FI conducted with BWC focal point for HIV, Dr. Marco Antonio Valeros |
| **Dr. Gerard Belimac<br>Program Manager<br>Department of Health—National AIDS/ STD Prevention and Control Program** | Past and prospective contributions of the workplace response to the national response; Insights on gaps of and future directions for the workplace response | Completed. |
| **Dr. Jojo Feliciano<br>OIC<br>Philippine National AIDS Council** | Past and prospective contributions of the workplace response to the national response; Insights on gaps of and future directions for the workplace response | Completed. |
| **Mr. Silvestre Barrameda<br>Unit Head<br>Local Government Academy** | Possible links of workplace response with DILG and the LGUs | Completed. |
| **Dr. Rolly Cruz, Epidemiologist, Quezon City Health Department** | LGU experiences in reaching workplaces; good practices in reaching populations most at risk; possible collaborations between workplace response and LGU / community response | Completed. |
| **Dr. Cesar Encinares,<br>Head<br>Pasay City Health Department** | LGU experiences in reaching workplaces; good practices in reaching populations most at risk; possible collaborations between workplace response and LGU / community response | Completed.<br>FI conducted with Pasay City Health Department HIV Coordinator, Dr. Nan Ranieses |
| **Dr. Bernard Sese<br>OIC<br>Makati City Health Department** | LGU experiences in reaching workplaces; good practices in reaching populations most at risk; possible collaborations between workplace response and LGU / community response | Completed.<br>FI conducted with Makati City Health Department HIV Coordinator, Nurse Tess Pagcaliwagan |

# HIV AND THE WORKPLACE

**Living positively in a world with HIV and AIDS**

Since the 1980s when HIV began to spread globally, there has been a steady rise in the number of new HIV infections worldwide. By the late 1990s, new infections started to decline although, for some regions and specific countries, including the Philippines, the spread of HIV has only just begun.

*Current impact of the global response*


*Reference: UNAIDS, 2014*

The UNAIDS estimates that there were 2 million people newly infected with HIV in 2014, as against 3.4 million new cases in 2001. There has been a 35% decrease in new HIV infections since 2000.

Some 36.9 million people were living with HIV by the end of 2014. Less than half (15.8 million) were on treatment.

AIDS-related deaths declined by 42% since 2004, when the most ever number of people who died of AIDS was recorded.

An estimated 17.1 million people living with HIV are not aware that they are infected.

**HIV and AIDS in Asia and the Pacific, 2014**

- 5 million [4.5 million–5.6 million] people living with HIV
- an estimated 340 000 [240 000–480 000] new HIV infections
- New HIV infections declined by 31% between 2000 and 2014
- Between 2000 and 2014 the number of AIDS-related deaths in the region increased by 11%

*Reference: "Fact Sheet 2015" UNAIDS. Accessed on: 11 Dec 15 File Path: http://www.unaids.org/sites/default/files/media_asset/20150901_FactSheet_2015_en.pdf*

*Future strategies and targets*

The UNAIDS has set the tone for the global targets for the next five years with the launch of the UNAIDS 2016-2021 Strategy, also known as the UNAIDS Fast-Track Strategy. This new strategy recommends a rapid scale up of the global response to outpace the epidemic. Among the positive outcomes the world stands to derive from implementing this strategy include: (1) 28 million HIV infections averted by 2030, and (2) 21 million AIDS-related deaths averted by 2030.

UNAIDS Targets 1, 3, 4, 6, 8 and 10 are all specifically important considerations in romping up the workplace response.

**Workplace Relevant UNAIDS Fast-Track Strategy Targets**

*Target 1:* 90% of PLHIV know their status; 90% of whom are receiving treatment; 90% of PLHIVs receiving ART have suppressed viral loads.

*Target 3:* 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV.

*Target 4:* 90% of women and men especially young people and those in high prevalence settings, have access to HIV combination prevention and sexual and reproductive health services.

*Target 6:* 90% of key populations, including MSM, PWID, TG people and prisoners, as well as migrants, have access to HIV combination prevention services.

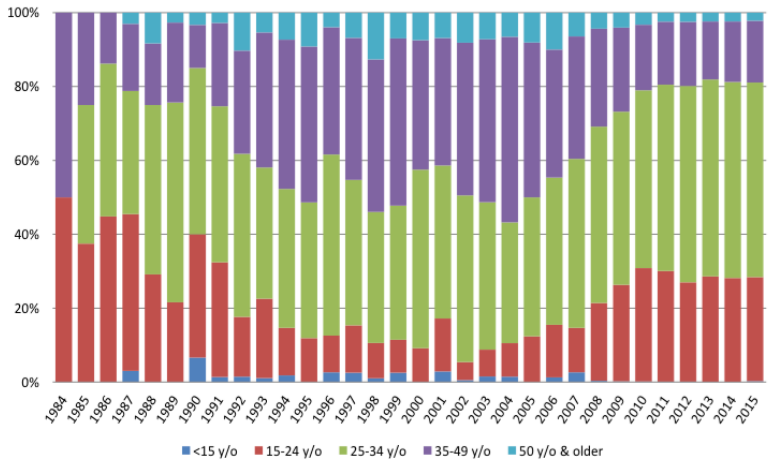
*Target 8:* 90% of PLHIV at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings.

*Target 10:* 75% of people living with, at risk of, and affected by HIV, who are in need, benefit from HIV-sensitive social protection.

## HIV and its impact on Filipino workers

In 2015, there are at least 22 new cases being recorded in the Philippines AIDS Registry everyday, compared to only one case every three days in 2000. While the entire Asia Pacific Region experienced a 31% decline in new HIV infections between 2000 and 2014, the number of new cases in the Philippines multiplied by 48 times during the same period.

**Distribution of PLHIV by Age Group, Jan 1984-October 2015**

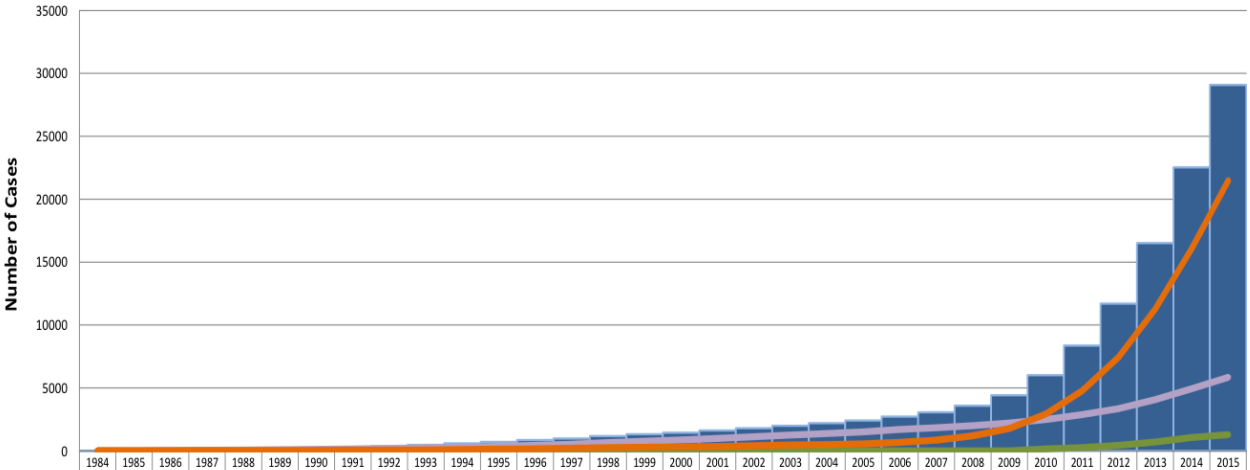



Since 1984 until October 2015, a total of 29,079 Filipinos have contracted HIV[3] — 21,649 (74%) of which were recorded only in the past five years (2011-October 2015).

Half of all who were infected were diagnosed with HIV between 25 and 34 years of age; while 7,722 (27%) were within the 15-24 age range. The median age for people infected is 28 years old. HIV is infecting Filipinos at the prime ages of 15 to 34 when productivity is at its peak.

Sexual transmission is the primary cause of infection for 94% of all cases ever recorded. For men who were infected, there are two primary modes of sexual transmission — male to male sex (52%) and sex with both males and females (33%).

**Cumulative Number of HIV Transmission by Year, January 1984-October 2015 (N = 29,079)**

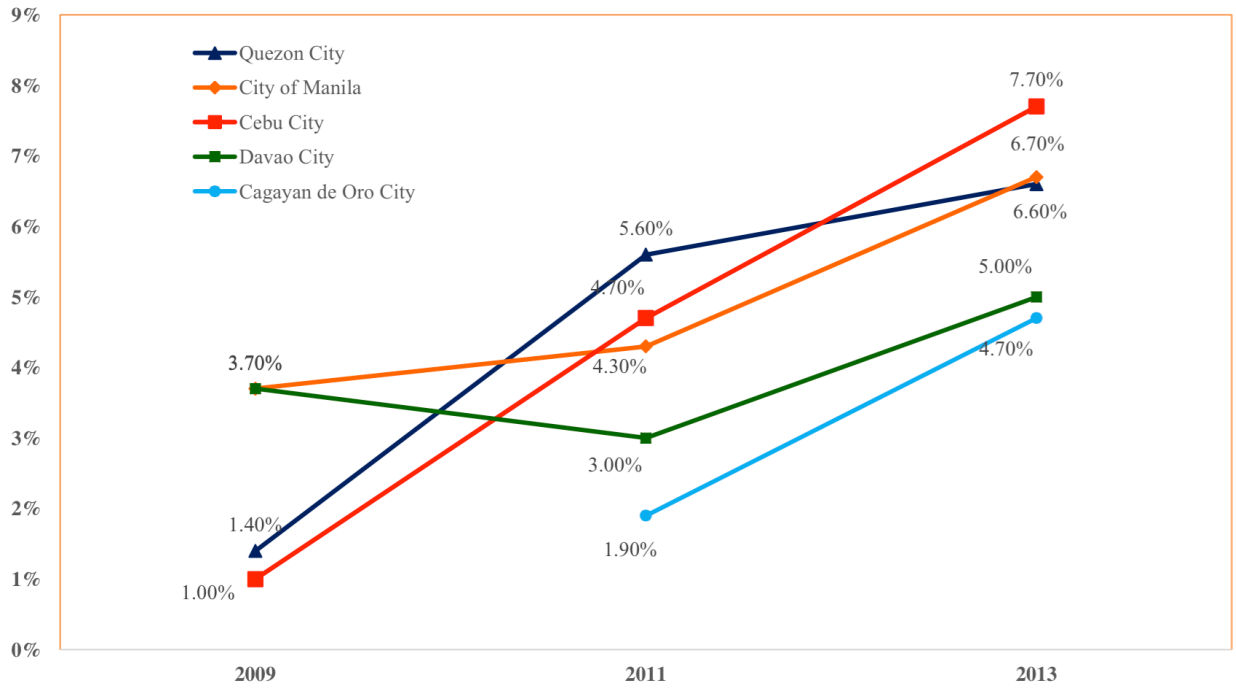



| | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of PLHIV | 2 | 12 | 41 | 79 | 111 | 150 | 216 | 301 | 373 | 475 | 593 | 709 | 863 | 980 | 1,169 | 1,327 | 1,450 | 1,624 | 1,808 | 2,001 | 2,200 | 2,410 | 2,719 | 3,061 | 3,589 | 4,424 | 6,015 | 8,364 | 11,702 | 16,516 | 22,527 | 29,079 |
| Male-Female Sex | 1 | 8 | 32 | 56 | 72 | 91 | 126 | 156 | 197 | 244 | 302 | 358 | 439 | 521 | 659 | 773 | 866 | 994 | 1123 | 1252 | 1375 | 1506 | 1699 | 1838 | 1,998 | 2,214 | 2,488 | 2,876 | 3,356 | 4,074 | 4,934 | 5,844 |
| IVDU | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 2 | 2 | 2 | 3 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 7 | 7 | 7 | 8 | 8 | 155 | 265 | 440 | 711 | 1,068 | 1,289 |
| MSM | 0 | 3 | 7 | 14 | 20 | 28 | 40 | 59 | 69 | 87 | 110 | 139 | 176 | 208 | 253 | 293 | 318 | 355 | 409 | 463 | 502 | 563 | 670 | 851 | 1,193 | 1,781 | 2,928 | 4,770 | 7,449 | 11,271 | 16,060 | 21,466 |

[3] HIV/AIDS and ART Registry of the Philippines. October 2015. Department of Health-Epidemiology Bureau.

Based on the IHBSS 2005-2013[4] data that appears in a study commissioned by UNAIDS[5], data has been made available on HIV prevalence among MSM focused on six key cities: Quezon City, Manila, Cebu City, Davao City and Cagayan de Oro.

**HIV prevalence among MSM in six key cities, IHBSS, DOH-NEC**




The following 70 cities across the country have been identified to be highly burdened by HIV:

| Category A | Category B | Category C |
|---|---|---|
| 1. Parañaque City<br>2. Muntinlupa City<br>3. Taguig City<br>4. Pasay City<br>5. Makati City<br>6. Mandaluyong City<br>7. Marikina City<br>8. Quezon City<br>9. Caloocan City<br>10. Navotas City<br>11. Las Piñas City<br>12. Manila City<br>13. Pasig City<br>14. San Juan City<br>15. Malabon City<br>16. Valenzuela City<br>17. Paterod<br>18. Angeles City<br>19. Davao City<br>20. Davao City<br>21. Cebu City<br>22. Mandaue City<br>23. Bacoor City, Cavite<br>24. Puerto Princesa City, Palawan<br>25. Zamboanga City<br>26. Cagayan de Oro City<br>27. Baguio City | 1. Danao City<br>2. Antipolo City<br>3. Olongapo City<br>4. Dasmariñas City, Cavite<br>5. Batangas City, Batangas<br>6. Cainta, Rizal<br>7. Imus, Cavite<br>8. Lipa City, Batangas<br>9. Iloilo City<br>10. Bacolod City, Negros Occidental<br>11. Lapu-Lapu City, Cebu<br>12. Talisay, Cebu<br>13. General Santos City<br>14. Butuan City<br>15. San Fernando, Pampanga<br>16. Mabalacat, Pampanga<br>17. San Jose del Monte, Bulacan<br>18. Meycauayan, Bulacan<br>19. Sta. Rosa, Laguna | 1. Dagupan City<br>2. San Fernando, La Union<br>3. Tuguegarao City, Cagayan<br>4. Tarlac City<br>5. Marilao, Bulacan<br>6. Malolos, Bulacan<br>7. Sta. Maria, Bulacan<br>8. San Pedro, Laguna<br>9. San Pablo, Laguna<br>10. Calamba, Laguna<br>11. Cavite City, Cavite<br>12. Lucena City, Quezon<br>13. San Mateo, Rizal<br>14. Taytay, Rizal<br>15. Puerto Galera, Mindoro Oriental<br>16. Legazpi City, Albay<br>17. Naga City, Camarines Sur<br>18. Malay, Aklan<br>19. Toledo, Cebu<br>20. Tagbilaran City, Bohol<br>21. Tacloban City<br>22. Iligan City<br>23. Tagum, Davao del Norte<br>24. Panabo, Davao del Norte<br>25. Cotabato City |

[4] Department of Health - National Epidemiology Bureau

[5] "Investment Options for Ending AIDS in the Philippines by 2022: Modelling different HIV Investment Scenarios in the Philippines from 2015 to 2030". UNAIDS. Manila: 2015 Accessed on: 11 Dec 15 File Path: http://www.unaids.org.ph/apanel/uploads/2015%20Investment%20Options%20Paper%20LAYOUT.pdf

National Capital Region is the most highly burdened area, with 40% of new infections diagnosed here. Following are Regions 4A (17%), 3 (8%), 7 (7%), 6 (6%), and 11 (5%).

These information on the HIV situation, how it is affecting working age people, and where people infected and affected may be reached are all important in setting the targets for the workplace response. Cities and regions recording the most number of cases must be prioritized. These lists help workplace actors identify the key LGU partnerships that will need to be forged to make the most impact in the workplace, and the most significant contributions to the community at large.

Philippines HIV and AIDS policies have long acknowledged the workplace as a strategic entrypoint in reaching populations at most risk of contracting HIV. The Department of Labor and Employment has mandated private enterprises to institutionalize HIV and AIDS policies and programs in their respective workplaces.

In 2013, there were 945,000 establishments operating all over the country[6].

For reference to key findings below, the Philippines classifies establishments into the following sectors:

| | | |
|---|---|---|
| **A - Agriculture, Forestry and Fishing** | **H - Transportation and Storage** | **P - Education Except Public Education** |
| **B - Mining and Quarrying** | **I - Accommodation and Food Service Activities** | **Q - Human Health and Social Work Activities Except Public Health Activities** |
| **C - Manufacturing** | **J - Information and Communication** | **R - Arts, Entertainment and Recreation** |
| **D - Electricity, Gas, Steam and Air Conditioning Supply** | **K - Financial and Insurance Activities** | **S - Repair of Computers and Personal and Household Goods; Other Personal Service Activities** |
| **E - Water Supply, Sewerage, Water Management and Remediation Activities** | **L - Real Estate Activities** | |
| **F - Construction** | **M - Professional, Scientific and Technical Activities** | |
| **G - Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles** | **N - Administrative and Support Service Activities** | |

For more detailed information on the types of companies classified under each of the sectors above, please refer to the Philippine Standard Industry Classification (PSIC).

It will be advantageous for the national workplace response to note some of the conclusions / observations made by the 2012 Updating of the List of Establishments (ULE):

- 82.6% (780,887) of establishments operates under Single Proprietorship.
- 89.4% (844,760) of establishments were micro enterprises (employing 1 to 9 workers); 9.7% (92,025) were small (employing 10 to 99 workers); while medium (employing 100-199 workers) and large (employing 200 workers or more) comprised less than 1% of all establishments.
- Almost half (44.4%; 1,813) of all large establishments were located in the National Capital Region (NCR), followed by Region 4A (CALABARZON) and Region 7 (Central Visayas).
- Majority of the large establishments were engaged in activities that fall under Sectors C, N[7] and S.
- It is estimated that some 71.6% of all workers are employed in the Services Sector (Sectors G-S), and ranked as follows in terms of the number of workers employed: G, N, I, K, P, J, Q, H, M, R, and L.
- The top three sectors employing the most number of workers are Sectors G (1.96M employed), C (1.60M employed) and N (.96M).
- The top three sectors with the highest average employment per establishment included Sectors D, B and N. The table below summarizes the number of workers employed in each sector:

[6] List of establishments, 2012. Philippine Statistics Authority. Date accessed: 15 Dec 15 Web Link: https://psa.gov.ph/content/2012-updating-list-establishments-ule-final-result

[7] Sector N includes call centers (voice) but not necessarily call centers (non-voice) nor the rest of the IT-BPO industry.

- 22.5% (212,408) of all establishments are located in the National Capital Region, each employing 14 people on the average. The following provinces rank highest in hosting establishments:

| Top 10 Provinces Outside NCR with the Most Number of Establishments: 2012 LE (Table adopted from the 2012 LE of the Philippine Statistics Authority) | | | |
|---|---|---|---|
| **Rank** | **Province** | **No. of Establishments** | **% Share to Total Philippines** |
| 1 | Cebu | 45,185 | 4.8% |
| 2 | Cavite | 38,158 | 4.0% |
| 3 | Rizal | 33,641 | 3.6% |
| 4 | Laguna | 32,648 | 3.5% |
| 5 | Bulacan | 31,376 | 3.3% |
| 6 | Davao del Sur | 28,091 | 3.0% |
| 7 | Pangasinan | 26,502 | 2.8% |
| 8 | Pampanga | 25,409 | 2.7% |
| 9 | Batangas | 22,673 | 2.4% |
| 10 | Nueva Ecija | 19,177 | 2.0% |

The Integrated Survey on Labor and Employment (ISLE) 2012 and 2013, which includes OSH practices, with 34,579 establishments sampled or, 3.65% of all establishments.

In 2013, only a quarter (23.3%) of the total number of establishments surveyed and employing 20 or more workers had a workplace policy and program on HIV and AIDS in place. Despite the low compliance rate, this is still a 7% jump from the 2009-2010 levels.

The top 10 sectors exhibiting the highest compliance rates are as follows, and these are shown side-by-side with sector ranking based on the number of workers employed:

| Top 10 Sectors based on Sector HIV workplace policy and program compliance rates, vs Top 10 Sectors based on Number of workers employed per Sector | | |
|---|---|---|
| **Ranking** | **Sectors Ranked Based on HIV Compliance Rates per Sector** | **Sectors Ranked Based on Number of Workers Employed per Sector** |
| 1 | Q | G |
| 2 | F | C |
| 3 | S | N |
| 4 | I | I |
| 5 | N | K |
| 6 | D | P |
| 7 | C | A |
| 8 | H | J |
| 9 | R | S |
| 10 | J | F |

Sector Q exhibited the highest compliance rate (67.7%) but only ranks 11th in terms of the number of workers employed. However, Sector Q, since establishments classified under this sector are involved in social and health services may be perceived to be at higher risk for HIV and AIDS, and are therefore more conscious of compliance to DO 102-10.

Sector G, although employing about a quarter of all workers, only registered 18.7% compliance rate. Sector K, although ranked 5th in terms of number of workers employed, registered the lowest compliance rate (7.2%).

Sectors C, N and I, with about a third of companies from each sector found to be compliant with DO 102-10, ranked 2nd, 3rd and 4th, respectively, in terms of the number of workers employed.

This summary table shows that a good percentage of workers employed in Sectors C, N and I are protected by policies and are receiving programs on HIV at the workplace / enterprise levels. In contrast, only about one-fourth of all workers employed by companies belonging to Sector G are covered by workplace policies and programs.

During the ISLE survey period, 2012 to 2013, an item was included to find out how many companies had policies incorporating a provision on non-discrimination of workers with HIV. Of those who said they had a workplace policy on HIV and AIDS, only 22.6% incorporated a provision on non-discrimination of workers with HIV.

The same report shows that there were also 26.6% of the establishments surveyed who said that their workplace policy on HIV carried a provision on non-mandatory HIV testing. Referring to the same parameter on the 2010-2011 OSH practices survey, only 18% (n=26,337) had such policy.

For the period January to December 2015, 77.5% of all establishments assessed[8] in the Philippines were in compliance with DOLE guidelines for the implementation of HIV and AIDS Prevention and Control in the Workplace Program[9].

By “compliant”, it means that establishments have satisfied the following requirements:

- Policy is written and disseminated to all officials and workers of the establishment
- Policy jointly formulated by management and workers
- Policy covers all officials and workers of the establishment
- Policy ensures that all workers, whether living with or without HIV, are treated in an equal and non-discriminatory manner in hiring, promotion, career development opportunities or in job assignment
- Policy ensures non-termination from work on the basis of actual, perceived or suspected HIV status
- Policy ensures that workers shall not be forced to disclose HIV status to employer
- Policy ensures non-mandatory HIV testing and ensures support for voluntary confedential counseling and testing (VCCT) for HIV
- Policy ensures the confidentiality of medical information
- Policy ensures that reasonable accommodation and arrangement is extended to person/s living with HIV to work as long as medically fit for appropriate work
- Program on prevention and control of HIV and AIDS should include:
  - Information, education and training of all workers on HIV and AIDS
  - Encouragement to workers to undergo non-mandatory HIV testing and ensures support for VCCT for HIV
  - Referral for treatment, care and support

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[8] The total sampled establishments, n=44,524 is equivalent to about 4.7% of the total number of establishments based on 2013 estimates (N=945,000)

[9] “Summary Report on Compliance in guidelines for the implementation of HIV and AIDS prevention and control in the workplace program” (Generated through LLCS-MIS for the period, 1 Jan 2015 to 31 Dec 2015.

- Monitoring and evaluation of policy and program done by the Safety and Health Committee or equivalent structure

The list of the criteria for compliance enumerated above have been provided to and considered by the Labor Law Compliance Officers (LLCO) during onsite inspections.

| Region | Total establishments covered | Compliance Rate (%) |
|---|---|---|
| **Philippines** | 44,524 | 77.50 |
| **NCR** | 10,590 | 67.17 |
| **CAR** | 1,151 | 89.83 |
| **I** | 1,498 | 99.40 |
| **II** | 1,272 | 56.60 |
| **III** | 5,458 | 74.20 |
| **IV-A** | 5,309 | 83.73 |
| **IV-B** | 1,143 | 84.78 |
| **V** | 1,873 | 69.73 |
| **VI** | 1,845 | 99.57 |
| **VII** | 3,964 | 60.62 |
| **VIII** | 993 | 69.99 |
| **IX** | 1,133 | 81.99 |
| **X** | 3,069 | 98.99 |
| **XI** | 2,664 | 90.92 |
| **XII** | 1,339 | 82.60 |
| **CARAGA** | 1,224 | 77.86 |

Available data[10] from 2012-2013 and, when and where available, 2009-2010 are reflected in the table below.

| | Total estab | Sectors | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F | G | H | I | J | K | L | M | N | P | Q | R | S |
| **Total No. of Establishments 2012-2013** | **34,579** | **1,258** | **189** | **6,555** | **422** | **314** | **1,042** | **7,562** | **1,140** | **4,670** | **859** | **1,510** | **498** | **739** | **2,130** | **4,002** | **917** | **248** | **488** |
| **2009-2010** | **23,723** | | | | | | | | | | | | | | | | | | |
| **HIV and AIDS Prevention and Control** *(Policies and Programs)* **2012-2013** | **23.3%** | 8.7 | 14.3 | 24.7 | 28.7 | 13.1 | 33.7 | 18.7 | 23.3 | 29.5 | 21.2 | 7.2 | 17.5 | 16.6 | 29.5 | 19.4 | 67.3 | 21.8 | 31.4 |
| **2009-2010** | **16.0%** | | | | | | | | | | | | | | | | | | |
| **Non-discrimination of workers with HIV** *(Policies and Programs)* **2012-2013** | **22.6%** | 15.8 | 18.5 | 25 | 25.6 | 10.5 | 34 | 19.5 | 26.4 | 27.7 | 19.3 | 12.8 | 24.3 | 28.4 | 24.7 | 12.1 | 48.9 | 37.1 | 27.5 |
| **Non-mandatory HIV testing** *(Policies and Programs)* **2012-2013** | **22.6%** | 15.8 | 18.5 | 25 | 25.6 | 10.5 | 34 | 19.5 | 26.4 | 27.7 | 19.3 | 12.8 | 24.3 | 28.4 | 24.7 | 12.1 | 48.9 | 37.1 | 27.5 |
| **HIV and AIDS Education in the workplace** *(Preventive and control measures implemented)* **2012-2013** | **29.4%** | 20.0 | 21.7 | 26.3 | 50.0 | 14.6 | 47.9 | 24.3 | 25.6 | 36.4 | 29.5 | 12.0 | 17.5 | 15.8 | 34.6 | 33.8 | 70.4 | 19.4 | 28.1 |
| **2009-2010** | **26.9%** | | | | | | | | | | | | | | | | | | |
| **HIV and AIDS Education in the workplace** *(Seminars availed by employees & conducting agency)* **2012-2013** | **19.0%** | 19.0 | 11.1 | 17.4 | 18.4 | 20.7 | 7.7 | 15.6 | 14.2 | 23.7 | 16.9 | 7.5 | 24.2 | 7.0 | 19.8 | 16.7 | 56.3 | 8.3 | 15.4 |
| **2009-2010** | **15.5%** | | | | | | | | | | | | | | | | | | |

HIV 101 is frequently offered by and to companies by different OSH service providers, including the DOLE-OSHC, as part of a larger OSH or health-related trainings. In rare instances, HIV 101 training sessions are offered as stand alone program. Below table reflects that OSH trainings are most often provided by Professional Organizations (such as the Philippine College of Occupational Medicine, and the Organizational Health Nurses Association of the Philippines).

[10] LabStat Updates (CY 2010-2013). Philippine Statistics Authority and the DOLE-Bureau of Labor and Employment Statistics.

| Number and percent of establishments employing 20 or more workers with occupational safety and health-related trainings / seminars availed by employees per conducting agency, 2013 | |
|---|---|
| **Conducting Agency** | **Percentage share in covered workplaces** |
| Total Number of Establishments: 25,857 | 19.0 |
| Occupational Safety and Health Center (DOLE) | 14.3 |
| Professional Organizations | 25.8 |
| DOLE-accredited safety training organizations | 16.9 |
| Employers' Organizations | 23.4 |
| Workers' Groups | 22.8 |
| Academe / University | 14.8 |
| Own Company | 16.7 |
| Others | 11.9 |

For the period 2010-2011, similar available data on OSH training providers only reflect "Workers' Health Trainings (e.g., HIV and AIDS, TB, drugs, etc.)" and thus does not offer a detailed breakdown for HIV and AIDS course offerings only.

For such grouping, only a quarter (24%) of the total number of establishments (N=24,222) provided these types of training to their workers. Of those who provided these, the trainings were facilitated by the DOLE-Regional and Provincial Offices (7.8%), DOLE-OSHC (15.0%), Professional Organizations (10.8%), Safety Training Organizations (4.3%), Employers' Organizations (3.9%), Workers' Organizations (1.0%), and Academe (4%). The companies and other training providers facilitated the most number of such trainings, with 53% and 17.5% share of companies covered, respectively.

**Summary**

There is undoubtedly a wealth of opportunities in reaching key target populations for HIV interventions by bringing the HIV and AIDS advocacy to the workplace—where most people spend majority of their waking hours everyday, and where a mass number of people converge daily.

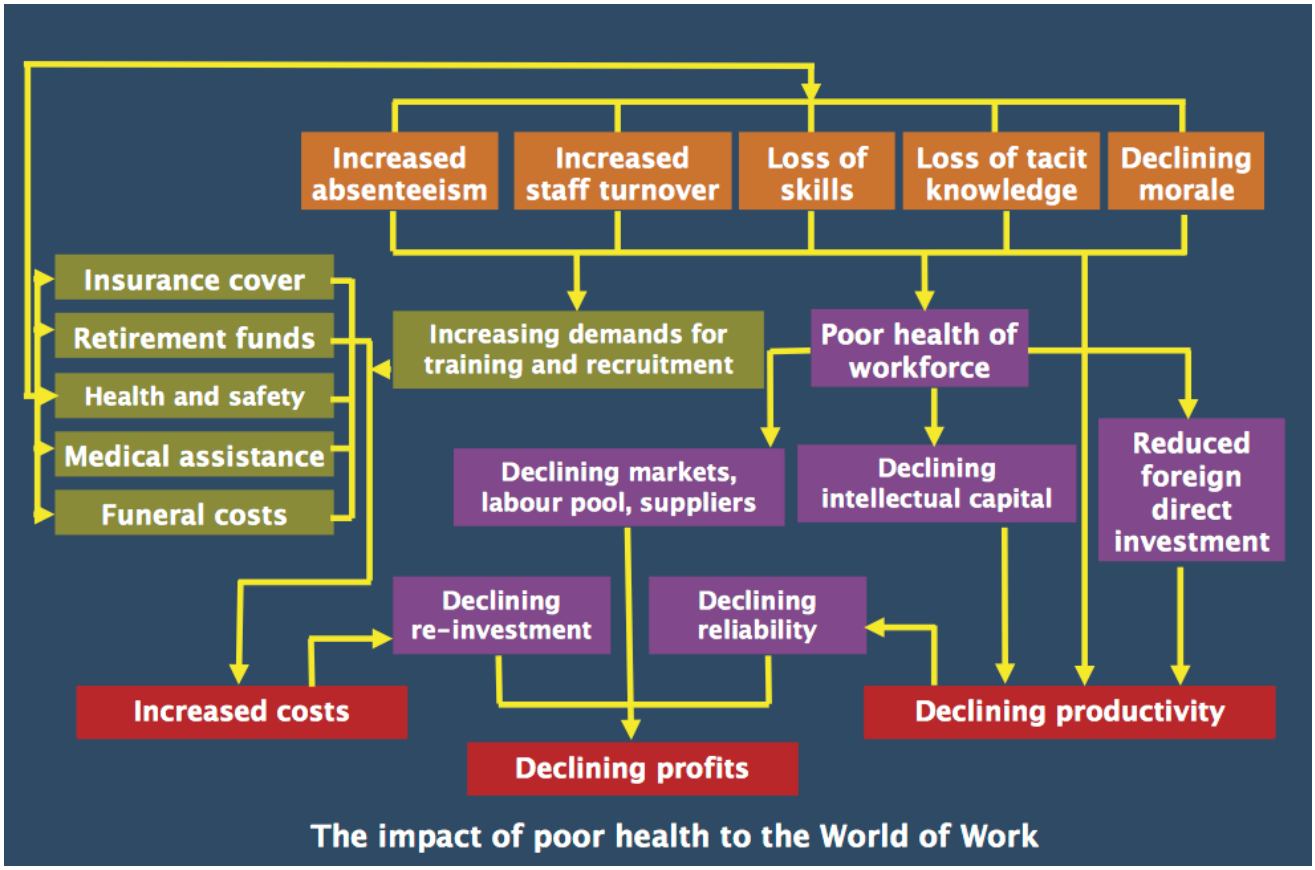
However, the workplace actors are being called to action to step up commensurately with, what has been described as, the "fast and furious" rise of HIV. In parallel, the workplace response must take into consideration where the bulk of workers may be reached, both in terms of the sectoral rankings and geographical location of establishments vìs-a-vìs the DOLE DO 102-10 compliance rates per sector and the geographical locations where most of the new HIV cases are being reported, accordingly.

It must be specially noted that most workplace responses are being targeted at medium and large scale establishments which only employ less than 1% of all workers. Micro and small enterprises, employing 99% of workers, are being left out in the response. Based on the fact that 71.6% of all workers are employed in the Services Sectors (Sectors G to S), the workplace response must reach out to more companies belonging to these sectors. Special attention must also be given to Sector C which is the second largest employer, employing some 1.60 million workers nationwide.

Without a sound strategy for targeting the workers, a strong commitment from the business sector, and a concerted effort from HIV service providers — workers' groups, employers' groups, the

DOLE, and other non-traditional workplace actors, the workplace response will continue to be sparse, not properly accounted for, and efforts will remain unsustainable.

Below is an illustration provided by UNAIDS which summarizes how the World of Work is affected by HIV and AIDS.




With inaction and a weak response to HIV, the World of Work suffers on three levels: individual workers, enterprise level, and the national level. HIV and difficulty of accessing HAART for workers infected result to poor health, less productivity, higher costs, and declining employment and growth opportunities — the perfect combination for poverty to set in. In the end, HIV impacts us all.

To be able to move forward, there is a need to pause, look back and around to determine the results which the workplace response has accomplished. More importantly, collate collective experiences of the Tripartite+ community so as to draw lessons from these and bring new insights that will revitalize the workplace response.

# WORKPLACE POLICIES AND PROGRAMS

Policy is the key to implementation—it defines what must be done; what is just and unjust; and, it shapes program implementation. With the rapidly changing face of the HIV and AIDS epidemic in the Philippines; broader, ongoing social dialogue on HIV, AIDS and the national response; and, wealth of experiences in implementing workplace programs on HIV and AIDS, it is timely for the implementers of the workplace response to look inward to examine:

- What are the gaps in the workplace policies and programs on HIV and AIDS?
- How are policy gaps affecting program implementation?
- What remedies may be introduced to policies and programs so as to enhance the workplace response?

The analysis offered below is outlined based on the ILO Code of Practice on HIV and AIDS and the World of Work.

**10 Key Principles**

RA 8504, PNAC Resolution No. 1 (IRR of RA 8504), and DOLE D.O. 102-10, in general, covered almost all aspects covered by the 10 key principles in the workplace response, as defined by the ILO Code of Practice. None mentioned as a policy the fostering of a healthy work environment to encourage productivity.

Overall, DOLE D.O. 56-03 did not need to be scored on almost all aspects of the 10 key principles. Of the four policies analyzed, only this policy has a provision on gender equality. As for social dialogue, this policy and DOLE D.O. 102-10 are the only policies that mentioned and implied that consultations are essential to program implementation.

DOLE D.O 56-03 is not an HIV-specific policy of the DOLE. However, it complements both the HIV policy and its implementation since DOLE's Family Welfare Program covers sexual and reproductive health and should, therefore include HIV and AIDS as well.

It is noteworthy that compulsory HIV screening and discrimination have been discussed specifically in relation to the employment process. All, except for DOLE DO 56-03, have ruled that termination due to actual or perceived HIV status is prohibited.

The matrix indicating the consistency of these four policies with the ILO 10 Key Principles is summarized in the matrix below:

| 10 Key Principles | RA 8504 | RA 8504 IRR | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| **1: Recognition of HIV and AIDS as a workplace issue** | Section 2, (a): recognizes the workplace as a venue for HIV response | Section 2, (a): recognizes the workplace as a venue for HIV response | Acknowledges the role of the workplace contribution to the national response to HIV | NA |
| **2: Non-discrimination** | Section 2, (b),(3): any form of discrimination is considered inimical | Section 2, (b),(3): any form of discrimination is considered inimical | III, B: states that workers should not be discriminated at any phase of the employment process | NA |
| **3: Gender equality** | Section 2, (d) declares it the policy of the State to eliminate gender inequality | Section 2, (d) declares it the policy of the State to eliminate gender inequality | No mention | Contains provisions on gender equality |
| **4: Healthy work environment** | No mention | No mention | Implied; IV, A, No. 9: Each employer, together with the company focal personnel for human resources and safety and health, shall provide appropriate personal protection equipment to prevent HIV exposure, especially for those handling blood and other body fluids | No mention |
| **5: Social dialogue** | No mention | No mention | Through the Inter-Agency Coalition on HIV and AIDS | Section 5 mentions the partners in implementing the policy |
| **6: Screening for purposes of exclusion from work or work processes** | Article 3, Section 15: compulsory HIV testing is prohibited<br><br>Article 3, Section 16: Makes compulsory HIV testing as a pre-condition for employment unlawful | Rule 4, Section 27: Makes compulsory HIV testing as a pre-condition for employment unlawful | III, C: Makes compulsory HIV testing as a pre-condition for employment unlawful | NA |
| **7: Confidentiality** | Article 6, Section 30: instructs all individuals with access to oe knowledge of HIV test results to ensure confidentiality of person infected<br><br>Specifies instances when confidentiality is waived | Rule 7, Section 41: instructs all individuals with access to oe knowledge of HIV test results to ensure confidentiality of person infected<br><br>Specifies instances when confidentiality is waived | III, B, (2): instructs all individuals with access to oe knowledge of HIV test results to ensure confidentiality of person infected<br><br>Also, rules that job applicants or workers must never be asked about their HIV status | NA |
| **8: Continuation of employment relationship** | Article 7, Section 35: states that HIV status must not be used as grounds for termination | Rule 8, Section 46: states that HIV status must not be used as grounds for termination | III, B, (1): states that HIV status must not be used as grounds for termination | NA |
| **9: Prevention** | Several mentions, including making available HIV education in the workplace | Several mentions, including making available HIV education in the workplace | Several mentions, including making available HIV education in the workplace, including stating in policy, and conduct of HIV training and awareness programs | NA |

| 10 Key Principles | RA 8504 | RA 8504 IRR | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| **10: Care and suport** | Universal access for all affected, guaranteed | Universal access for all affected, guaranteed | III, B, (3): lays down guidelines on reasonable work accommodation for workers with HIV | NA |

**General rights and responsibilities**

Accountability defines the effectiveness of policy and is a precursor for efficient program implementation.

*Governments and their competent authorities*

All four policies have identified the DOLE as the primary national government agency to lead, strategize and implement the workplace response on HIV and AIDS.

The ILO Code of Practice enumerates the areas / criteria to look at in examining the extent of accountability of Government in ensuring a responsive workplace policy and program on HIV and AIDS. The Researcher has discerned that Items, stipulated in the ILO Code of Practice as (5),(5.1): (a), (b), (c), (d), (f), (g), (h), (i), (k), (l), (m), and (q), discussed vis-a-vis observations made on the four policies under examination in this study. Analysis summarized below:

1. Coherence. The role of the workplace is well recognized in all three policies on HIV and AIDS, and ensure the alignment of the workplace response with the national strategy of HIV and AIDS prevention and control. DOLE is a member of the Philippine National AIDS Council (PNAC), which has been mandated by RA 8504 and its IRR to coordinate the national response to HIV and AIDS.

2. Multi-sectoral participation. The workplace response details the involvement of tripartite partners — workers, employers and Government — and although even the policies that predate the DOLE DO 102-10 recognize the significance of involving PLHIVs, the involvement of non-traditional partners, including non-government organizations and other OSH service providers have been poorly recognized. Thus, too, these groups' roles and responsibilities in teh workplace response remains to be poorly defined. With the absence of clear accountabilities of stakeholders, the workplace response has been poorly orchestrated.

3. Coordination. Quoting the ILO Code of Practice, "Coordination should build on measures and support services already in place." Traditional workplace actors have been contributing well to the workplace response but, so too have non-traditional partners.

4. Prevention and health promotion. This area is well covered by all four policies.

5. Social protection. All three HIV and AIDS policies have recognized the need to provide social protection. As a result of the studies on social protection that can be extend to PLHIVs, RA 8504 (Section 26) and IRR (Section 37), PLHIVs now benefit from the Outpatient and Inpatient Treatment Package made available through the Philippine Health Insurance Corporation (PHIC). The benefits which PLHIVs can avail of are as follows:

   <u>Outpatient HIV/AIDS Treatment Package</u>:

   - Annual reimbursement is P30,000/year; released in 4 quarterly payments of P7,500 payable to the treatment hub

- Maximum of four (4) treatment sub-packages per year may be claimed by the treatment hub
- Coverage is only for confirmed HIIV/ADS cases
- Package includes drugs and medicines, laboratory exams including Cluster Difference 4 (CD$) count; test for monitoring of ARVs toxicity and professional fees of providers

Inpatient Package
- PLHIV member can receive in-patient benefits in confined in an accredited facility

TB DOTS Package
- P4,000 per case
- Available in all TB DOTS Centers / Facilities

6. Research. This area is not thoroughly explored and covered by any of the policies examined. To strengthen the workplace response, it has to be researched-based, particularly when resources are scarce, and scarce resources must be deployed to make the most impact.

   In practice, DOLE has included HIV and AIDS parameters in the ISLE biennially. However, there may be need to revisit these parameters to go beyond identifying whether or not an enterprise has set up a workplace policy and program on HIV and AIDS. It is good to highlight how, in recent years, the survey has helped identify specific policy areas, like policy on discrimination and policy on non-mandatory HIV testing. However a review of the survey parameters is due to ensure that the correct parameters are being monitored, and that these are standardized to allow for comparisons over time to be made, particularly as regards a baseline year.

7. Financial resourcing. Through the creation of the PNAC and the participation of the DOLE, resources spent, required, and resource gaps are reflected in contry AIDS Spending reports.

8. Legislation. To quote the ILO Code of Practice, "…governments…should provide the relevant regulatory framework…" There are penalties stipulated in all four policies reviewed for violation of any of their respective provisions. However, in practice, National Government Agencies now have a more developmental rather than a regulatory function, ever since the enactment of the Local Government Code which devolved national government roles and mandates to counterpart offices at the LGU level.

   This means, whatever penalties are currently stipulated in these policies may only be strengthened and increase the likelihood of achieving the purpose why the penalties are there in the first place, only when these are reflected in LGU policy instruments.

   The minimal mention of the role of the workplace response in policy instruments that have been enacted by far at the LGU level is a reflection of the litte to no involvement of the DOLE in LGU level discussions to strengthen the role of the workplace. At the same time, it is vital that the correct language involving workplace and HIV and AIDS finds its way into these policies, so too do the full menu of policies recommended to be covered in such policies involving the workplace. This ensures that the rights of workplace actors are protected and upheld at all times.

   These realities makes now the perfect time for DOLE and other workplace actors to link up and forge stronger partnerships, most especially with LGUs.

9. Enforcement. As in Item No. 8 above, DOLE is no longer focused on enforcement of labor requirements but have now shifted its attention to its more developmental role. Again, ensuring that policies are enforced makes the involvement of LGUs in the workplace response inevitable.

10. Workers in informal activities (informal sector). There are no mention of workers in the informal sector in any of the policies reviewed. These groups of workers must be included in workplace policies on HIV and AIDS, most especially because these group of workers include street hawkers, public transport drivers and daily wage earners who may be at higher risk of contracting HIV and AIDS.

    HIV policies, strategies and interventions must be drafted specifically with their circumstances and needs in full consideration, albeit further discussion as to how the informal sector workers may be reached more efficiently and more effectively will have to be further discussed.

11. Mitigation. DOLE DO 102-10 purports that management shall provide referral services if and when such are not available in the workplace. However, the policies examined failed to identify the role of Government, not just the DOLE, in facilitating and ensuring that such referral mechanisms are put in place.

    DOLE currently does not provide a masterlist of contact information for the full spectrum of HIV and AIDS services that employers and workers alike may refer to if and when they require certain services. Some companies who may be interested to formulate their policies or to train a few people from their ranks to conduct HIV 101 often do not know who to contact or where to avail of such services. While DOLE may be the government entity mandated to lead the workplace response, the referral mechanisms that need to be put in place requires the greater involvement of other government agencies, most especially the DOH and LGUs, and non-government entities as well, in building a robust and efficient referral system that benefits employers and workers alike.

12. Vulnerability. All policies reviewed fail to mention the most vulnerable groups of workers to target with the response or, mention the need to focus the workplace response on workers with higher risk of contracting the infection. The policies speak of the workplace in general and seems to be recommending a generic response.

    However, the workers' demographics are broad and highly varied. Specific and targeted workplace policies and programs on HIV and AIDS are required to cater to their differing and unique needs if the workplace response should be successful in its advocacy.

    It is inevitable for the DOLE to identify the industries and / or sectors where key affected population are employed, such as young workers and migrant workers, particularly when resources are very limited and need to focus on implementation programs that have the potential for high impact.

*Employers, Workers, and their organizations*

The roles and responsibilities of employers and workers alike are well-defined and detailed under DOLE DO 102-10. Again, the key principles to support these roles and responsibilities, such as non-discrimination on the basis of HIV status, non-mandatory HIV testing, and confidentiality, are covered by RA 8504 and its IRR.

**Prevention through information and education**

The ILO Code of Practice places premium on making available information on HIV prevention in the workplace because "It can significantly reduce HIV-related anxiety and stigmatization, minimize disruption in the workplace, and bring about attitudinal and behavioural change". Among the factors that have to be considered in developing workplace programs on HIV, based on this reference, are:

> Programmes should be developed through consultations between governments, employers and workers and their representatives to ensure support at the highest levels and the fullest participation of all concerned. Information and education should be provided in a variety of forms, not relying exclusively on the written word and including distance learning where necessary. Programmes should be targeted and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. They should be delivered by trusted and respected individuals. Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of programmes.

Key concepts mentioned in the quote above — content development considerations (age, gender, sexual orientation, sectoral characteristics and behavioural risk factors), and peer education, other than consultations / social dialogue which has been covered in detail by DOLE DO 102-10 — are not aptly reflected by the policies reviewed in this study. DOLE DO 102-10 provides for the element of social dialogue through the setting up of the Inter-Agency Coalition on HIV and AIDS (IAC), and the creation of workplace-based Safety and Health Committees. Overall, however, there was no mention of tailor-fitting information and education content and channels to specific groups or sub-groups, particularly those communication information and channels targeted to reach key populations.

The ILO Code of Practice recommendation on linking back the workplace response to the larger, national response, is reflected in DOLE DO 102-10. The policy includes a provision that requires companies to either provide HIV services in the workplace or, provide a referral system to external institutions that may be able to provide workers with additional information and support with regards to HIV. The policy also encourages companies to extend their workplace programs on HIV and AIDS to stakeholders external to the organization which may include workers' families, supply chain and communities adjacent to office facilities.

Another practical recommendation made by the ILO is in making available list of information that must be included in workplace HIV advocacy and training programs, including:

- risks that face them personally (both as individuals and as members of a group) and reduce these risks through decision-making, negotiation and communication skills, as well as educational, preventative and counselling programmes;
- give special emphasis to high-risk behaviour and other risk factors such as occupational mobility that expose certain groups of workers to increased risk of HIV infection;
- provide information about transmission of HIV through drug injection and information about how to reduce the risk of such transmission;
- promote campaigns targeted at young workers and women;
- give special emphasis to the vulnerability of women to HIV and prevention strategies that can lessen this vulnerability;
- emphasize that HIV cannot be contracted through casual contact, and that people who are HIV-positive do not need to be avoided or stigmatized, but rather should be supported and accommodated in the workplace;
- explain the debilitating effects of the virus and the need for all workers to be empathetic and non-discriminatory towards workers with HIV/AIDS;
- instruct workers (especially health-care workers) on the use of Universal Precautions and inform them of procedures to be followed in case of exposure;
- provide education about the prevention and management of STIs and tuberculosis, not only because of the associated risk of HIV infection but also because these conditions are treatable, thus improving the workers' general health and immunity;

- promote hygiene and proper nutrition;
- promote safer sex practices, including instructions on the use of male and female condoms;
- encourage peer education and informal education activities.

The recommendation also stresses the importance of regularly conducting activities to monitor, evaluate, review and revise workplace programs which becomes especially important to discern if the programs are accomplishing the goals it was set to accomplish, and to determine as well which activities are effective and which are not.

Another important point made by the ILO is in integrating HIV and AIDS in a wider health promotion program that ideally also covers substance abuse, stress and reproductive health:

> Educational programmes should be linked, where feasible, to health promotion programmes dealing with issues such as substance abuse, stress and reproductive health at the workplace. Existing work councils or health and safety committees provide an entry point to HIV/AIDS awareness campaigns and educational programmes. This linkage should highlight the increased risk of infection in the use of contaminated needles in intravenous drug injection. It should also highlight that intoxication due to alcohol and drugs could lead to behaviour which increases the risk of HIV infection.

DOLE DO 102-10 provides employers and workers with two options for introducing HIV in the workplace policies and programs — either as a stand alone intervention or, integrated with other OSH concerns.

DOLE 56-03 possibly covers HIV and AIDS in its discussion of the priority subjects under the Family Welfare Program enumerated below, although further investigation on the content of these training programs may have to be conducted:

a) Family Planning
b) Maternal and Child Health and Nutrition
c) Prevention nad Management of Abortion and its Complications
d) Prevention and Management of Reproductive Tract Infections
e) Education and Counseling on Sexuality and Sexual Health
f) Breast and Reproductive Tract Cancers and other Gynecological Conditions
g) Men's Reproductive Heath
h) Adolescent and Youth Health
i) Violence Against Women and Children; and,
j) Prevention and Treatment of Infertility and Sexual Dysfunction

**Training**

All policies reviewed have emphasized the need to train key people to cascade the response to different groups. DOLE DO 102-10 specifically provides that employers and workers both have the right to access HIV information as well as the responsibility to train colleagues at the workplace.

All of the policies have specifically pointed out training on universal precautions and building a culture of safety among health workers most especially but also, among all workers who come into contact with human blood and other body fluids.

However, none of the policies reviewed have reflected key groups of workplace actors to receive specific training, except workers who come into contact with human blood and other body fluids, as specified by DOLE DO 102-10.

The ILO has identified the training needs of some of the primary groups of workplace actors that will have to be trained on HIV and AIDS as follows:

7.1. Training for managers, supervisors and personnel officers. In addition to participating in information and education programmes that are directed at all workers, supervisory and managerial personnel should receive training to:
– enable them to explain and respond to questions about the workplace's HIV/AIDS policy;
– be well informed about HIV/AIDS so as to help other workers overcome misconceptions about the spread of HIV/AIDS at the workplace;
– explain reasonable accommodation options to workers with HIV/AIDS so as to enable them to continue to work as long as possible;
– identify and manage workplace behaviour, conduct or practices which discriminate against or alienate workers with HIV/AIDS;
– enable them to advise about the health services and social benefits which are available.

7.2. Training for peer educators. Peer educators should receive specialized training so as to:
– be sufficiently knowledgeable about the content and methods of HIV/AIDS prevention so that they can deliver, in whole or in part, the information and education programme to the workforce;
– be sensitive to race, sexual orientation, gender and culture in developing and deliv- ering their training;
– link into and draw from other existing workplace policies, such as those on sexual harassment or for persons with disabilities in the workplace;
– enable their co-workers to identify factors in their lives that lead to increased risk of infection;
– be able to counsel workers living with HIV/AIDS about coping with their condition and its implications.

7.3. Training for workers' representatives. Workers' representatives should, during paid working hours, receive training so as to:
– enable them to explain and respond to questions about the workplace HIV/AIDS policy;
– enable them to train other workers in trainer education programmes;
– identify individual workplace behaviour, conduct or practices which discriminate or alienate workers with HIV/AIDS, in order to effectively combat such conduct;
– help and represent workers with AIDS-related illnesses to access reasonable accommodation when so requested;
– be able to counsel workers to identify and reduce risk factors in their personal lives;
– be well instructed about HIV/AIDS in order to inform workers about the spread of HIV/AIDS;
– ensure that any information that they acquire about workers with HIV/AIDS in the course of performing their representative functions is kept confidential.

7.4. Training for health and safety officers. In addition to becoming familiar with the information and education programmes that are directed at all workers, health and safety officers should receive specialized training in order to:
– be sufficiently knowledgeable about the content and methods of HIV/AIDS prevention so that they can deliver information and education programmes to workers;
– be able to assess the working environment and identify working methods or conditions which could be changed or improved in order to lessen the vulnerability of workers with HIV/AIDS;
– verify whether the employer provides and maintains a healthy and safe working environment and processes for the workers, including safe first-aid procedures;
– ensure that HIV/AIDS-related information, if any, is maintained under conditions of strict confidentiality as with other medical data pertinent to workers and disclosed only in accordance with the ILO's code of practice on the protection of workers' personal data;
– be able to counsel workers to identify and reduce risk factors in their personal lives;
– be able to refer workers to in-house medical services or those outside the workplace which can effectively respond to their needs.

7.5. Training for factory/labour inspectors. This training should include:

– information on relevant international labour standards, especially the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), and national laws and regulations;
– how to provide awareness about HIV/AIDS to workers and management;
– how to incorporate HIV/AIDS topics into their regular occupational safety and health briefings and workplace training;
– how to assist workers to access available benefits (such as how to complete benefit forms) and to exercise other legal rights;
– how to identify violations, or the lack of implementation of, workers' rights in respect of HIV status;
– skills to collect and analyse data relating to HIV/AIDS in workplaces when this is for epidemiological or social impact studies and in conformity with this code.

7.6. Training for workers who come into contact with human blood and other body fluids. The programmes should provide training:
– in the provision of first aid;

– about Universal Precautions to reduce the risk of exposure to human blood and other body fluids (see Appendix II);
– in the use of protective equipment;
– in the correct procedures to be followed in the event of exposure to human blood or body fluids;
– rights to compensation in the event of an occupational incident,
and emphasize that the taking of precautions is not necessarily related to the perceived or actual HIV status of individuals.

**Care and support**

Of utmost importance is the point made by the ILO as to how HIV and AIDS should be treated as any other serious illness:

(a) HIV infection and clinical AIDS should be managed in the workplace no less favourably than any other serious illness or condition.
(b) Workers with HIV/AIDS should be treated no less favourably than workers with other serious illnesses in terms of benefits, workers' compensation and reasonable accommodation.
(c) As long as workers are medically fit for appropriate employment, they should enjoy normal job security and opportunities for transfer and advancement.

None of the policies reviewed was able to reflect the important points made by (a) and (b) above. These two policies rightfully highlight that HIV and AIDS should be treated and approached just like any other illness or disease that can affect the viability of any workplace to be a healthy workplace environment. By providing for special treatment or accommodation or, by giving PLHIV workers less than any other employee is given, discrimination occurs. On the other hand, (c) is covered by DOLE DO 102-10, particularly providing for justifiable work accommodation as well as continuation of employment without bias to any worker's HIV status.

Provisions on the following areas of care and support have been moderately covered by the policies reviewed:

- Counseling
- Occupational and other health services
- Linkage with self-help and community-based groups
- Benefits
- Social security coverage
- Privacy and confidentiality
- Employee and family assistance programs

**Workplace actors and the workplace response**

On a more programmatic level, the DOLE, through the OSHC, has made HIV and AIDS education for workers and employers a steady offering in a number of training programs regularly conducted by the Center, both as a stand alone module or, as a part of more holistic occupational safety and health programs.

Specifically:

- HIV and AIDS in the workplace learning sessions were facilitated, where 135 employers and workers, representing 64 companies, participated.

- The highest training participation rates were registered for the Basic Occupational Safety and Health (BOSH), and Construction Safety Trainings which, together, covered 7,971 participants representing 4,749 companies. Basic information about HIV and AIDS are mainstreamed in both training modules.

- OSH appreciation courses ranked third in yielding the most number of participants (n=2,665) and the most number of companies covered (n=146). This course is offered to companies, students, the informal sector, and business process outsourcing companies (as part of the partnership forged between DOLE and the IT and Business Process Association Philippines).

- The e-BOSH has a modest reach in terms of the number of participants but, was still able to reach out to 115 companies via the OSHC online e-learning platform.

In addition, HIV and AIDS is also discussed in Construction Safety Orientation; Work Relatedness of Diseases; and, Managing Emerging Health Issues in the Workplace.

In as far as DOLE's OSHC programs are concerned, this report shows that the most effective channels to disseminate information on HIV and AIDS to the broadest number of participants is through courses where this subject is mainstreamed, particularly through the BOSH, e-BOSH and Construction Safety Trainings, and OSH Appreciation Orientations.

Moreover, OSHC reports that IEC materials, including a primer on DOLE DO 102-10 and the CHANGE (Cigarette Smoking, HIV / AIDS / STI, Alcohol and Drug Abuse, Nasal / Lung Ailments / TB, Good Nutrition and Exclusive Breastfeeding, Exercise) materials developed with the ILO, have been reprinted and disseminated to training participants. The CHANGE e-learning modules have also been uploaded and made available for free to the public via the OSHC e-learning website, though OSHC did not report the number of site visitors who signed up for these modules.

The OSHC website likewise provides a medium by which HIV and AIDS information may be shared and disseminated to the workplace actors, and even to the public per se. However, some of the information may have to be either provided by the Department of Health (DOH) and PNAC on a periodic basis or, visitors will have to be redirected to the DOH and PNAC websites for specific information, such as directories of testing centers and treatment hubs.

Besides training, the DOLE is also in a prime position to offer care and support services for PLHIVs, through its various bureaus and agencies offering alternative livelihood programs, oversight for statutory coverage including access to PhilHealth benefits, and redress through labor arbitration.

While the reported accomplishments of DOLE represents the bulk of reach in the workplace response, the accomplishments of the workplace response as a whole is not captured, whereas the tripartite partners, traditional and non-traditional workplace actors have been steadily conducting HIV intervention programs that reach more workers and employers with information on HIV and AIDS.

Workers, employers, and non-traditional workplace actors including PLHIV groups, corporate foundations and other non-government organizations also have workplace programs on HIV and

AIDS. These include HIV orientations, peer education, traning of trainers, and onsite HIV counselling and testing.

Non-traditional workplace actors, which include PLHIV groups, corporate foundations and other volunteer groups, have been actively engaging with employers and workers, and have staged several workplace-based HIV orientation and training programs.

Currenty, the most innovative ongoing initiatives are those forged by Pilipinas Shell Foundation, Inc. (PSFI) with The Love Yourself Foundation, and others forged with LGUs. Both initiatives involve either referral to VCT or, makes available VCT onsite — similar to the strategy employed by ILO's VCT@Work Initiative which have yet to be implemented in the Philippines.

**Local Government Units and the workplace response**

With the passage of Republic Act No. 7160 (Local Government Code) in 1991, the policy, administrative and regulatory landscape of the Philippines was significantly revamped as power and authority began to be devolved and decentralized from the National Government to favor the LGUs to exercise more control over their respective jurisdictions. With these changes, LGUs were apportioned their respective budgets to carry out new roles and functions that were previously under the purview of the National Government.

Title I, Section 16 of the Local Government Code stipulates that LGUs have been given the responsibility to ensure the general welfare of their constituents, which includes the promotion of health and safety, and full employment of residents. The creation of Local Health Boards at every province, city and municipality, as provided for in Title 5, Section 102 of the law, also gives local health officers greater power and broader mandate to drive local health programs and allocate resources to achieve health goals.

The power of the LGUs to strategize and implement the HIV and AIDS response is duly recognized by RA 8504 and its accompanying IRR.

RA 8504, Article IV (Health and Support Service), Section 23:

> Community-based Services — Local government units, in coordination and in cooperation with concerned government agencies, non-government organizations, persons with HIV / AIDS and groups most at risk of HIV infection shall provide community-based HIV / AIDS prevention and care services.

RA 8504 IRR, Section 34:

> Community-Based Services — The LGUs, through its health, social welfare and population officers, in collaboration, cooperation or partnership with the following:
> 1. concerned government agencies
> 2. NGOs
> 3. organizations and establishents
> 4. People Living with HIV / AIDS; and,
> 5. other vulnerable groups

Other than RA 7160 and RA 8504, two key DILG Memorandum Circulars further solidifies the role of LGUs in the HIV and AIDS response, and make LGUs a strategic partner for the workplace response.

DILG MC 99-233 (HIV and AIDS Education in Communities and Related Concerns) reiterates the role of the LGUs in providing community-based HIV / AIDS prevention and care services. The same instrument invites LGUs to enact local ordinances and programs to support the implementation of RA 8504.

DILG MC 2013-29 (Strengthening Local Resonses Toward More Effective and Sustained Responses to HIV and AIDS) highlights the contributions key cities can make in the HIV and AIDS response beginning with instituting Local AIDS Councils (LAC). The instrument proposes the composition of the LACs: Local Chief Executive (Chair), Sangguniang Committee Chair on Health / Social Concerns (Vice Chair), Health Officer, Social Welfare Officer, DILG Officer, DOH Representative, Superintendent / Representative from DepEd, Local Focal Point for STI / HIV / AIDS, and (1) Representative from PLHIV Group. Non-permanent members may include: (1) Representative from faith-based organization, Representatives from accredited NGOs / POs representing / working with groups vulnerable or most at risk to HIV, and (1) Representative from an agency / institution as identified by concerned LGU (business sector / academe).

DILG MC 2013-29 also encourages LGUs to tap NGAs and partners from other sectors as well.

These policy instruments make the LGUs key partners for an impactful workplace response to be accomplished. The LGUs are practically placed at the center of the HIV and AIDS epidemic — both as a receiver of the epidemic's impact and as a key enabler in the response.

The Local Government Code and the newfound authority on the part of the LGUs, although a positive way forward to achieving more local autonomy, is also beset with systemic policy and programmatic roadblocks and bottlenecks. For instance, several LGU policies have been pointed out to be completely contrary to what is provided for in the law. Program wise, coordination and synergy with National Government strategies is also a persistent concern of the national response.

Nevertheless, already there exists a number of good practices among LGU level responses to HIV and AIDS. These developments should be taken well into consideration in shaping a more responsive, practical and targeted workplace response to HIV and AIDS.

*HIV in the workplace programs at a glance*

In a study commissioned by the UNDP in 2012[11], it was pointed out that policy instruments on HIV and AIDS by far issued by LGUs generally cover five areas, namely:

1. Provisions on educational strategies. These provisions stress trainings on STI, HIV and AIDS targeted at different populations which includes entertainment establishments, schools, workplaces and local residents per se.

2. Regulatory provisions. Most of which involving issuance or revocation of permit to operate on the part of the establishments and work permits on the part of sex workers for non compliance. Some require setting up workplace policies on HIV and AIDS. Some LGUs have made HIV / AIDS Orientation a requirement in securing work permits.

3. Surveillance provisions. Provisions on this note mandate and empower Local AIDS Councils to conduct periodic HIV surveillance and to devise reporting and monitoring mechanisms.

4. Support and care services. Many mirror the national policy to provide universal access to healthcare for STI cases, including HIV and AIDS.

5. Provisions on principles. Most notably sounded through these local policies are the provisions on right to privacy and non-discrimination.

Based on the same study, and information available to this current research, the following LGUs have filed local policies on HIV and AIDS, using one or more of three types of policy instruments — Local Ordinance, Executive Order, and Resolution:

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[11] de Jesus, Armando, et.al. National and Local Policies Related to AIDS and Drug Use: Content and Review Assessment. Policy Review. UNDP. Manila: 2012.

| City / Provincial / Municipal Ordinance | Davao City | Isabel, Leyte | Matnog, Sorsogon |
|---|---|---|---|
| Manila | Guimaras Province | Maribojoc, Bohol | Sorsogon City |
| Pasay City | Naga City | **City / Provincial/ Municipal Resolution** | **Executive Order** |
| Quezon City | San Fernando City (Pampanga) | Cebu Province | Davao City |
| Angeles City | Sipalay City | Cebu City | Ilocos Norte Province |
| Bauang, La Union | Surigao City | Lapu-Lapu City | |
| Dagupan City | Tabaco City | Makati City | |

Several policy instruments are at the disposal of the LGUs, the ones most commonly used as vehicles to set and communicate local policies on HIV and AIDS are Local Ordinances, Board Resolutions and Executive Orders. Local Ordinances carry the most weight and bearing among the three, and serve as laws at the local level which cannot be easily undone or revised without going through a defined political process, dialogue and required series of consultations.

*Quezon City: Local innovator of HIV response and workplace response*

As early as 1995, before RA 8504 was even enacted into law, Quezon City has already issued Sangguniang Panglungsod (SP; City Ordinance) Ordinance No. 380, s. 1995 which made HIV and AIDS orientation a prerequisite in securing health certificates. Workers from several categories of business establishments, including entertainment houses, night clubs, hotels and restaurants were then required to secure such health certificates.

In 2001, SP-380, S-1995 was expanded when Quezon City became the first LGU to ever issue a policy instrument defining its political stance and standards on HIV and AIDS. SP-1053, S-2001 (An Ordinance Strengthening Quezon City STD / AIDS Council in Implementing the Policies and Measures for the Prevention and Control of STD / HIV / AIDS in Quezon City Providing Penalties for Violations Thereof and for Other Purposes) is especially focused on regulating health practices and improving HIV and AIDS prevention and control in registered entertainment establishments, defined in the ordinance as:

> "any establishment which includes bars, nightclubs, disco houses, cocktail lounges, massage clinics, videoke bar / sing along pub houses that secured permit to operate within Quezon City"

Salient points of the ordinance include:

1. Mandatory attendance of entertainment establishment owners, managers and staff to the STD / HIV / AIDS prevention seminar. Attendance to which is a prerequisite for the issuance of business permit or license to operate on the part of the establishment, and issuance / renewal of a health certificate on the part of workers;
2. Requires all entertainment establishments to maintain at least one peer educator;
3. Obliges workers employed by entertainment establishments to submit themselves to regular STD screening;
4. Reiterates RA 8504's provision on confidentiality of medical information, including HIV status; and,
5. Provides penalties for non-compliance, as follows:
    - 5.1. First offense: fine of P2,000 and/or imprisonment of one month
    - 5.2. Second offense: P3,000 and/or imprisonment of three months
    - 5.3. Third offense: fine of P5,000 and/or imprisonment of P5,000 and/or imprisonment of six months and/or permanent revocation of establishment's license to operate

HIV was barely receiving any attention or causing any alarm back in 2001 when SP-1053, S-2001 was promulgated by the local government of Quezon City. Only one case every two days was being reported during that time, and policy and programmatic interventions were still very much focused on sex workers and people who paid for sex, and thus, this ordinance targeted its interventions on entertainment establishments.

Significantly expanding the workplace HIV and AIDS response in Quezon City is the passage into law of SP-2210, S-2013 (An Ordinance Prohibiting All Forms of Discrimination of Workers Perceived or Suspected or Even Found to be Positively Infected with HIV in Workplaces Within the Jurisdiction of Quezon City). This local policy instrument is the first to specifically tackle discrimination in relation to employment status and a worker's HIV status.

Below is a comparison of the Ordinance's definition of *Discrimination* with two key International Labour Standards advanced by the ILO — ILO Convention, 1958 (No. 111) on Discrimination (Employment and Occupation) which is one of eight ILO fundamental conventions, and ILO Recommendation, 2010 (No. 200) concerning HIV and AIDS and the world of work.

SP-2210, S-2013:

> "any act that may degrade human dignity. It also refers to unequal treatment given, whether in the form of policy, decision, action or sanction, to an employee or applicant with regard to hiring, termination, promotion, compensation, job training, or any other term, condition, or privilege of employment due to the reason that the said employess or applicant is perceived, suspected or confirmed to be infected with HIV."

ILO C. 111:

> "any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation."

ILO R. 200:

> "means any distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation, as referred to in the Discrimination (Employment and Occupation) Convention, 1958, and Recommendation, 1958"

Based on the above, the definition of *Discrimination* provided for in SP-2210, S-2013, although not exactly similarly worded or reflects to the full extent as definitions provided for by the ILO, is consistent with International Labour Standards. The definition rightly sets the policy of the ordinance against any unjustifiable and unlawful discrimination and exclusion of any worker from the principle of equal opportunity in employment, covering the full spectrum of phases of employment.

Another important term that needs careful definition pertains to disability. While the ILO Code of Practice on HIV / AIDS and the world of work, precursor of ILO R. 200, defines *persons with disabilities* as:

> defined "in accordance with the definition given in the Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159), namely individuals whose prospects of securing, retraining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment".

SP-2210, S-2013 provides conditions for when an HIV-positive individual may be considered a person with disability:

an HIV-positive individual can be regarded as one of the following conditions are present:

a. A physical or mental impairment that substantially limits one or more of your major life activities, and
b. There is a record of such impairment; or,
c. He/She is regarded as having such an impairment

How these two terms, "discrimination" and "disability" are defines greatly affect the impact of SP-2210, S-2013, Section 3 (Prohibition) which states that, "Employers cannot simply equate HIV to disability".

The Ordinance goes above and beyond DOLE 102-10 in grounding the policy for non-discrimination in employment on the basis of an individual's HIV status, by further providing for the following:

1. It requires all workplaces to "implement, evaluate and fund" workplace policies and programs, including HIV and AIDS education.
2. It also requires all workplaces to prepare and follow a well-defined HIV Protocol for the proper handling and management of HIV cases in the workplace. This provision vests additional responsibility on the DOLE to provide guidance on the creation and adoption of such a workplace guideline.
3. The Ordinance brings more authoritative and regulatory elements into the policy instrument by defining,
    - 3.1. a grievance process that will serve to protect and uphold the rights and interests of affected or discriminated individuals, with the support of the LGU through the Public Employment Service Office (PESO) and the guidance of the Quezon City Tripartite Industrial Peace Council (QC-TIPC); and,
    - 3.2. a sanction that threatens to revoke an enterprise's business license to operate if found guilty of violating any provision of this Ordinance.

SP-2210, S-2013 demonstrates how, when its power is utilized to the full extent while remaining consistent with existing laws, the LGUs can bring more meaningful and practical policies, including solutions, to HIV and AIDS issues in the workplace.

One inconsistency of the ordinance, however, is its referral to DOLE of all workplace concerns pertaining to the institution of workplace HIV protocol. DOLE's purview is limited to private workplaces. Since the Ordinance includes private and government offices in its definition of 'workplaces', involvement from the Civil Service Commission for government workplaces may be necessary.

The HIV and AIDS programs of Quezon City are just as innovative as the local ordinances which the LGU have introduced.

## Insights

Dr. Rolly Cruz, Epidemiologist, Quezon City Health Department:

On the role of Government in the Workplace Response:

*"Advocacy is the primary role of DOLE and the rest of Government, including LGUs in the workplace response."*

How a partnership forged between DOLE and the LGUs can step up the workplace response:

*"The LGU's regulatory function may be tapped to compel business establishments to comply with DOLE DO 102-10, particularly by exploring possible penalties in the issuance and suspension of business permits, licenses to operate, and work permits."*

*"DOLE and the LGUs can work together in capacitating LGU and labor inspectors as to how compliance to workplace policies and programs requirements may be measured and evaluated."*

How the workplace response must be approached (following workplace-based interventions conducted by the Quezon City Health Department):

*"Simplify workplace orientation programs to emphasize prevention and testing information. Take a general population approach but emphasize testing, since that is the only way we can capture the KAPs so that further, more targeted interventions may be provided to them."*

Pursuant to its mandate to engage entertainment establishments, the Quezon City Health Department was one of the first LGUs to offer Mobile VCCT where the bars, the pubs, the massage clinics are located. Onsite HIV orientation, peer education and same day voluntary HIV testing are conducted at night—unconvential times for an LGU to operate.

Another more recent HIV intervention introduced in Quezon City, which was accomplished successfully in partnership with the DOH, is the setting up and continued operation of Klinika Bernardo. It is a sundown clinic that operates until the wee hours of morning to cater to the special and specific needs of MSMs but also of others who require help and counselling on sexual and reproductive health.

In 2014 alone, Klinika Bernardo performed HIV testing to 7,500 male clients[12].

*Other policy and program innovations at the LGU level*

The next LGU to step up its response on the escalating HIV and AIDS problem was Pasay City. Barely a year after the Quezon City SP-2210, S-2013 was passed into law, Pasay City enacted SP Ordinance No. 2341, s. 2002, also known as the Pasay City AIDS Prevention and Control Ordinance. However, it was not until 10 years after that, in 2012, when its IRR was finally promulgated by the Pasay City AIDS Council through Resolution No. 1.

Since Resolution No. 1 is more recent and as it lays down the practical, on-the-ground protocols for Pasay City SP Ordinance No. 2341, s. 2002, it is discussed in detail below.

**Insights**

Dr. Nan Ranieses, Physician, Pasay City Health Department:

On services that can be accessed from LGUs:

"Resident and non-residents alike may avail of free services and commodities from the Social Hygiene Clinics, including HIV testing."

"We provided HIV Orientation to groups that request it, including employers. As for Peer Education, Trainers' Training and Counselling services, we provide these to KAPs only."

The IRR includes a definition for discrimination, defined as:

> "a prejudicial act of making distinctions or showing partiality in the granting of privileges, benefits or services to a person on the basis of his/her actual, perceived or suspected HIV status"

Section 3 (Declaration of Policies) upholds the rights of PLHIVs:

> (b) The City shall extend to every person suspected or known to be infected with HIV/AIDS full protection of his/her human rights and civil liberties.
>
> Towards this end,
> i. Compulsory HIV testing shall be considered unlawful unless otherwise provided in this Ordinance; the right to privacy of individuals with HIV/AIDS shall be guaranteed;
> ii. Discrimination, in all its forms and subtleties, against individuals with HIV/AIDS or persons perceived or suspected of having HIV/AIDS shall be considered inimical to individual and society in general; and
> iii. Provision of basic health and social services for individuals with HIV/AIDS shall be assured.

Also under Section 3, Pasay City acknowledges the benefits of forging partnerships with and among different groups:

> (f)(i) Multi-sectoral involvement is essential to national and local responses to HIV infection/AIDS

[12] "2014 Key Accomplishments of Quezon City" Accessed on: 10 Dec 15 Page Link: http://quezoncityhivresponse.blogspot.com

Section 5 (Compulsory HIV / AIDS / STI EDUCATION) continues to acknowledge and does not repeal the provision of Pasay City Ordinance No. 236, s. 1993, requiring workers' attendance to the AIDS / STI Seminar as a prerequisite to the issuance of a Mayor's Work Permit or Occupational Health Permits. Workers in entertainment establishments are obliged to undergo the same seminar regularly for both issuance and renewal of their permits.

Under the same section, Pasay City also orders that all employees are required to undergo HIV and AIDS education in the workplace. To quote:

> (f) HIV/AIDS Education in the workplace
> HIV/AIDS/STI Information dissemination shall be conducted for all employees at their workplace, including sanitary inspectors, local PNP, local social welfare and development workers, and economic and fiscal sector on the time and date convenient for them. The City Health Office, in partnership with the City Tourism Office shall spearhead this activity in close coordination with PCAC"s Committee on Education.
>
> Special emphasis on the following shall be provided during the interaction:
> i. Simple Illustration that clearly shows the correct step in using condom
> ii. Advice against the use of non-water based lubricants like baby oil or petroleum jelly; and
> iii. Advice that each condom is used only once.

Section 16 penalizes persons committing any of the acts prohibited by the Ordinance as follows:

> a. First Offense – a fine of P2,000.00 and/or imprisonment of one (1) month;
> b. Second Offense – a fine of P3,000.00 and/or imprisonment of three (3) months;
> c. Third Offense – a fine of P5,000.00 and/or imprisonment of six (6) months and/or permanent closure of establishment.

Makati City more recently joined the growing list of cities to enact an ordinance on HIV and AIDS through Ordinance No. 2012-036 (An Ordinance Creaeting the Makati City Local AIDS Council and Providing for its Powers and Functions Subject to All Laws and Existing Legal Rules and Regulations).

The Ordinance bestows the function of reaching out to private establishments so as to extend HIV and AIDS education to workplaces. Section 4, (2)(i) reads:

> "Encourage owners / operators / managers of registered entertainment establishments, sauna and massage parlors, call center agencies to actively participate in the prevention and control of STI / HIV / AIDS"

The Ordinance, similarly with those of Quezon City and Pasay City, has identified registered business establishments as its primary targets for workplace response. The Makati Ordinance, however, extends this target to include call centers. The workplace target is very limiting, and to some extent, may be interpreted to be discriminating to call centers as these establishments have been pinpointed as a target, despite that call centers are just like any other workplace and should receive the same attention rendered to workplaces belonging to other industries.

Also, by specifying its workplace targets, and in the absence of a broader workplace provision in this Ordinance, the Makati City

## Insights

Ms Teresita Pagcaliwagan, Nurse III / HIV Coordinator, Makati City Health Department:

On reaching out to private establishments:

"We offer HIV orientation and other HIV related services whenever companies approach us. We tried to actively engage companies before but, our invitations are hardly heeded to. That's why, we value the linkages which Pilipinas Shell Foundation has been facilitating for us, by such, we are able to reach more private establishments with HIV 101 and free VCT services."

On the importance of instituting a local ordinance on HIV and AIDS:

"It is very challenging to get a local policy on HIV and AIDS approved. When a policy is deemed required, I suggest that an Ordinance be pursued because that will have bearings similar to a law, and it cannot be undone by succeeding authority without convening proper channels and relevant stakeholders."

LAC will have deliberately excluded a significant number of workplaces located within its jurisdiction.

Essential HIV and AIDS provisions on the following are reflected and reiterated in the Ordinance:

1. Prohibition against divulging of confidential information of persons living with HIV / AIDS / STI (Section 6);
2. Prohibition against misleading information (Section 7); and,
3. Prohibition of unsafe practices and procedures

Meanwhile, Section 10 provides for specific penalties for violation of the abovementioned prohibited acts. Penalties range from a minimum of six months up to a maximum of one year imprisonment, with the possible combination of fines, suspension or, revocation / withdrawal of permit to operate and license to practice profession.

*Current workplace interventions implemented by LGUs*

Key informants, Dr. Nan Ranieses, Social Hygiene Clinic Physician and HIV and AIDS Focal Point, Pasay City; and, Nurse Teresita Pagcaliwagan, HIV Coordinator, Makati City shared LGU services which are available for everyone in the community to access, regardless of residency, and including workplace actors.

Despite the devolution of the Department of Health (DOH) with the creation of Local Health Boards, LGUs are aligned with the strategies set forth and pursued by the DOH. Most notable is that the operation, strategies and logistics of Social Hygiene Clinics (SHC) still follow and emanate from the DOH through its Central Office and the Centers for Health Development (DOH Regional Offices). By this, the SHCs are able to extend free HIV counselling and testing to anybody who requires these, whether they are residents or not.

Regular trainings, including for workplaces, are limited to HIV 101; counselors are available for VCCT; while Peer Educators are maintained as volunteers as LGUs rarely make available funding or allowances for them. Peer Educators serve only the highly specific needs of populations most-at-risk, particularly MSMs and TGs.

Through partnerships that LGUs forge with other private sector players and NGOs, including PLHIV groups, they are now better able to access the workplace. A particularly emerging good practice of conducting free HIV 101 services to companies facilitated by private sector partners, accompanied by free mobile / offsite VCCT taken cared of by LGUs is helping LGUs improve their workplace reach. In this arrangement, their partners provide the entrypoint to reach out to private companies which, otherwise, are difficult for LGUs to access.

Without these partnerships, LGUs are limited to passively waiting for a handful of private companies who write to the LGU requesting for HIV 101 to be conducted in their respective workplaces.

LGUs do not offer Treatment, Care and Support for PLHIVs but are very much knowledgeable and capable of referring PLHIVs to Treatment Hubs and other institutions offering care and support so that proper attention may be provided to them.

**Summary**

*Overall policy evaluation*

The current local HIV policy context for HIV is highly supportive of global standards for workplace response. However, the issuance of a policy instrument is called for to update and provide further,

more detailed guidelines as to the scope of workplace policies on HIV and the corresponding breadth of workplace programs on HIV.

During the conduct of the FGDs for this study, DOLE officials have identified that the most practical policy instrument that may be issued is a Departmental Advisory.

*Strengths and limitations of the workplace response*

The DOLE, employers, workers, and non-traditional workplace actors are taking very different approaches to the workplace response. On one hand, this has been beneficial as it now provides program implementers with a robust implementation approaches from which insights can be drawn as to what works and what does not. However, the learnings are unconsolidated, and therefore cannot be used to redesign and re-program the national strategy for workplace HIV response.

At the same time, workplace-based HIV programs are often not regularly offered and are hardly sustained. Even with currently active programs, there are no evident sustainability mechanisms in place that neither ensures a scale up nor longer-term implementation.

HIV and AIDS as a workplace issue struggles to capture attention amidst other labor and workplace concerns, coupled by the employers' and workers' limited capability to facilitate, and equally limited capacity to absorb the requirements of funding and sustaining HIV interventions at the workplace, despite being required by the law.

Overall, the workplace HIV programs are sparse and scattered, hardly consolidated by any overarching strategy that dictates where scarce resources — of NGAs, LGUs, and traditional and non-traditional actors, alike — must be directed to ensure the attainment of the most significant impacts with the least amount of resources possible.

Even when strong partnerships have been forged, the absorptive capacity will always be limited, so that there will be need to prioritize workplace programs to focus on sectors / industries / geographies where KAPs can be most likely captured, particularly where young workers and migrant workers are employed.

It may be more strategic to identify priority industries and sectors. After all, even the ILO[13] has pointed out that workers may be at different levels of risks for contracting HIV, based on the following factors:

> Factors that increase the risk of infection for certain groups of workers. Certain types of work situations are more susceptible to the risk of infection than others although the main issue is one of behaviour, not occupation. The following is an indicative list:
> – work involving mobility, in particular the obligation to travel regularly and live away from spouses and partners;
> – work in geographically isolated environments with limited social interaction and limited health facilities;
> – single-sex working and living arrangements among men;
> – situations where the worker cannot control protection against infection;
> – work that is dominated by men, where women are in a small minority;
> – work involving occupational risks such as contact with human blood, blood products and other body fluids, needle-stick injury and infected blood exposure, where Universal Precautions are not followed and/or equipment is inadequate.

*Strengths and opportunities in linking with LGUs*

Currently, there are a number of factors that put DOLE at a disadvantaged position in effectively driving the workplace response, particularly where LGUs and policies that emanate from the LGUs are concerned. Issues relative to this point are summarized and discussed further below:

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[13] "Factors that increase the risk of infection of certain groups of workers" ILO Code of Practice on HIV and AIDS, Appendix 1

- DOLE has not constant presence in local HIV initiatives.
- The workplace is hardly recognized as a potent entry point for HIV and AIDS interventions.
- The workplace strategy is hardly reflected in the local ordinances.
- Not all of the essential policies, as put forth by the DOLE DO 102-10, ILO Recommendation, 2010 (No. 200) and the ILO Code of Practice are thoroughly covered in the local policies. By far, Quezon City has issued the first and only local HIV and AIDS ordinance that is centered on the workplace response.
- Essential provisions concerning the workplace, other than the 10 key principles as promoted by the ILO, some of which have already been passed as labor requirements through the DOLE DO 102-10, are either not at all reflected or only partially provided for in local ordinances. Anyhow, even the DOLE DO 102-10 needs to be updated for completeness and recency of information contained therein.
- The roles and responsibilities for the LGU counterpart of DOLE, the Public Employment Service Office (PESO), is not readily recognized as a strategic partner in the LGU response to HIV and AIDS. In fact, the Pasay City AIDS Council Resolution No. 1 appoints the Tourism Officer as the focal point for workplace HIV and AIDS education. The DOLE, in this context, misses the opportunity to exercise influence over the workplace initiatives of the Pasay City AIDS Council. Despite LGUs being autonomous, and given the limited control that DILG can exercise over LGUs, DOLE may have to explore direct partnerships with key LGUs affected by HIV and AIDS, so that the Department may find a strategic role in driving LGU responses on HIV that affect workplaces and workplace actors.

  Another possible DOLE representative for LGU initiative on HIV and AIDS are the Labor Law Compliance Officers and DOLE officers present in its Regional Offices.

Previous LGU level consultations[14] have revealed that employers / local enterprises are more keen on complying with local laws and regulations than with national laws since local compliance automatically affects their operations, particularly in the issuance of required permits and licenses to operate their businesses. The workplace HIV response must tap on the regulatory functions of LGUs, making partnering with the LGUs inevitable and critical to romp up the workplace response. DOLE may focus its partnerships with the LGUs to advocate on the following:

- Consideration of the workplace requirements and the proper language of labor in local ordinances on HIV and AIDS, more specifically for provisions that involve the workplace response and in requiring establishments to comply with workplace requirements concerning HIV and AIDS policies and programs.
- Push for the LGUs to provide for penalties and sanctions for non-compliance to DOLE DO 102-10 or a parallel local policy that involves the issuance of business permits and workers' permits. Another possibility is in requiring the attendance of management and workers to compulsory HIV orientations for the renewal of business and workers' permits and other licenses.
- Including discussion of requirements of DOLE DO 102-10 or a parallel local policy in mandatory courses on HIV and AIDS
- the greater involvement of PESO managers and officers in Local AIDS Councils
- the replication of QC SP-2210, S-2013 (Anti-Discrimination on persons perceived or suspected or having found to be positively infected with HIV in workplaces) in other key cities characterized both as major business districts and cities highly burdened by HIV
- Expand regulatory function by involving the LGU's Business Permits and Licensing Office (BPLO) to ensure that penalties involving suspension or revocation of business permit to operate are fairly served when violations to the Ordinance are committed. Also, the BPLO may be tapped by DOLE to consider the criteria for establishment's compliance to DOLE DO 102-10 and / or a parallel local policy, similar to the criteria used by the BWC in its compliance surveys.

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[14] Consultations conducted in NCR, Cebu City and Davao City which included local employers and local chambers as participants completed in 2013 as inputs to the then planned ILO-WHO Joint Programme on HIV and AIDS.

Key informants from the LGUs have consistently pointed out their limited capability to reach the business sector. When the strength of the LGU to provide HIV services, and the strength of the DOLE to tap industries and individual business establishments are combined, both parties will be able to extend and expand workplace coverage.

- LGUs currently experience difficulties in tapping business establishments. Workplace actors, on the other hand, can provide the entry points.

- Business establishments trust non-government entities, including NGOs, more than the government but the DOLE and, most especially, the LGUs have more to offer than any workplace actor-led response. LGUs are capable of providing awareness and training programs on HIV that range from HIV 101 to VCCT Counselling. Moreover, LGUs have the resources to provide onsite VCCT to companies who want to offer such services during onsite HIV 101 engagements. LGUs receive HIV logistics from the DOH and are mandated to provide HIV services for free to anybody who may need these, regardless of whether or not a person's place of residence is within the jurisdiction of the LGU approached to provide HIV services.

- Entertainment establishments are workplaces, nonetheless, relatively less attention is being bestowed on it by the DOLE, and somehow, the regulation of enterprises and workers in this sector has become the primary responsibility of LGUs, particularly in relation with the Sanitation Code of the Philippines but also, due to the tone carried by local AIDS ordinances that give special focus to these types of workplaces. Given the strong thrust of the LGUs in regulating entertainment establishments, as workers in these sectors are considered to be among populations at higher risk for HIV, partnering with LGUs will provide DOLE with an entry point to make significant contributions to the health and welfare of workers employed in this sector.

An ILO study[15] revealed that workers trust medical professionals when discussing HIV matters. Medical professionals at the LGUs are better informed of the rigors of RA 8504 and receive regular training and information updates. Thus, making them better able to provide sound health and practical advice to workers and employers who need to be better informed about HIV. Perhaps, the DOLE can work with the DOH to include employment-related rights into the basic HIV modules provided to LGU-based professionals so that they may be in a better position to provide basic information during counselling.

[15] ILO Baseline Study for Project CHANGE. Manila: 2012

# WORKPLACE RESPONSES: CASES

In this section, we present experiences of workplace actors in setting up and in implementing HIV and AIDS policies and program in workplace settings. The first is a government-led initiative with a leading and fast growing industry association. The next two are management-led inititatives of two prominent local companies, both with multi-country presence and both globally renowned for their HIV and AIDS efforts.

**Case Study 1: DOLE and IT-Business Process Association of the Philippines**

*Background on the DOLE-IBPAP Partnership*

In 2014, the DOLE hosted a forum with the IT-BPO industry players. One of the areas identified where labor compliance of companies belonging to the industry is low was in the area of Occupational Safety and Health (OSH). To improve compliance, the DOLE was requested to conduct awareness raising activities, while the companies that signed up agreed to undergo a voluntary joint assessment following their participation in OSH orientations that followed.

These two primary agreements were formalized through a Memorandum of Agreement signed by the DOLE Secretary and the IBPAP President. The parties agreed to conduct the activities beginning in April 2014 and completed these by December 2015.

*Actions taken*

The parties formed a Technical Working Committee (TWC) for the immediate implementation of the action plans. The activities included orientation sessions and subsequent refresher courses on general labor and occupational safety and health laws module for IT-BPMs were provided to business leads, human resource personnel, and safety officers of IBPAP member-companies. The 4-hour activity also discussed the alternative dispute resolution system using industry-specific situational cases.

A total of 6 batches of orientation courses covering 152 member-companies of IBPAP have been conducted since June 2014.

To promote voluntary compliance of IT-BPO companies to General Labor Standards (GLS) and OSH, a Joint Assessment was carried out by the parties after the orientations and seminars have been concluded. The results of the Joint Assessment now serves as the baseline from which future compliance monitoring activities will be compared against to determine progress against a set of indicators.

*Results and impact*

1. Orientation Sessions on Labor Laws Compliance System (LLCS) conducted

| Date of Orientation | Number of Participants | Number of Companies |
|---|---|---|
| June 23, 2014 | 58 | 34 |
| August 11, 2014 | 72 | 41 |
| September 8, 2014 | 50 | 26 |
| October 20, 2014 | 41 | 21 |
| November 17, 2014 | 35 | 19 |
| February 16, 2015 | 16 | 11 |
| **Total** | **272** | **152** |

Topics Discussed During the Orientation Sessions on LLCS:

1. Salient provisions in the OSHS applicable to IT-BPM industry
    1.1. Provision of adequate numbers of accredited Safety Officers
    1.2. Formulation of Safety and Health Committees
    1.3. Training and accreditation of personnel in OSH
    1.4. Notification and keeping of records of accidents and/or occupational illnesses
    1.5. Reportorial requirements to DOLE Regional Offices
    1.6. Formulation of OSH policies and programs

2. Pertinent DOLE issuances on OSH applicable to IT-BPM industry
    2.1. DO 56-03: Guidelines for the Implementation of a Drug-Free Workplace Policies and Programs for the Private Sector
    2.2. DO 73-05: Guidelines for the Implementation of Policy and Program on Tuberculosis (TB) Prevention and Control in the Workplace
    2.3. DO 102-10: Guidelines for the Implementation of HIV and AIDS Prevention and Control in the Workplace Program
    2.4. DA 05-10: Guidelines for the Implementation of a Workplace Policy and Program on Hepatitis B
    2.5. DC 01-08: Policy Guidelines Governing the Occupational Safety and Health of Workers in the Call Center Industry
    2.6. DO 119-12: Rules Implementing Republic Act 10151, "An Act Allowing the Employment of Night Workers Thereby Repealing Articles 130 and 131 of Presidential Decree 442, as Amended, otherwise known as the Labor Code of the Philippines"

Refresher courses on GLS and OSHS are currently being undertaken.

| Date of Refresher Course | Topic | Number of Participants | Number of Companies |
|---|---|---|---|
| October 27, 2015 | OSHS | 60 | 39 |
| January 2016 | GLS | - | - |

The Joint Assessment that ensued showed that 197 of 249 IT-BPAP member companies were able to undergo and complete the assessment. Of whom, 55 have been bestowed with Certificates of Compliance.

*Lessons Learned*

The partnership redounded to quick wins both on the part of DOLE and IBPAP. Consequently, the compliance rates were raised while areas of improvement on the part of participating companies were highlighted for their immediate action and improvements. Given the success of this sectoral agreement, the DOLE shall explore similar partnerships with other industry associations. It is emphasized that a more holistic workplace health promotion program is favored over a stand-alone HIV intervention.

**Case Study 2: Alliance of Labor Unions**

*Organizational Background*

The Associated Labor Unions was established in 1954. It has been hence organizing unions in various industries both in the private and public sector workers, formal and informal. ALU is the biggest affiliate of the Trade Union Congress of the Philippines and the largest labor federation in the Philippines with the most number of Collective Bargaining Agreements. Aside from servicing

our union members with trade union rights, the ALU helps its union members with medical, dental, legal, and financial needs through our offices from the national headquarters located in Quezon City and through its regional offices and buildings located in Luzon, East and Western Visayas, Western and Southern Mindanao.

The ALU has 200 regular staff to service its union members nationwide. Aside from these, the ALU also has strong advocacies on economic and political issues through its advocacies on general labor standards such wages, security of tenure, and occupational safety and health standards by engaging the executive, legislative and judiciary branches of government through bipartite, tripartite and multi-partite dialogue.

*How the need for a workplace HIV and AIDS policy and program was identified*

The need for workplace HIV and AIDS policy and program was identified through regular interface with our members through the ALU policy advocacy officers, its education and information division.

The initiative began two years ago, as a direct outcome of ALU's representation and regular participation in PNAC meetings and activities. ALU made a proposal to PNAC for the conduct of HIV and AIDS 101 to ALU unions. The proposal was borne out of the union's motivation to better inform and educate union members who mostly did not know what HIV is and how it can be contracted. The PNAC approved the proposal and linked up ALU with Pilipinas Shell Foundation, Inc. (PSFI) which is recognized to have a strong advocacy on the issue.

PSFI first conducted an HIV and AIDS 101 orientation for national office staff, where a number of observations about the training were also cited, from which the training module Used by PSFI was revised accordingly.

A follow up session was conducted for some 200 ALU union members at the enterprise level for a company located in Parañaque. PSFI was again engaged to conduct similar seminars and workshops for ALU union members based in Cebu, Davao and Cagayan de Oro.

In time for the World AIDS Day 2015, another round of HIV Orientation was conducted, again with PSFI facilitating, this time targeting the ALU YOUTH union members. A total of 283 workers were reached; 52 of whom volunteered to take VCT onsite.

*Actions taken*

"Most of the HIV activities that we conduct are seminar-type or brown bag discussions," ALU Policy Advocacy Officer Alan Tanjusay. "We make sure that union members are aware of how they can access testing, treatment, care and support services from qualified institutitions."

He describes that such activities compel their members to coordinate the activity with employers. "We have also been inviting employers to participate in HIV 101 sessions but, none have participated by far," he adds.

*Results and Impacts*

Central Office: 293
Cebu: 50
Cagayan de Oro: 100
ALU YOUTH: 283

*Lessons Learned*

"With PNAC and Shell Foundation as our technical partners, ALU is in-charge of coordination and communication with the union members as participants," says Mr. Tanjusay.

Asked if workers' groups are better trained as trainers or educators themselves, Mr. Tanjusay says, "I think our current arrangements are working out quite well. ALU can focus on facilitating coverage and reach. Besides, our union officers and members have their own limitations when it comes to giving them the responsibility to cascade learnings to other union members. For one, they have limited union leaves. Unions also have limited resources to allocate so we appreciate that PNAC and PSFI can facilitate such trainings for us for free."

"Educating the workers comes with inherent advantages — not only are they participating because they believe that these kinds of trainings will further strengthen the union but also, they can become agents for disseminating this very important information about HIV and AIDS to family members and others in their communities."

"Reaching employers must also be given the same emphasis as they are in a much better position to help broaden the coverage and reach of the workplace response. For instance, employers can compel workers to attend HIV orientations." He adds, "employers, including HR officers must equally be informed so that a practical, operational workplace HIV and AIDS program may be instituted".

**Case Study 3: Standard Chartered Bank**

*Company Background*

Standard Chartered Bank opened its office in the Philippines in 1872 and now employ more than 500 staff. It is the oldest international bank operating in the Philippines and one of the first to launch premium currency investments onshore.

The Bank's business has built a solid track record as leaders in client-focused services, offering a wide range of tailored solutions for our global and local corporate.

*How the need for a workplace HIV and AIDS policy and program was identified*

Standard Chartered Bank had a strong presence in Africa where HIV and AIDS took a toll on the lives of thousands when the infection began to spread in the 1980s. The Bank, thus, took much interest and were concerned with the welfare of their employees and residents of the communities where it had presence.

Following the findings of a global study commissioned by the Bank in 1999 which recommended that educating workers on HIV is a key prevention strategy, the Bank launched a Global Policy on HIV and AIDS.

*Actions taken*

By 2003, Standard Chartered Bank offices worlwide, including its Philippines firm, have adopted the Global Policy on HIV and AIDS in their respective local settings.

The Bank launched its global HIV Program, "Living with HIV", and with it, a training module which aims to raise employees' awareness of the infection and how they can avoid becoming infected. The Program required all local member firms to set targets and commitments to contribute to the global workplace program on HIV and AIDS — Philippines included.

Each country was also required to nominate an HIV Champion. Currently, in the Philippines, the title is held by Corporate Social Responsibility Manager Anna Marie dela Torre.

What began as an internal HIV and AIDS workplace education program, quickly became a CSR program for the Bank which, soon enough, also became a regular offering for external partners consisting of other private enterprises and non-government organizations.

Today, the Bank has tagged their program, "Positive Living" to emphasize that people living with HIV may continue to be active, productive, and proactive about their status.

"As we progressed with implementation, we also began to strategize our targets. Recently, we have teamed up with the Philippine Financial Industry Pride (PFIP) to conduct trainings on HIV 101 and Trainers' Training for other financial institutions." PFIP is a newly established LGBT group of workers infected and affected by HIV who are employed in various financial institutions in the country.

The Bank has also been involved in the local staging of "The Normal Heart," a play that highlights the spread of HIV and the real, humanly difficulties of avoiding infection. The Bank sponsored the play in partnership with its employees, clients, other financial institutions and NGOs.

*Lessons Learned*

"It's not easy to run a workplace HIV and AIDS Program. It's difficult to get companies onboard and open their doors, even with a program such as ours that we give free of charge. It is likewise challenging to keep people's attention glued on the subject during HIV training sessions. People still feel that HIV is so remote and doubt that they can ever get infected."

"I think though that slowly, the times are changing. We're getting more interest now and people are more receptive yet, more work needs to be done."

Asked what else Ms. dela Torre would like to accomplish with Standard Chartered Bank's HIV Program, she responded, "Our current CEO formerly headed the Business Coalition on HIV and AIDS in Sri Lanka. I know that he is very much interested to head a similar organization here and I want to see him do because there are significant contributions that he can make."

**Case Study 4: Shell companies in the Philippines and Pilipinas Shell Foundation, Inc.**

*Company Background*

The Shell companies in the Philippines (SciP) started its operations in the Philippines in 1914. Since then, the company has been closely coordinating with communities adjacent to its worksites and involved in social, political and environmental issues faced by locals. In 1982, owing to SciP's desire to make more strategic contributions to society, the Pilipinas Shell Foundation, Inc. (PSFI) was founded and registered as a non-stock, non-profit organization. To this day, PSFI serves as the social development arm of SciP.

*How the need for a workplace HIV and AIDS policy and program was identified*

Following the findings of a global business case study commissioned by Shell around the benefits of instituting a workplace program on HIV and AIDS, the Royal Dutch Shell International issued a Directive outlining the company's global policies concerning HIV and AIDS in the workplace. The salient points include the following:

- confidentiality of HIV results and related medical records;
- non-compulsory HIV testing to workers and prospective employees from pre-employment, employment and post-employment;
- non-discrimination in employment, promotion, benefits and other emoluments of workers living with HIV;

- inclusion of confidential and voluntary HIV testing, and treatment including full provision of antiretrovirals in medical benefits;
- extension of reasonable accommodation to infected and affected workers; and,
- dissemination of information on HIV and AIDS prevention in the workplace.

*Actions taken*

SciP issued a local policy to reflect the same principles in [YEAR].

When at least two new cases of HIV was being reported to the Philippine HIV and AIDS Registry everyday in 2009, successive meetings as to how the workplace response can be improved took place between Pilipinas Shell Foundation, Inc., International Labour Organization, UNAIDS, UN Development Program, Philippine Business for Social Progress, and the Philippine National AIDS Council. It was then that the Philippine Business Sector Response to HIV and AIDS (PBSR) was formed.

SciP and PSFI rendered full support to PBSR.

The founding of PBSR sent the workplace response rolling beginning with CEO Forums convened by SciP Country Chair Edgar Chua; development of HIV and AIDS training curriculum and instruction for private sector companies; trainings conducted for other companies on HIV 101, peer education, training of trainers, and counselling; and, periodic follow through meetings with companies engaged.

What started out as a company's motivation to support the HIV and AIDS response has now become more strategic and robust. PSFI now sits in four Local AIDS Councils (LAC) — Quezon City, Makati City, Pasay City, and Caloocan City— and a partner of one—Manila. LACs have been mandated by the Department of Interior and Local Government (DILG) to be the lead strategy and planning body to address HIV and AIDS at the local government unit level. By becoming a member of LACs, the PBSR is in a better position to elevate concerns and issues in the workplace response, while influencing the LGUs' workplace outreach strategies as well.

In 2015, PBSR also adopted a new strategy in reaching workplaces. Every workplace reached is now provided HIV 101 and free VCT. The partnerships that PBSR has forged with the LGUs have been beneficial in this significant change in strategy, particularly in making possible mobile VCT services in worksites of partner companies.

Another significant change is the more focused attention and additional resources being poured into Palawan by SciP and PSFI. Palawan hosts Malampaya, the country's largest natural gas plant which supplies over a third of the country's power demand. Based on the latest IHBSS results, from a Category B, Palawan is now a Category A province and registered the second highest percentage increase in new HIV cases.

PSFI continues to be the lead convenor of PBSR.

*Results and Impacts*

PSFI and its growing network of partners have reached out to close to 100 companies. Of whom, PSFI has supported 23 companies in drafting their workplace policies and programs on HIV and AIDS based on the template developed by ILO under Project CHANGE.

This year alone, 1,529 workers have availed of onsite HIV testing; all of whom are informed of their test results. At least 21 have been confirmed positive for HIV; ages range from 21 to 29 years old. All 21 have been provided post-test counselling. These results have been made possible through referral to Treatment Hubs, and the very able management of Social Hygiene Clinics.

In commemoration of World AIDS Day 2015, PBSR forged a partnership with the Alliance of Labor Unions (ALU) which made possible the conduct of HIV 101 to an additional 283 workers; 52 of whom volunteered to be tested for HIV onsite.

*Lessons Learned*

HIV Project Coordinator Julius Elopre points out that the program draws strength from the solid backing of Shell and PSFI management for the program, and the personal knowledge of coordinators like himself in providing HIV101 and VCT Counseling.

The significant partnerships that it has forged has also further strengthened the program and rendered it more valuable to the workplace response. "We are able to help LGUs reach workplaces which are often unresponsive to their calls. On the other hand, we are able to inform workers and employers of the free HIV testing available at City Health Offices and Social Hygiene Clinics."

"Overall, we and our partners see that by pulling our resources together, we are able to do more at a much lesser cost."

Admirable as it is, the possible greater impact of the program is currently being tied down to modest results due to limited resources, including human resources who can only exert so much effort to reach the workplaces. As such, the sustainability of the program, including those of the companies the program was able to reach are threatened and need to be addressed.

"Most companies are only after compliance with DOLE, and some, LGU requirements. It will be ideal if the companies can build and sustain internal capability to conduct HIV 101. However, it may still be more convenient, and perhaps more sustainable, for companies to be able to tap another group to conduct the trainings and information dissemination." He also suggests for a referral mechanism to be put in place so that all private workplaces can follow a common protocol for any of the full spectrum of HIV and AIDS services, and supporting their workers as well in accessing specific services.

**Case Study 5: Pinoy Plus**

*Organizational Background*

Pinoy Plus Association Inc. (PPA+), is the pioneer organization of People Living with HIV (PLHIV) in the Philippines established on 24 November 1994. It is a support group dedicated to the welfare of PLHIVs in the country. The organization implements community-based HIV & AIDS prevention, treatment, care and support services to people infected with and affected by HIV and AIDS. The organization brings the voice of the Filipino positive community in all forums, dialogues, structures and bodies, and networks at all levels.

*How the need for a workplace HIV and AIDS policy and program was identified*

PPA+ has been implementing workplace-based HIV interventions, the most recent ones involved the following companies:

- Toyo Construction Company, the partnership was brought about by a compulsory pre-construction training for HIV and AIDS orientation which was required by the Department of Public Works and Highways (DPWH), and lately, mandated as well by the DOLE.

- Resorts Word Manila, a luxury entertainment establishment, through the Pasay City Health Department, requested PPA+ to conduct an HIV orientation which was a prerequisite for the LGU's issuance of a Health Certificate. The Pasay City Health Department also offered rapid VCT onsite.

- Kilusang Jollibee, a workers' union, reached out to PPA+ through the TUCP, in line with its recognition that all union members nationwide need to be better informed about HIV and AIDS.

- Calamba Doctors Hospital, the partnership was brought about by the hospital administration's goal of raising HIV awareness among its medical staff, which is also in line with the hospital's bid to become a Treatment Hub for HIV.

*Actions taken*

For all establishments engaged, save for Toyo Construction Company, PPA+ conducted the first batch of trainings this year, with an agreement for PPA+ to do so yearly thereafter, onsite.

All engagements called for the conduct of HIV orientations. Additional emphasis on stigma and discrimination in workplace settings was made for training conducted for the Calamba Doctors Hospital.

*Results and Impacts*

- No. of workers reached
  - Toyo Construction Company / Sta. Ana, Manila: 50
  - Toyo Construction Company / Pasig: 200
  - Resorts World Manila: 120
  - Kilusang Jollibee: 200
  - Calamba Doctors Hospital: 300

- No. of companies reached: 4 (Two worksites of Toyo Construction Company were reached)
  - Four (4)

*Lessons learned*

Compliance to DPWH and DOLE in as far as construction companies are concerned, will help sustain the workplace response among employers and workers in the construction industry.
As per attribution of PPA+, "Resorts World Manila prefers to sustain the partnership with PPA+ because of the receptiveness of the first batch of participants and their agreement that having PLHIVs as facilitators alone have greatly desensitized the audience of PLHIVs".

In all of four engagements, the PPA+ observes that many workers and employers are remotely aware of what HIV and AIDS is all about. Misconceptions as to transmission alone abound, and, thus, the need to inform and educate workers remains necessary, and ideally must be captured in a company's training / work plan.

PPA+ is looking forward to forging a partnership with PLDT, the Philippines' largest telecommunications provider, with PPA+ expected to conduct HIV awareness activities in PLDT offices nationwide.

# CONCLUSIONS AND RECOMMENDATIONS

All players involved in the workplace response, including DOLE, have limited capabilities to contribute significantly. However, when the strengths of these different institutions are combined, and the strengths of other potential partners, such as the DOH and LGUs, are added, the impact of the workplace response may snowball for it to become a major contributor in the national response to HIV and AIDS.

The workplace response has a great potential for contributing to the national targets for HIV and AIDS for the following reasons:

(1) The workplace provides access to a captive audience, and a large number of people – about 39 million people employed, half of which are employed by the Services Sector;

(2) High level of participation among target population than in non-captive population;

(3) Potentially low level of attrition since population is stable;

(4) Presence of peer support and positive peer pressure;

(5) Established channels of communication to publicize programs;

(6) Employers can offer incentives to increase participation;

(7) Provides access to those with low medical consultation rates;

(8) Dissemination of HIV and AIDS information by employees to their families and social networks, thus having indirect effect on the health of the larger community; and,

(9) Improved economic and productivity factors such as medical costs, compensation benefits, employee absenteeism, job satisfaction and productivity.

Undoubtedly, the workplace has more to offer.

The recommendations of this study are summarized and detailed in the succeeding sub-sections.

**Recommendation # 1: Set the right tone**

The local policy context for HIV and AIDS upholds the primary international labor standards. The policies remain supportive of the workplace response.

Policy remediation, however, is called for, given the current local HIV situation, changing context of the workplace response, and the renewed perception on the importance of linking back the workplace response to the community, particularly in tapping on the strengths and resources available at the level of the LGUs and that can be accessed from both national and local health delivery systems.

In addition, the workplace policy is weak in defining specifically the content that workplace actors should include in their respective workplace policies on HIV and AIDS, and the minimum requirements for a workplace program on HIV and AIDS.

DOLE DO 102-10 must be followed through with another policy instrument that defines the scope and limitations of the workplace response, and highlight the need to collaborate with external actors as well.

Based on the final results of this study, the most practical policy instrument to pursue is a Departmental Advisory.

**Recommendation # 2: Strengthen existing mechanisms to better orchestrate the workplace response to HIV and AIDS**

The workplace needs the DOLE to drive the response. The DOLE, in consultation with the Inter-Agency Committee (IAC) on HIV and AIDS, needs to provide clear directions and better orchestrate the programs in order to deliver significant contributions to the national response.

The supervisory role of the DOLE to drive the workplace response will have to be reiterated, while the advisory role of the IAC will have to be redefined and reinvented for the proper guidance of all players in the workplace response. Ideally, the IAC must set priority targets, obtain commitments from all traditional and non-traditional workplace actors, including the tripartite partners, in implementing the targets, and devise a mechanism by which everybody is accountable for the results and contributions of the workplace response in relation to the national strategy on HIV and AIDS.

The DOLE will necessarily have to link back to the DOH as the government agency mandated to provide overall oversight to RA 8504 implementation. This ensures that the workplace response never acts or is never perceived to be acting in isolation from the rest of the national response. As such, the DOLE and the IAC are also kept abreast with developments in the national response and the potential partnerships which can be forged by IAC members with other local, national and multilateral organizations involved in the HIV response.

**Recommendation # 3: Learn from experiences and focus on achieving impact.**

Overall, the workplace response is weak in the following areas that directly impact the quality and results of the workplace response to HIV and AIDS:

1. There is no one clear strategy that defines the directions of the workplace response, to which all other players — both traditional and non-traditional workplace actors — can align to in implementing their respective activities contributory to the national workplace response, and to which they can be jointly accountable for results. On the other hand, even if such a strategy existed, there is no form of policy which the DOLE can issue that will stop players from doing the things that they are already doing or, that will compel them to align with the national workplace strategy.

2. In many ways, the workplace response has been operating in isolation and independently from the national response. This fact has limited the reach and capability of workplace actors to reach more workers, employers and workplaces.

3. Failure of the national workplace response to periodically gather its actors and to consistently focus on specific targets have led to workplace activities being sparsed and unaccounted for.

Based on the rapid assessment of programs being implemented currently by key players, the following are recommended:

1. Certain standards will have to be set as to the content of information dissemination and training delivered to workplace actors. All players will be requested to adhere to such standards, and perhaps even be requested to participate in a training to be provided by DOLE so as to ensure that relevant labor policies and other related information are covered during engagement with employers and workers.

2. Indicators and targets to gauge the overall performance of the workplace response will have to be set and agreed to at the level of the Inter-Agency Committee on HIV and AIDS (IAC).

3. Workplace response must become more agressive in building partnerships that will help scale up the response, without necessarily having to individually conduct activities for each company or workplace.

4. The DOLE-OSHC, as the lead agency responsible for coordinating and rolling out the workplace response must come up with a sound and practical strategy to scale up and simplify the response.

5. Raise the accountability of all players in the workplace response.

Tripartite partners, apart from the DOLE, must shift from a largely trainer and service provider role into a more facilitative function.

In general, the workplace response must rationalize information and education activities to veer away from highly specialized and technical content. This can be achieved by setting the core message of the workplace response for workplace actors, and determining the right channels and media to reach them.

On the contrary, more emphasis must be put towards strengthening referral mechanisms, including linkages with health and other support systems. Through which, more detailed and more technical information may be made available to those who need them, including KAPs from workers' and employers' groups. Also, referral to other HIV services, particularly testing, treatment, care and support, which mostly cannot be covered by workplace settings, will help ensure access for workers and employers who may need to access these services or need more in-depth information about HIV and AIDS.

There are four key areas where DOLE and other players in the workplace response can contribute the most, which builds on the strengths inherent to the workplace and the long-established tripartite mechanism:

Component 1: Policy Development and Standards Setting. While the DOLE DO 102-10 has clearly identified workplace policies and standards on HIV and AIDS, this may be taken further by clearly defining the scope of workplace policies and programs, such that employers and workers are guided as to the:

- key principles as per ILO Code of Practice on HIV and AIDS that should be incorporated in all workplace policies on HIV and AIDS;
- minimum workplace program on HIV and AIDS
- minimum HIV services / list of services that must be provided to all workplaces to ensure that referral services and information on other service providers may be readily made available to workplace actors
- minimum requirements for all training activities
- minimum requirements for all information dissemination activities

## Insights

Dr. Gerard Belimac, Program Manager, Department of Health—National AIDS/STD Prevention and Control Program:

On building a partnership between DOH and DOLE:

"DOH has forged a highly effective partnership with DSWD. Perhaps we should expand it to make a three-way partnership with DOLE, which will primarily be focused on providing livelihood support to PLHIVs and disseminating prevention information to the general population, including workplaces."

On sustaining prevention interventions, primarily VCT, in workplace settings:

"We have to provide workers with options where they can access VCT. For now, we can point them to Government facilities and hospitals and DOH-accredited VCT clinics. I hope to see VCT more and more available through company Annual Physical Exams."

On recommendations on the future directions of the workplace response:

"I think that the workplace response has become rather complicated. We should review and simplify the expectations for this leg of the response. Similarly, we should simplify HIV education in the workplace to focus on prevention information and favor a behavioral rather than a medical approach. We should keep in mind that the workplace response requires a general population intervention, and it is just the first step for us to reach KAPs. "

"HIV should be re-integrated in workplace health promotion programs."

"The indicators and metrics to measure the accomplishments of the workplace response is also best standardized so that we have a way to tell if the response is progressing. However, we should keep the measures simple and realistic.

"We have to find more ways to link and reintegrate the workplace response with the rest of the national response programs."

- standard Knowledge, Attitude, Practice and Behavior (KAPB) survey for all recipients of HIV trainings conducted in workplaces

Component 2: Advocacy and Partnerships Promotion — The workplace response should look within the tripartite structure to build on its facilitative function; and, look back to the community to makeup for limitations inherent to the workplace and to the capability of the tripartite partners, workers and employers in implementing the workplace response to HIV and AIDS. The DOLE and the IAC must build stronger partnerships and coordinative mechanisms with the DOH and LGUs.

Component 3: Capacity-Building for partners in the workplace HIV and AIDS response — This will involve short orientations with various partners to ensure that the policies and standards developed under Component 1 are properly disseminated and well understood by both traditional and non-traditional workplace actors.

Component 4: Generation of strategic information, knowledge management, and communication activities. Activities geared towards devising technical tools, creating communication materials, and creating a web-based platform where HIV information and services may be promoted to cater to the needs of workers and employers will be pursued under this Component.

Activities under this component will be implemented to favor co-implementation with mandated agencies, such as the DOH and PNAC — particularly in making available updated directories of HIV services providers which workplace actors will be able to easily access anytime; and, BWC — particularly in generating information to inform the strategy and accomplisments of the workplace response.

Under this component too, the workers' and employers' need to independently access information about HIV and AIDS will be addressed, and will favor the creation of online based platforms and social media to reach more workplace actors.

**Insights**

Dr. Jojo Feliciano, OIC, Philippine National AIDS Council

On recommendations on the future directions of the workplace response:

"Perhaps a partnership among DOH, the labor sector and the PIA is timely. We should start looking at a more holistic communication campaign again for the general public, the information from which will be taken and disseminated to workplaces via the DOLE."

"It is important to set the metrics right so we have a way to gauge what the impact of various workplace interventions are. In this area, the entire national response, not just the labor sector, needs to do more work."

**Recommendation # 4: Strategize to win the war against HIV and AIDS**

Both traditional and non-traditional workplace actors need to drive at a common goal and be accountable to the same measures; in no way will an open-ended intervention be beneficial to the workplace response and impactful to the national response. The status quo implementation of workplace-based interventions need to be revamped to favor better orchestration for more significant impacts to be made, and to incorporate practical monitoring indicators and tools to better capture results reportable at the national level.

The workplace response has to focus on two primary objectives:

Objective 1: To conduct general population HIV and AIDS intervention strategies in key sectors / industries / geographies, particularly where KAPs will likely be found and particularly including young workers and migrant workers. The DOLE and the IAC needs to take advantage of the workplace's captive population in capturing KAPs for further, more targeted interventions to be made. The approaches will have to be adjusted based on the demographics and preferences of targeted audience, that is face-to-face interventions will work for some, while online information will work more effectively for others.

Objective 2: To promote the creation of stigma-free workplace environments, and uphold the employment-related rights of workers infected and affected by HIV and AIDS.

Reaching more workers more effectively and more efficiently requires carefully thinking out a viable and practical strategy. Consider the following:

1. Only 1% of workers are employed by medium and large scale enterprises; 99% are employed by micro and small establishments. This means that while the current, most predominant approach of working with large establishments, is contributing to the workplace response to HIV, the results will continue to barely scratch the surface of the problem if the strategy for reaching more employers and workers stays the same.

   The DOLE and the IAC therefore will have to start exploring other approaches in raising the reach and impact of the HIV response among workers and employers. Simultaneously, alternative means of delivering prevention and referral information and messages targeting workers and employers, including social media, will have to be tapped too.

2. Services Sector (comprised of Sectors G to S) employ 71.6% of workers. The workplace response therefore will benefit from targeting to reach employers and workers belonging to these sectors. DOLE may have to explore forging bilateral partnerships with each of these sectors, similar to the partnership that it entered to with the IT-BPAP, if only to obtain quick wins initially, and hopefully be able to identify longer term partnerships to deliver longer term results.

3. Manufacturing Sector, which is not under the Services Sector, is the second largest employer. The DOLE and the IAC may also consider means by which to reach employers and workers belonging to this sector.

4. Identify specific workplace targets to provide focus to the response — industry specific, sector specific, location specific. DOLE and the IAC may have to make decisive targets and answer 'Where?' The players in the workplace response will have to jointly saturate a certain area / sector / industry, particularly pinpointing where KAPs are likely to be captured, while also making sure that referral systems are in place to provide more targeted information and highly specialized services for the KAPs that will be assimilated through generic workplace interventions. Without identifying specific focus areas, it will be very difficult for the workplace response to achieve any real, significant impact.

5. A large majority of HIV infections are being recorded in the National Capital Region, followed by Regions 4A, 3, 7, 6 and 11, including major cities nationwide. Geographically, this may be good areas where the workplace response should focus on.

**Recommendation # 5: Set the record straight**

Overall monitoring and evaluation of the workplace response may be improved further by:

1. Setting clear parameters to measure and record the workplace response, which all players in the workplace response will be required or expected to report to the DOLE. There is a need to build consensus over what should be monitored so that these may be consolidated by DOLE and reported back to the national response through the Philippine National AIDS Council (PNAC).

2. Consistently monitoring the same parameters over periodic time periods to allow comparisons , of enterprise compliance to DOLE DO 102-10 for example, to be made over time. This will show what progress has been made, if any, and what strategies may be working more effectively with less resources.

3. Better defining and carrying out the frequency of data gathering and reporting activities.

The DOLE, with the help of the IAC, must find a way to make accountable all groups doing some form of workplace response. A good start will be to agree on national key performance indicators,

obtain the commitments of implementers to contribute to the targets, get an indication of the level of contribution of each, and agree on monitoring and reporting mechanisms. This way, the DOLE reports submitted to PNAC may also reflect the efforts of other organizations doing some form of workplace response.

To establish accountability, simple measures must be put in place. HIV intervention programs must report on the same indicators, using common tools that make it easy for the DOLE to consolidate and report back to the DOH and PNAC as the oversight of the national HIV and AIDS response.

Similarly, the content and frequency of surveys and other studies must be reviewed for consistency across multiple reporting periods to allow for comparisons to be made so as to discern any real, significant improvements in the workplace response. Equally important is for such information to be made publicly available, most especially to inform future interventions, and traditional and non-traditional workplace actors and workplace partners.

**Recommendation # 6: Keep building strategic partnerships**

DOLE and the IAC must forge stronger partnerships with the DOH and LGUs.

1. The capability of the DOH and LGU to deliver HIV and AIDS services are mature. The workplace need only to tap and provide them with entry points to access private workplaces.
2. Enhance the regulatory side of DOLE DO 102-10 implementation by ensuring that these are reflected in local AIDS laws or similar local policies.
3. Where majority of establishments and workers are located are areas that have been identified to be highly burdened by HIV.

Other possible game changers include:

4. Philippine Economic Zone Authority (PEZA)
5. Key industry and professional associations
6. Chambers of Commerce and Industry in key locations

*Workplace policies are robust*
*…but policy advocacy is called for*
*Workplace programs are mature*
*…but impact requires scale up*

# ANNEX A: MATRIX COMPARISON OF KEY POLICIES

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| Title | Philippine AIDS Prevention and Control Act of 1998 | Rule 1, Section 1:<br><br>Rules and Regulations Implementing the Philippine AIDS Prevention and Control Act of 1998 (RA 8504) | Guidelines for the Implementation of HIV and AIDS Prevention and Control in the Workplace Program | Rationalizing the Implementation of Family Welfare Program (FWP) in DOLE |
| Declaration of Policies | Section 2, (a): The State shall promote public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV / AIDS through a comprehensive nationwide educational and information campaign organized and conducted by the State. Such campaigns shall promote value formation and employ scientifically proven approaches, focus on the family as a basic social unit. and be carried out in all schools and training centers, workplaces, and communities. This program shall involve affected individuals and groups, including people living with HIV/AIDS. | Section 2, (a): The State shall promote public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV / AIDS through a comprehensive nationwide educational and information campaign organized and conducted by the State. Such campaigns shall promote value formation and employ scientifically proven approaches, focus on the family as a basic social unit. and be carried out in all schools and training centers, workplaces, and communities. This program shall involve affected individuals and groups, including people living with HIV/AIDS. | To strengthen the workplace response in implementing the provisions of Republic Act 8504 otherwise known as The Philippines AIDS Prevention and Control Act of 1998 and its Implementing Rules and Regulations, and the DOLE National Workplace Policy, in collaboration with the Inter-Agency Committee (IAC) on STD, HIV and AIDS in the Workplace, the following guidelines are issued to provide directions for employers, employees and program implementers in the workplace.<br><br>I. Coverage — The guideline shall apply to all workplaces and establishments in the private sector. | Section 1. Basis Pursuant to Article 134 of the Labor Code and its IRR, and in line with the Department's commitments to the 1995 International Conference on Women in Beijing, the 1999 International Conference on Population and Development Programme of Action, the Philippine Population Management Program, the Directional Plan for 2002-2004, and the Phiippine Plan for Nutrition 1999-20004, the priorities of the Family Welfare Program (FWP) are hereby modified. |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| | | | II. Formulation of Workplae Policy and Program<br><br>A. It is mandatory for all private workplaces to have a policy on HIV and AIDS and to implement a workplace program in accordance with the RA 8504 and its Implementing Rules and Regulations, the goals of the DOLE National Workplace Policy, the provisions of the Labor Code and other International Standards (e.g. ILO Code of Practice on HIV and AIDS and the World of Work). | |
| | | | B. The HIV and AIDS workplace policy and program may be a separate policy and program or integrated into existing occupational safety and health policy and programof the establishment. | |
| | | | C. There shall be collaborative efforts from the management and the workers representatives in the development and the implementation of the policy and program. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| | | | D. In establishment / workplace where there exists an organization of workers / workers union, the policy and program may be included as provisions of the Collective Bargaining Agreements. | |
| | | | E. The DOLE Inter-Agency Committee chaired by the Occupational Safety and Health Center shall assist the workplace / estbalishment in the formulation and implementation of HIV and AIDS Prevention and Control Policy and Program. The DOLE Regional Offices shall also serve as technical advisers in their respective areas on matters concerning HIV and AIDS prevention and control in the workplace. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| *Roles and Responsibilities of Employers and Workers* | | | IV. Roles and Responsibilities of Employers and Workers, A:<br><br>Employers Responsibilities<br><br>1. Each employer, together with workers / labor organizations shall develop, implement, evaluate and fund HIV and AIDS prevention and control in the workplace policy and program<br>2. Each employer, together with workers / labor organizations, company focal personnel for human resources, safety and health personnel shall address all aspects of implementing the workplace HIV and AIDS prevention and control in the workplace policy and program.<br>3. Each employer shall ensure that their company policy and program shall be made known to all workers.<br>4. Each employer shall ensure that their policy and program, is in adherence to existing government legislations and guidelines, including provision of leaves, benefits and insurance. | Section 6:<br><br>Employers' Responsibilities — Establishments employing more than 200 workers in any locality shall form a Family Welfare Committee (FWC) through the assistance of the DOLE Regional Offices. The FWC will be responsible for planning, organizing and implementing an in-plant family welfare program. The in-plant program shall focus on the 10 dimensions of the FWP.<br><br>Employers are likewise urged to provide the necessary support, assistance and resources to the Family Welfare Committee (FWC) in the conduct of capacity building activities for labor and management leaders, members of the FWC, plant clinic staff (nurses, midwives, and doctors), and peer educators.<br><br>Establishments with less than 200 workers are encouraged to establish / organize a FWC and implement a family welfare program. |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| | Section 2, (b):<br>The State shall extend to every person suspected or known to be infected with HIV/ AIDS full protection of his/her human rights and civil liberties.<br><br>Towards this end, | Section 2, (b):<br>The State shall extend to every person suspected or known to be infected with HIV/ AIDS full protection of his/her human rights and civil liberties.<br><br>Towards this end, | | |
| | Section 2, (b), (1):<br><br>compulsory HIV testing shall be considered unlawful unless otherwise provided in this Act; | Section 2, (b), (1):<br><br>compulsory HIV testing shall be considered unlawful unless otherwise provided in this Act; | | |
| | Section 2, (b), (2):<br><br>the right of privacy of individuals with HIV shall be guaranteed; | Section 2, (b), (2):<br><br>the right of privacy of individuals with HIV shall be guaranteed; | | |
| | Section 2, (b), (3):<br><br>discrimination, in all forms and subtleties, against individuals with HIV or persons perceived or suspected of having HIV shall be considered inimical tot individual and national interest; and, | Section 2, (b), (3):<br><br>discrimination, in all forms and subtleties, against individuals with HIV or persons perceived or suspected of having HIV shall be considered inimical tot individual and national interest; and, | | |
| | Section 2, (b), (4):<br><br>provision of basic health and social services for individuals with hIV shall be assured. | Section 2, (b), (4):<br><br>provision of basic health and social services for individuals with hIV shall be assured. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| | Section 2, (c):<br><br>The State shall promote utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission. | Section 2, (c):<br><br>The State shall promote utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission. | | |
| | Section 2, (d):<br><br>The State shall positively address and seek to eraicate conditions that aggrravate the spread of HIV infection, including but not limited to, poverty, gender inequality, prostitution, marginalization, drug abuse and ignorance. | Section 2, (d):<br><br>The State shall positively address and seek to eradicate conditions that aggrravate the spread of HIV infection, including but not limited to, poverty, gender inequality, prostitution, marginalization, drug abuse and ignorance. | | |
| | Section 2, (e):<br><br>The State shall recognize the potential role of affected individuals in propagating vital information and educational messages about HIV/AIDS and shall utilize their experience to warn the public about the disease. | Section 2, (e):<br><br>The State shall recognize the potential role of affected individuals in propagating vital information and educational messages about HIV/AIDS and shall utilize their experience to warn the public about the disease. | | |
| | | Section 2, (f):<br><br>Consistent with the abovementioned policies and in consonance with the Philippine National HIV / AIDS Strategy, the State further recognizes that: | | |

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| | | 1. Multisectoral involvement is essential to national and local responses to HIV infection; | IV. Roles and Responsibilities of Employers and Workers<br><br>A: Employers Responsibilities<br><br>10. Each employer shall continue to improve the program by networking with government and organizations promoting HIV and AIDS prevention and control. | |
| | | 2. People should be empowered to prevent further HIV transmission. Empowerment for all Filipinos will come through access to appropriate information and resources for prevention; | | |
| | | 3. The formulation of socio-economic development policies and programs should include the consideration of the impact of HIV infection / AIDS; | | |
| | | 4. Resources should be allocated taking into consideration the unique vulnerabilities of various population groups, including children, affected by HIV / AIDS and its impact; and, | | |

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| | | 5. Continued efforts should be made to constantly improve the performance and assure the quality of HIV / AIDS related programs. | | |
| | | | | Section 2:<br><br>New Priorities of the Family Welfare Program — From its original thrust of promoting family planning, the program will shift its focus to providing family welfare services to workers. The 10 dimensions of the program which shall serve as guide to both labor and management in the implementation of programs and projects consist of the ff:<br>a. Reproductive Health and Responsible Parenthood<br>b. Education / Gender Equality<br>c. Spirituality or Value Formation<br>d. Income Generation / Livelihood / Cooperative<br>e. Medical Health Care<br>f. Nutrition<br>g. Environmental Protection, Hygiene and Sanitation<br>h. Sports and Leisure<br>i. Housing<br>j. Transportation |

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| Definition of Terms<br><br>*Note: Only terms deemed necessary for the workplace response have been selected and included here. | | Section 4. Definition of Terms<br><br>1. Acquired Immune Deficiency Syndrome (AIDS) — A condition characterized by a combination of signs and symptoms, caused by HIV contracted from another which attacks and weakens the body's immune system, making the afflicted individual susceptible to other life-threatening infections. | | |
| | | 2. AIDS Registry - The official record of the number of reported HIV positive and AIDS cases and deaths confirmed by either the Bureau of Research and Laboratories (BRL) or the Research Institute for Tropical Medicine (RITM), and reported to the National HIV Sentinel Surveillance System (NHSSS) | | |

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| | | 3. Anonymous Testing- An HIV test procedure whereby the identity of the individual being tested is protected or not known. The *unlinked anonymous* method tests blood drawn for other purposes for HIV antibodies without the subjects' knowledge and with all identifying data removed, while the *voluntary anonymous* method tests blood drawn from volunteers who have no indetifying information, except a code number which is matched with a similar code of a given test result. | | |
| | | 4. Behavioral Surveillance System (BSS) - A systematic and regular collection of information on risk behaviors and co-factors of the transmission of HIV infection among selected population groups. | | |
| | | 6 Compulsory HIV Testing — An HIV testing of a person attended by the lack of consent; lack of consent of the parent when said person is a minor or the legal guardian when the same is insane; or, use of physical force, intimidation or any other form of compulsion. | | |

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| | | 7. Discrimination — A prejudicial act of making distinctions or showing partiality in the granting of privileges, benefits or services to a person on the basis of his / her actual, perceived or suspected HIV status. | | |
| | | 8. Government Agency — Any of the various units of government, including a department, bureau, office, instrumentality or government-owned or -controlled corporation or a local government or a distinct unit therein. | | |
| | | 9. Government Office — Any major functional unit of a department or bureau, including regional offices, within the framework of the governmental organization. It also refers to any position held or occupied by individual persons, whose functions are defined by law or regulation. All establishments or offices outside this definition are considered private offices. | | |

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| | | 10. Health Worker — a person engaged in health or health-related work in hospitals, sanitaria, health infirmaries, health centers, rural health units, barangay health stations, clinics and other health-related establishments. | | |
| | | 11. High-risk Behavior — A behavior or activity which when done increases the risk of acquiring or transmitting HIV. Examples are unprotected sex with multiple partners, low condom use and sharing of intravenous needles. | | |
| | | 12. Hiring — The process of selecting an individual for a specific position or job. | | |
| | | 13. HIV / AIDS Education — The provision of information on the causes, prevention and consequences of HIV / AIDS and activities designed to assist individuals to develop the confidence and skills needed to avoid HIV / AIDS transmission, and to develop more positive attitudes towards people living with HIV / AIDS (PLWHA) | | |

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| | | 14. HIV / AIDS Monitoring — The documentation and analysis of the number and the pattern of spread and transmission of the HIV / AIDS infection and the prevention and conrtol measures directed against it. | | |
| | | 15. HIV / AIDS Prevention and Control — The program, strategies and measures aimed at protecting non-infected persons from contracting HIV and minimizing the impact of the condition of PLWHAs. | | |
| | | 16. HIV-negative — Denotes the absence of HIV or HIV antibodies upon HIV testing. | | |
| | | 17. HIV-positive — Denotes the presence of HIV infection as demonstrated by the presence of HIV or HIV antibodies upon HIV testing. | | |
| | | 18. HIV Status — Denotes whether a person who has undergone an HIV test is HIV-positive or HIV-negative. | | |
| | | 19. HIV Testing — A laboratory procedure done on an individual to determine the presence or absence of HIV infaction. | | |

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| | | 20. HIV Transission — The transfer of HIV from an infected person to an unifected one, more commonly through sexual intercourse, blood transfusion, sharing of intravenous needles or, from the mother to the fetus or infant. | | |
| | | 21. Human Immunodeficiency Virus (HIV) — The virus which causes AIDS. | | |
| | | 22. Informed Consent — The voluntary verbal or written agreement of agreement of a person to undergo or be subjected to a procedure based on full information. | | |
| | | 23. Injecting Drug Users (IDUs) — Individuals who inject prohibited or regulated drugs. | | |

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| | | 24. Medical Confidentiality — The expectation or situationof protecting and upholding the right to provacy of a person who had an HIV test or was diagnosed to have HIV. Confidentiality encompasses all information that directly or indirectly lead to the disclosure of the identity and HIV status of said person. This information includes, but is not limited to, the name,a ddress, picture, physical characteristic or any other similar identifying characteristic. | | |
| | | 25. Non-Government Organization (NGO) — A private, non-profit voluntary organization that is committed to the task of socio-economic development and established primarily for service. | | |
| | | 26. Perceived or suspected HIV status — A judgment or suspicion about the HIV status of a person which may or may not correspond with the actual HIV status. | | |

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| | | 27. Person with HIV — An individual whose HIV test indicates, directly or indirectly, that he / she is infected with HIV. | | |
| | | 28. Pre-employment to Post-employment — The continuity of employment starting from the hiring process, through employment, resignation, retirement and after retirement or resignmation of an employee. | | |
| | | 29. Pre-Test Counseling — The process of providing information on the biomedical aspects of HIV / AIDS and the possible results of the HIV test; and providing emotional support for any psychological implicationof undergoing HIV testing to an individual before he or she undergoes the HIV test. | | |
| | | 30. Post-Test Counseling — The process of providing risk-reduction information and emptional support to a person who submitted to HIV testing at the time that the test result is released. | | |

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| | | 31. Private Sector — The sector composed of non-government organizations, people's organizations, private schools and universities, business enterprises owned and operated by private individuals or groups, and other organizations and establishments which are not part of the government. | | |
| | | 32. Prophylactic — A medical agent or device used to prevent the transmission of a disease. It does not include antibiotics and vitamins. | | |
| | | | | Section 3:<br><br>Reproductive Health — shall refer to the state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and its functions and processes. Furthermore, Reproductive Health Care is defined as interventions or services to include, but are not limited to the following concerns: |

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| | | | | a) Family Planning<br>b) Maternal and Child Health and Nutrition<br>c) Prevention nad Management of Abortion and its Complications<br>d) Prevention and Management of Reproductive Tract Infections<br>e) Education and Counseling on Sexuality and Sexual Health<br>f) Breast and Reproductive Tract Cancers and other Gynecological Conditions<br>g) Men's Reproductive Heath<br>h) Adolescent and Youth Health<br>i) Violence Against Women and Children; and,<br>j) Prevention and Treatment of Infertility and Sexual Dysfunction |
| | | 33. Sexually Transmitted Disease (STD) — Any disease that is acquired or transmitted through sexual contact. | | |

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| | | 34. Standardized Basic Information — The amount of knowledge on HIV / AIDS deeme sufficient by the Department of Health, the Department of Labor and Employment, tbe Department of National Defense and teh Civil Service Commission, that enablesindividuals to take action for their own protection. It includes information on the nature of HIV / AIDS, its mode of transmission and causes. It duscusses the issues of medical confidentiality, the dignity of the person afflicted with HIV / AIDS, the rights and obligation of employers and employees towards persons with HIV / AIDS, and the particular vulnerability of women. | | |
| | | 35. Termination from work — Dismissal from work of the end of an employer-employee relationship. | | |
| | | 36. Treatment or Care — A health, psychological, spiritual or social intervention extended to a person with HIV / AIDS. | | |

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| | | 37. Voluntary HIV Testing — HIV Testing done on an individual who, after having undergone pre-test counseling, willingly submits himself / herself to said test. | | |
| | | 38. Window Period — Period of time, usually lasting from two (2) weeks to six (6) months during which an individual will test “negative” for HIV antibodies but, since the HIV is present, he / she is capable of transmitting the same. | | |

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| Education and Information | Artice I. Education and Information, Section 6:<br><br>HIV / AIDS Education in the Workplace — All government and private employees, workers, managers, and supervisors, including members of the Armed Forces of the Philippines (AFP) and the Philippine National Police (PNP), shall be provided with the standardized basic informationa and instruction on HIV / AIDS which shall include topics on confidentiaity in the workplace and attitude towards infected employees and workers. In collaboration with the Department of Health (DOH), the Secretary of the Department of Labor and Employment (DOLE) shall oversee the anti-HIV / AIDS campaign in all private companies while the Armed Forces Chief of Staff and the Director General of the PNP shall oversee the implementation of this section. | Rule 2. Education and Information. Section 5:<br><br>Nature and Scope — HIV / AIDS education and information shall consist of knowledge, skills and attitude competencies, accessible and available to all Filipinos, and targeted for the following groups:<br><br>1. Students and teachers in the primary, secondary, tertiary and vocational schools;<br>2. Health workers and their clients in the government and private offices;<br>3. Employers and employees in government and private offices;<br>4. Filipinos going abroad;<br>5. Tourists and transients;<br>6. Communities; and,<br>7. Population groups with relatively higher risk of acquiring or transmitting HIV / AIDS. | IV. Roles and Responsibilities of Employers and Workers<br><br>A: Employers Responsibilities<br><br>5. Each emplyers shall provide information, education and training on HIV and AIDS for its workforce; if not available within the estabilshment, then provide access to information.<br><br>—<br>B. Workers Responsibilities<br><br>1. Labor unions, federation, workers organization / association are required to take an active role in educating and training their members on HIV and AIDS including its prevention and control. The IEC program must also aim at promoting and practicing a healthy lifestyle with emphasis on high risk behavior and other risk factors that expose workers to increased risk of HIV infection. | Section 4:<br><br>Major Activities that can be undertaken under the FWP — The DOLE through the Bureau of Women and Young Workers (now, BWSC) and the DOLE Regional Office as well as establishments covered by this Department Order shall provide orientation-seminars on the FWP focusing on reproductive health, gender equality and nutrition. Appropriate IEC materials promoting family welfare concerns shall likewise be developed and provided. The Regional Offices shall facilitate the organization of Family Welfare Committees in establishments employing more than 200 workers.<br><br>To institutionalize the program, capability building activities shall be provided for labor and management leaders, members of Family Welfare Committeees, plant clinic staff (nurses, midwives, doctors), and peer educators. |

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| | | Section 7:<br><br>Content — THe standardized basic information on HIV / AIDS shall be the minimum content of an HIV / AIDS education and infomration offering. Additional content shall vary with the target audience.<br><br>Selection of content or topic shall be guided by the following criteria: | | |
| | | 1. Biomedical and technical information is consistent with empirical evidence of the World Health Organization, the DOH, or other recognized scientific bodies. Published research may be cited to establish the accuracy of the information presented | | |
| | | 2. Clear — The target audience readily understands the content and message. | | |
| | | 3. Concise — The content is short and simple. | | |
| | | 4. Appropriate — Content is suitable or acceptable to the target audience. | | |

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| | | 5. Gender-sensitive — Content portrays a positive image or message of the male and female sex; it is neither anti-women or anti-homosexual; | | |
| | | 6. Culture-sensitive — Content recognizes differences in folk beliefs and practices, respects these differences and integrates, as much as possible, folkways and traditions that are conducive to health. | | |
| | | 7. Affirmative — Alarmist, fear-arousing and coercive messages are avoided as these do not contribute to an atmosphere conducive to a thorough discussion of HIV / AIDS. | | |
| | | 8. Non-moralistic and non-condemnatory — Education and information materials or activities do not impose a particular moral code on the target audience and do not condemn the attitudes or behaviors of any individual or population group. | | |

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| | | 9. Non-pornographic — Content or activity informs and educates and do not titillate or arouse sexual desire. | | |
| | | Section 8:<br><br>A prototype module or instructional design shall be developed on the standardized basic information on HIV / AIDS. Additional content suitable to a selected target audience may be added on the prototype.<br><br>This HIV / AIDS education and information prototype shall include the following:<br><br>1. instructional objectives;<br>2. content or topics and recommended time allocation<br>3. teaching methods and activities;<br>4. evaluation methods and tools; and,<br>5. recommended qualifications of resource persons. | | |

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| | | Partnership and consultation shall be used in the development of the HIV / AIDS education and information prototype. THe Department of Health (DOH), through the Special HIV / AIDS Prevention and Control Service (SHAPCS) shall develop the prototype, within six (6) months from the effectivity date of this IRR, in partnership and consultation with the:<br>1. Department of Education (DepEd), Commission on Higher Education (CHED), and Technical Education and Skills Development Authority;<br>2. Philippine Information Agency;<br>3. Department of Labor and Employment;<br>4. Department of National Defense;<br>5. Department of Foreign Affairs<br>6. Department of Tourism<br>7. Department of Transportation and Communication<br>8. Civil Service Commission<br>9. Representatives of private offices and NGOs | | |

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| | | Suitability and flexibility shall be the basis for the adoption and modification of the prototype. The specific needs of each target audience for HIV / AIDS education and information shall be addressed by add-ons to the prototype.<br><br>DOH, in collaboration with its partners, shall assure the quality of the prototpe through an annual review or as often as the need arises. | | |

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| | | Section 9:<br><br>Types of HIV / AIDS Education and Information Offerings. The HIV / AIDS education and information offerings shall make appropriate use of the multimedia, namely:<br>1. Face-to-face instruction as in tutorials, classes, seminars, workships and discussion groups;<br>2. Print materials as in modules and other self-instructional materials, brochures, flyers, comic books and magazines;<br>3. Audio-visual activities and materials as in jingles, cassette tapes, radio broadcast, radio programs, film strips, VHS and beta tapes, and TV programs; and.<br>4. HIV / AIDS distance education where self-instructional materials are sent to the target audience in accordance with adult learning principles. | | |

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| | | Section 12:<br><br>Training of HIV / AIDS Education and Information Trainors and Educators — … Qualifications of the participants for the training of trainers shall include:<br>1. a health worker, teacher or individual working in the area of human resource development;<br>2. a representative of a government or private office or agency, school NGO, community or local government unit (LGU) that will offer HIV / AIDS education and information training; and<br>3. Commitment to offer and HIV / AIDS education and information training for educators.<br><br>Trainers, in turn, shall conduct the HIV / AIDS education and information training for educators at the group, organization, school and community levels or LGU levels.<br><br>Educators shall conduct the HIV / AIDS education and information offerings at the individual, group, organization, course, school and community or LGU levels. | | |

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| | | Other existing venues for the HIV / AIDS trainers and educators' training that may be considered by SHAPCS are the health profession education programs, continuing professional education programs of teh 42 nationally accredited professional organizations and the human resource development programs of the NGOs, academe and private agencies. | | |

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| | | Section 15:<br><br>HIV / AIDS Education in the Workplace — HIV / AIDS education shall be integrated in the orientation, training, continuing education and other human resource development programs of employees and employers in all government and private offices.<br><br>Each employer shall develop, implement, evaluate and fund a workplace HIV / AIDS education and information program for all their workers. The program shall include the following elements:<br>1. The HIV / AIDS education prototype and the modifications therein, that are suited to the target audience;<br>2. List of trainers and other resource persons from the same or other workplace(s);<br>3. Training schedule;<br>4. Self-learning information materials such as booklets, brochures, flyers and taoes;<br>5. Dissemination and distribution of self-learning materials; and | III. Components of the HIV and AIDS Prevention and Control Workplace Policy and Program, (A):<br><br>Advocacy, Information, Education and Training<br><br>1. All workers shall be provided with a standardized basic information and education on HIV and AIDS.<br>2. Emplyers shall be responsible for providing appropriate, accurate and updated information on HIV and AIDS. Topics for information and education activities shall include<br>a. Magnitude of HIV and AIDS Epidemic<br>b. The nature of HIV / AIDS, its modes of transmission and causes<br>c. Ways to prevent HIV infection, to include responsible sexual behavior and condom promotion and / or provision<br>d. Diagnosis, care, support and treatment of HIV and AIDS<br>e. Impact of AIDS on individual, family, community and workplace | |

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| | | | g. Salient features of national laws and policies<br>i. Republic Act 8504 or the Philippine AIDS Prevention and Control Act of 1998 and its Implementing Rules and Regulations (IRR), with emphasis on the provisions that concern workers and the workplace.<br>ii. The DOLE National HIV and AIDS Workplace Policy and its goals<br>3. Employers are encouraged to extend their HIV and AIDS advocacy, information, education adn training activities to their contractors and supply chain, workers' families, the community and other establishments, as part of their Corporate Social Responsibility (CSR) and for strengthening the multi-sectoral partnership in the prevention and control of HIV and AIDS.<br>4. The workplace education package on HIV and AIDS based on the curriculum developed by the IAC shall be used extensively to intensify the information and education drive on HIV and AIDS. The module may be expanded based on the enterprise's | |

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| | | | 5. Program implementers, occupational safety and health personnel, training officers, human resource officers, employers, workers, DOLE trainers, labor standards enforcers shall continuously receive education and training on HIV and AIDS. | |
| | | | IV. Roles and Responsibilities of Employers and Workers<br><br>B. Workers Responsibilities<br><br>6. Workers are enjoined to share information on prevention and control of HIV and AIDS to their famiities and communities. | |

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| | | Monitoring and assessmenet of the workplace HIV / AIDS education program in the private sector shall be the responsibility of the DOLE, in collaboration with the DOH. The DOLE agencies in charge shall be the Inter-Agency Committee on STD / HIV /AIDS, chaired by the Occupational Safety and Health Center of DOLE, as well as the Department's Regional Offices. The Labor Inspectorate under the DOLE Bureau of Working Condition, shall be responsible for enforcing compliance to the HIV / AIDS Workplace Program.<br><br>…Upon inspection, employers shall present records and materials of teh HIV / AIDS education and information program and related activities undertaken.<br><br>The quality of the HIV / AIDS education and information program shall be under the Collective Bargaining Agreement, the human resource development unit or its equivalent in the agency or establishment. | V. Implementation and Monitoring<br><br>A. Within the establishment, the implementation of the policy and program shall be monitored and evaluated periodically; the safety and health committee or its counterpart shall be tasked for this purpose.<br>B. The DOLE throught its regional offices, in collaboration with the DOH, DILG and LGUs shall oversee and monitor the HIV and AIDS Prevention and Control in the Workplace Program for private establishments and dissemination of information on HIV and AIDS Prevention and Control in the Workplace Program.<br>C. The OSHC, members of the IAC on HIV and AIDS and the Regional AIDS Assistance Teams (RAATs) shall provide preventive services and technical assistance in the implementation of the HIV and AIDS in the workplace program<br>D. The Bureau of Working Conditions (BWC) through the DOLE Regional Offices shall enforce this Guidelines, related to OSH Standards and other related | Section 5:<br><br>Implementing Mechanism — The DOLE, through the Bureau of Women and Young Workers (BWSC) and the DOLE Regional Office shall ensure full implementation of the Family Welfare Program in partnership with concerned government agencies, employers groups, workers organizations and the rest of civil society.<br><br>In particular, as program manager, the BWSC shall<br><br>1. Provide the technical supervision and support interventions that will enable the operating units to attain maximum program targets and objectives.<br>2. Issue a checklist of existing programs, projects and activities related to FWP implementation<br><br>As program implementers, the Regional Offices shall: |

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| | | | | 1. Coordinate activities with the regional development councils, regional population coordinating council, or other similar appropriate committee or groups to create strong linkages and convergence among various stakeholders;<br>2. Ensure the enforcement of Article 134 of the Labor Code, as amended as well as strengthen advocacy in the implementation of the Family Welfare Program; and,<br>3. Provide information and render support services on matters concerning reproductive health to the Regional Population Coordinating Council or other appropriate committee or group, which is the regional focal point in orchestrating and monitoring the implementation of the national population policy. |

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| | | | Advocacy, Information, Education and Training | |

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| Safe Practices and Procedures. | Article II. Safe Practices and Procedures, Section 13:<br><br>Guidelines on Surgical and Similar Procedures — The Department of Health (DOH), in consultation and in coordination with concerned professional organizations and hospital associations, shall issue guidelines on precautions against HIV transmission during surgical, dental, embalming, tattooing or similar procedures. The DOH shall likewise issue guidelines on the handling and disposition of cadavers, body fluids or wastes of persons known or believed to be HIV positive. The necessary protective equipment such as gloves, goggles and gown shall be made available to all physicians and health orkers and similary exposed personnel at all times | Rule 3: Safe Practices and Procedures, Section 21:<br><br>Universal Precautions — Universal Precautions is the basic standard of infection control. The underlying principle is to assume that all patients and staff are potentially infected with blood-borne pathigens such as HIV adn Hepatitis B virus. Universal Orecautions is intended to prevent transmission of infection from patient to staff, staff to staff, and patient to patient.<br><br>The procedures for Universal Precautions shall include:<br>1. Stanndard hygienic procedures, especially handwashing, should be followed at all times;<br>2. Hospital or medical center guidelines for disinfection and sterilization should be consulted and followed faithfully;<br>3. skin disease or injury should be adequately protected with gloves or impermeable dressing to avoid | IV. Roles and Responsibilities of Employers and Workers<br><br>A: Employers Responsibilities<br><br>9. Each emplyer, together with the company focal personnel for human resources and safety and health, shall provide appropriate personal protection equipment to prevent HIV exposure, especially for those handling blood and other bodily fluids.<br><br>—<br>B: Workers Responsibilities<br><br>4. Workers shall comply with universal precaution and the preventive measures. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | | 4. Any spills of blood or other potentially contaminated material should be liberally covered with household bleach…<br>5. Gown, gloves, mask and protective eyewear should be worn if possible, during surgery, childborth and othrer procedures where contact with blood or body fruids is likely.<br>6. Sharp obhects should be discarded immediately after use in pubcture-proof containers marked BIOHAZARD. Do not bend or break needles by hand. Do not recap used disposable needles.<br>7. Needles and syringes should be handled with extreme care and safely stored prior to cleaning and sterilization or disinfection'<br>8. Linen soiled with blood or other body fluids should be worn while handing soiled linen;<br>9. Specimens of blood and body substances should be | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 14:<br><br>Penalties for Unsafe Practices and Procedures — Any person who knpwingly or negligently causes another to get infected with HIV in the course of his / her profession through unsafe or unsanitary practice or procedure is liable to suffer a penalty of imprisonment for six (6) years to twelve (12) years without prejudice to the imposition of administrateive sanctions such as, but not liited to, fines and suspension or the revocation of license to practice his / her profession. The permit or license of any business entity and the accreditation of hospitals, laboratory and clinics may be cancelled or withdrawn if said establishments fail to maintain such safe practices and procedures as may be required by the guidelines to be formulated in compliance with Section 13 of this Act. | Section 25:<br><br>Penalties for Unsafe Practices and Procedures — Unsafe practices and procedures shall refer to the non-compliance with the recommended universal precautions in Section 21 of this IRR.<br><br>The penalties of an individual committing unsafe practices and procedures shall be imprisonment of six (6) to twelve (12) years, without prejudice to the imposition of administrateive sanctions such as but not limited to the following:<br>1. fines; and / or<br>2. Suspension or revocation of license to practice the profession. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| Testing, Screening and Counselling | Article III. Testing, Screening and Counseling, Section 15:<br><br>Consent as a requisite for HIV Testing — No compulsory HIV testing shall be allowed. However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV; Provided, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he / she is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual. Lawful consent to HIV testing of a donated human body, organ, tissue, or blood shall be considered having been given when:<br><br>(a) a person volunteers or freely agrees to donate his/her blood, organ, tissue for transfusion, transplantation or research;<br>(b) a person has executed a legacy in accordance with Section 3 og Republic Act No. 7170, also known as “Organi | Rule 4: Testing, Screening and Counseling, Section 26:<br><br>Consent as a Requisite for HIV Testing — A written informed consent shall be obtained before HIV testing. Said consent shall be made by the — individaul to be tested; parent of a minor; or, legal guardian of a mentally incapacitated person — except for unlinked and voluntary anonymous testing as provided for in Section 29 of the IRR. | III, C:<br><br>Diagnosis, Treatment and Referral for other services<br><br>1. If feasible, estabishments shall provide preventive, diagnostic and treatment services for sexually transmitted infections to minimize the risk of HIV infection.<br>2. If preventive, diagnostic, treatment and other health services for STI are not available in the establishment, management shall provide access to these services. A referral mechanism shall be developed for workers to access the services of the nearest social hygiene clinics, and / or private and government health service providers, and positive community / HIV support groups. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 16:<br><br>Prohibitions on Compulsory HIV Testing — Compulsory HIV testing as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stain in the country or the right to travel, the provision of medical service or any other kind of service or the continued enjoyment of said undertakings shall be deemed unlawful. | Section 27:<br><br>Prohibitions on Compulsory HIV Testing — HIV Testing shall not be imposed as a precondition for the following:<br>1. Employment<br>2. Admission to an educational institution<br>3. Exercise of freedom of abode<br>4. Entry or continued stay in the country<br>5. Right to travel<br>6. Provision of medical service or any kind of service; and.<br>7. The enjoyment of human rights and civil liberties, including the right to enter into marriage and conduct a normal family life. | III, C:<br><br>3. Voluntary Confidential Counseling and Testing (VCCT) for HIVa. Compulsory HIV Testing as a precondition to employment, and/or provision of any kind of service, is unlawful.<br>i. Management shall encourage positive health-seeking behavior which shall include VCCT.<br>ii. Management shall provide the referral procedure for VCCT and the list of service providers. | |
| | | | IV. Roles and Responsibilities of Employers and Workers<br><br>A: Employers Responsibilities<br><br>7. Each employer shall not force or condone forced disclosure of HIV status of workers. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 17:<br><br>Exception to the Prohibition on Compulsory Testing — Compulsory HIV testing may be allowed only in the following instances:<br><br>(a) When a person is charged with any of the crimes punishable under Articles 264 and 266 as amended by Republic Act No. 8353, 335 and 338 of Republic Act No. 3815, otherwise known as the "Revised Penal Code" or under Republic Act No. 7659;<br>(b) When the determination of the HIV status is necessary to resolve relevant issues under Executive Order No. 309, otherwise known as "Family Code of the Philippines"; and,<br>(c) When complying with the provisions of Republic Act No. 7170, otherwise known as the "Organ Donation Act" and Republic Act No. 7719, otherwise known as the "National Blood Services Act". | Section 28:<br><br>Exception to the Prohibition on Compulsory Testing — THe prohibition on comulsory HIV testing shall be lifted in the following instances:<br><br>Upon a court order when a person is charged with the crime specified in the following: *(shortened)*<br>*1.RA 3815 — Revised Penal Code*<br>*2.RA 8353 or the — Anti-Rape Law of 1997*<br>*3.Executive Order No. 209 (s. ) — Family Code of the Philippines* | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 18:<br><br>Anonymous HIV Testing — The State shall provide a mechanism for anonymous HIV testing and shall guarantee anonimity and medical confidentiality in the conduct of such tests. | Section 29:<br><br>Anonymous HIV Testing — Anonymous HIV Testing is a procedure whereby teh identity of the individual being tested is protected of not known. Two methods of anonymous HIV Testing are the unlinked anonymous and the voluntary anonymous.<br><br>Any person who submits to anonymous testing shall not be required to provide a name, age, adress or any other information that may potentially identify the same. In the case of voluntary anonymous HIV testing, and identifying symbol is substituted for the person's true name or identity. The symbol enabled the laboratory doing the test and the test person to match the test result with the said symbol. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 20:<br><br>Pre-test and Post-test Counselling — All testing centers, clinics, or laboratories which perform any HIV test shall be required to provide and conduct free pre-test counselling and post-test counselling for persons who avail of their HIV / AIDS testing services. However, such counselling services must be provided only by persons who meet the standards set by the DOH. | Section 31:<br><br>All individuals, centers, clinics, blood banks or laboratories offering HIV testing shall provide, free of charge, pre-test and post-test counseling for persons who avail of their HIV testing services.<br><br>Pre-test counseling shall include the following: purpose of HIV testing; other disesaes that should be tested, if applicable; window period; HIV test procedure; meaning of a negative and a positive result; guarantees of confidentiality and risk-free disclosure; when the result is available and who can receive the result; basic information on HIV / AIDS infection: nature, modes of transmission, risk behaviors and risk reduction methids; and, informed consent and prohibition of compulsory testing under most circumstances. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | | Post-Test Counseling after a positive test result shall include the following: Release of teh test result to the test person or legal guardian of a minor; assistance and emotional support to the person in coping with the positive test result; Discussion of the person's immediate concerns; review of the meaning of a posirive test result; review of HIV / AIDS infection transmission and risk reduction; explanation of the importance of seeking health care and supervision; arrangement for referral to health care and other community services and to any organization of people living with HIV / AIDS; and, assistance with the disclosure of HIV status and health condition to the spouse or sexual partner as soon as possible.<br><br>…Only health workers who had undergone HIV / AIDS counsling training shall provide pre-test and post0test counseling… | IV. Roles and Responsibilities of Employers and Workers<br><br>B: Workers Responsibilities<br><br>5. Workers living with HIV may be encouraged to inform the health care provider such as company physician, on their HIV status, that is, if their work activities may increase the risk of HIV infection and transmission or put the HIV positive at risk for aggravation. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 21:<br><br>Support for HIV Testing Centers — The Deparmtent of Health shall strategically build and enhance the capabilities for HIV testing of hospitals, clinics, laboratories, and other testing centers primarily, by ensuring the training of competent personnel who will provide such services in said testing sites. | | | |
| Health and Support Service | Article IV. Health and Support Service, Section 23:<br><br>Community-based Services — Local government units, in coordination and in cooperation with concerned government agencies, non-government organizations, persons with HIV / AIDS and groups most at risk of HIV infection shall provide community-based HIV / AIDS prevention and care services. | Section 34:<br><br>Community-Based Services — The LGUs, through its health, social welfare and population officers, in collaboration, cooperation or partnership with the following:<br>1. concerned government agencies<br>2. NGOs<br>3. organizations and establishents<br>4. People Living with HIV / AIDS; and,<br>5. other vulnerable groups | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 25:<br><br>Control of Sexually Transmitted Diseases — The Department of Health in coordination and cooperation with other concerned government agencies and non-government organizations shall pursue the prevention and control of sexually transmitted diseases to help contain the spread of HIV infection. | | | |
| | Section 26:<br><br>Insurance for Persons with HIV — The Secretary of Health, in cooperation with the COmmissioner of the Insurance COmmissiona dn other public and private insurance agencies, shall conduct a study on the feasibility and viability of setting up a package of insurance benefits and, should such study warrant it, implement an insurance coverage program for persons with HIV> The study shall be guided by the principle that access to health insurance is part of an individual's right to health and is the respoonsibility of th State and of society as a whole. | Section 37:<br><br>Insurance for Persons with HIV —…The Secretary of Health and the Commissioner of the Insurance Commission shall create a Task Force that shall oversee a study or studies on the feasibility of offering a package of insurance benefits for PLWHAs in accordance with the guiding principles of Section 26 and 39 of RA 8504.<br><br>…The PHIC shall oversee the implementation of the said insurance program. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| Confidentiality | ARTICLE VI. Confidentiality, Section 30:<br><br>Medical Confidentiality — All health professionals, medical instructors, workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of any medical record, file, data, or test results are irected to strictly observe confidentiality in the handling of all medical information, particularly the identiy and status of persons with HIV. | Rule 7. Confidentiality, Section 41:<br><br>Medical Confidentiality — Medical confidentiality shall protect and uphold the right to privacy of an individual who undergoes HIV testing or is diagnosed to have HIV. It includes safeguarding all medical records obtained by healht professionals, health instructors, co-workers, employers, recruitment agencies, insurance companies, data encoders, and other custoduans of said record, file or data.<br><br>Confidentiality shall encompass all forms of communication that directly or indirectly lead to the disclosure of information on the identitiy or health status of any person who undergoes HIV Testing or is diagnosed to have HIV. This information may include but is not limited to the name, address, picture, physical description or any other characteristic of a person which may lead to his / her identification. | III, B. Social Policy, 2:<br><br>Confidentiality<br><br>a. Access to personal data relating to a worker's HIV tatus should be bound by th eriles of confidentiality consistent with the provisions of RA 8504 and the ILO Code of Practice.<br>b. Job applicants or workers must not be asked to disclose HIV-related personal information. Co-workers must not be obliged to reveal such personal informaiton about fellow workers.<br>c. HIV / AIDS related information of workers shouls be kept strictly confidential and kept only on medical files, whereby access to information should be strictly limited to medical personnel or it legally rewuired in accordance with the provisions of RA 8504 and its IRR. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | | | IV. Roles and Responsibilities of Employers and Workers<br><br>A: Employers Responsibilities<br><br>6. Each employer shall maintain confidentiality of all information and records pertaining to HIV and AIDS status of workers.<br><br>—<br>B: Workers Responsibilities<br><br>3. Workers and workers' oranizations should not have access to personnel data relating to a workers' HIV status. The rules of confidentiality should apply in carrying out union and organization functions. | |
| | | To safeguard the confidentiality of a person's HIV / AIDS record, protocols and policies shall be adopted by concerned officials, agencies and institutions. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Exceptions to the Mandate of Confidentiality — Medical confidentiality shall not be considered breached in the following cases:<br>(a) when complying with reportorial requirments in conjunction with teh AIDSWATCH programs provided in Section 27 of this Act;<br>(b) when informing other health workers directly involved or about to be involved in the treatment or care of a person with HIV / AIDS: Provided, that such treatment or care carry the risk of HIV transmission; Provided further, that such workers shall be obliged to maintain the shared medical confidentiality;<br>(c) when responding to a subpoena duces tecum and subpoena ad testificandum issued by a Court with jurisdiction over a legal proeeding where the main issue is the HIV status of an individual: Provided, that the confidential medical record shall be properly sealed by its lawful custodian after being double-checked for accuracy by the head of the office or department, hand delivered and personally opened by the | Section 42:<br><br>Exceptions to the Mandate of Confidentiality — The rewuirement for medical confidentiality shall be waived in the following instances:<br>1. When responding to a subpoena duces tecum and subpoena ad testificandum issued by a Court with jurisdiction over a legal proeeding where the main issue is the HIV status of an individual:<br>2. When complying with the reporting requirements for AIDSWATCH as provided in Section 39 of this IRR; and,<br>3. When informing other health workers directly involved or about to be involved in the treatment or care of a person with HIV / AIDS and such treatment or care carry the risk of HIV transmission. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | | Health workers who are exposed to invasive procedures and may potentially be in contact with blood and bodily fluids likely to transmit HIV shall be informed of the HIV status of a person, even without his / her consent. This information is vital to their protection against racquiring and transmitting the HIV infecion through safe practices and procedures in accordance with Sections 21 and 24 of this IRR.<br><br>Those who are not at risk of transmission, must not be informed of a person's HIV status.<br><br>All health workers shall maintain shared medical confidentiality. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 32:<br><br>Release of HIV / AIDS Test Results — All results of HIV /AIDS testing shall be confidential and shall be released only to the following persons:<br><br>(a) the person who submitted himself / herself to such a test;<br>(b) either parent of a minor child who has been tested;<br>(c) a legal guardian in the case of insane persons or orphans;<br>(d) a person authorized to receive such results in conjunction with the AIDSWATCH program as provided in Section 27 of this Act;<br>(e) a justice of hte Court of Appeals or the Supreme Court, as provided under the subsection (c) of this Act and in accordance with the provision of Section 16 hereof. | Section 43:<br><br>The result of HIV / AIDS testing shall be confidential and shall be released only to the following:<br>1. Person who was tested;<br>2. Parent of a minor who was tested;<br>3. Legal guardian of an insane person or orphan who was tested;<br>4. Person authorized to receive said result for AIDSWATCH in accordance with Section 39 of this IRR; and / or<br>5. A judge of the Lower Court, Justice of the COurt of Appeals or Supreme Court Justice | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 33.<br><br>Penalties for Violation of Confidentiality — Any violation of medicatl confidentiality as provided in Section 30 and Section 32 of this Act shall suffer the penalty of improsonment for six (6) months to four (4) years, without prejudice to administrateive sanctions such as fines and suspension or revocation of the violator's license to practice his / her profession, as well as the cancellation or withdrawal of the license to operate any business entity and the accreditation of hospitals, laboratories and clinics. | Section 44:<br><br>Penalties for Violations of Confidentiality<br><br>Penalties for violating medical confidentiality, as provided in Sections 30 and 32 of RA 8504, include improsonment for six (6) months to four (4) years. Administrative sanctions may likewise be imposed, such as:<br>1. fines;<br>2. suspension or revocation of license to practice the profession; or,<br>3. Withdrawal of the license to operate any business entity, and the accreditation of hospitals, laboratories or clinics. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| Disciminatory Acts and Policies | Article VII. Disciminatory Acts and Policies, Section 35:<br><br>Discrimination in the Workplace — Discrimination in any form from pre-employment to post-employment, including hiring, promotion or assignment, based on actual, perceived or suspected HIV status of an individual is prohibited. Termination from work on the sole basis of actual, perceived or suspected HIV status is deemed unlawful. | Rule 8. Discriminatory Acts and Policies. Section 46:<br><br>Discrimination in the Workplace — Discrimination in any form from pre-employment to post-employment, including hiring, promotion or assignment, based on actual, perceived or suspected HIV status is prohibited.<br><br>All individuals seeking employment shall be treated equally by employers who shall not make any distinction among job applicants on the basis of their actual, perceived or suspected HIV status.<br><br>Persons with HIV / AIDS already emplyed by any public or private company shall be entitled to the same eployment rights, benefits and opportunities as other employees, namely:<br>1. Security of tenure<br>2. Reasonable alternative working arrangements, when necessary;<br>3. Social security, union, credit and other similar benefits; and,<br>4. Protection from stigma, demotion, discrimination and termination by co-workers, unions, employers and clients | III, B. Social Policy, 1:<br><br>Non-discriminatory Policy and Practices<br><br>a. Workers shall not be discriminated aggainst, from pre- to post-employment, including hiring, promotion or assignment, regardless of the HIV status, be it actual, perceived or suspected HIV infection.<br><br>—<br>III, B. Social Policy, 3:<br><br>Work Accommodation and Arrangement<br><br>a. Employers should take measures to reasonably accommodate the workers with AIDS-related illnesses.<br>b. Through agreements made between the management and workers, work accommodation measures to support workers with HIV and AIDS is encouraged through flexible leave arrangements, rescheduling of working time and | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | | Termination from work on the basis of actual, perceived or suspected HIV status is deemed unlawful.<br><br>HIV-infected employees shall act responsibly to protect their own health and prevent HIV transmission.<br><br>Acts of discrimination against any individual seeking employment or, in the course of employment, because of his / her actual, perceived or suspected HIV status, shal be reported to the DOLE by those in the private sector and tot the CSC by those in the government offices and government-owned corporations. DOLE and CSC shall resolve any such matters brought to their attention, including the implementation of administrative sanctions, as may be appropriate. | III, B. Social Policy, 1:<br><br>Non-discriminatory Policy and Practices<br><br>b. Workers shall not be terminated from work if the basis is actual, perceived or suspected HIV status. | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | | | IV. Roles and Responsibilities of Employers and Workers<br><br>A: Employers Responsibilities<br><br>8. Each employer shall ensure non-discriminatory practices in the workplace<br><br>—<br><br>B: Workers Responsibilities<br><br>2. Workers shall practice non-discriminatory acts against co-workers. | |
| | Section 39:<br><br>Exclusion from Credit and Insurance Services — All credit and loan service, including health, accident and life insurance shall not be denied to a person on the basis of his / her actual, perceived, or suspected HIV status: Provided, that the person with HIV has not concealed or misrepresented the fact to the insurance company upon application. Extension and continuation of credit and loan shall likewise not be denied solely on the basis of said health condition. | | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
|---|---|---|---|---|
| | Section 42:<br><br>Penalties for Discriminatory Acts and Policies — All discriminatory acts and poicies referred to this Act shall be punishable with a penalty of imprisonment for six (6) months to four (4) years and a fine not exceeding Ten Thousand Peson (P10,000.00). In addition, licenses / permits of schools, hospitals and other institutions found guilty for committing discriminatory acts and policies described in this Act shall be revoked. | Section 53:<br><br>Penalties for Discriminatory Acts and Policies — All discriminatory acts and poicies referred to this Act shall be punishable with a penalty of imprisonment for six (6) months to four (4) years and a fine not exceeding Ten Thousand Peson (P10,000.00). In addition, licenses / permits of schools, hospitals and other institutions found guilty for committing discriminatory acts and policies shall be revoked. | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| The Philippine National AIDS Council | Article VIII. The Philippine National AIDS Council, Section 44.<br><br>Functions…<br><br>(a) The Council shall likewise ensure that there is adequate coverage of the following:<br><br>(1) The institution of a nationwide HIV / AIDS informatioin and education program;<br>(2) The establishment of a comprehensive HIV /AIDS monitoring system;<br>(3) The issuance of guidelines on medical practices and other procedures that carry the risk of HIV transmission;<br>(4) The provision of accessible and affordable HIV testing and counselling services to those who are in need of it;<br>(5) The provision of acceptable health and support services for persons with HIV / AIDS in hospitals and in communities;<br>(6) The protection and promotion of the rights of individuals with HIV; and,<br>(7) The strict observance of medical confidentiality | Section 55:<br><br>Functions — The Council shalll be the central advisory, planning and policy-making body on the prevention and control of HIV / AIDS in the Philippines. The Council shall have the following functions:<br>a. Secure from government agencies concerned, recommendations on how thier respective government agencies could operationalize specific provisions of RA 8504. THe Council shall likewise ensure that there is adequate coverage of teh following:<br>1. The institution of a nationwide HIV / AIDS information and education program;<br>2. The establishment of a comprehensive HIV / AIDS monitoring system;<br>3. The issuance of guidelines on medical and other practices and procedures that carry the risk of HIV transmission;<br>4. The provision of accessible and affordable HIV testing and counseling services to those who are in need of it;<br>5. The provision of acceptable health and support services for persons with HIV / AIDS in hospitals and in communities;<br>6. The protection and promotion of the rights of individuals with HIV; and | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 44, (b):<br><br>Monitor the implementation of the rules and regulations of this Act; | Section 55, b:<br><br>Monitor the implementation of these rules and regulations, issue or cause the issuance of orders or make recommendations to the implementing agencies as the Council considers appropriate; | | |
| | Section 44, (c):<br><br>Develop a comprehensive long-term national HIV / AIDS prevention and control program and monitor its implementation; | Section 55, c:<br><br>c. Develop a Strategic Plan and update regularly, through a process of multisectoral consultation, that details a comprehensive national HIV / AIDS prevention and control program. The Plan shall be integrated into the Medium-Term Development Plan. Said Plan shall include indicators and benchmarks against which PNAC shall monitor its implementation; | | |
| | Section 44, (d):<br><br>Coordinate the activities of and strengthen working relationships between government and non-government agencies involved in the campaign against HIV / AIDS; | Section 55, d:<br><br>Coordinate the activities of, and strengthen working relationships between all partners in the response including GOs, NGOs, private sectors, academe, media, vulnerable communities and people with HIV; | | |

| Policy Areas | RA 8504 | RA 8504 IRR (PNAC Resolution No. 1) | DOLE D.O. 102-10 | DOLE D.O. 56-03 |
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| | Section 44, (e):<br><br>Coordinate and cooperate with foreign and international organizations regarding data collection, research and treatment modalities concerning HIV / AIDS; and, | Section 55, e:<br><br>Coordinate and cooperate with foreign and international organizations regarding data collection, research and treatment modalities concerning HIV / AIDS; and, | | |
| | Section 44, (f):<br><br>Evaluate the adequacy of and make recommendations regarding the utilization of national resources for the prevention and control of HIV / AIDS in the Philippines. | Section 55, f:<br><br>Evaluate the adequacy of and make recommendations regarding the utilization of national resources… | | |
| Penalties and Consequences (in General) | | | VI.<br><br>Consequences of Policy and Program Violations shall be subject to the pertinent provisions of RA 8504. | |

# ANNEX B: HIV COUNSELING AND TESTING CENTERS

**LIST OF HIV COUNSELING AND TESTING CENTERS**
**OFFERING FREE HIV COUNSELING AND TESTING SERVICES[16]**
(Source: DOH-National AIDS & STI Prevention and Control Program,
Updated: April 2015)

**NCR/METRO MANILA**

| SITE | INSTITUTION | CONTACT PERSON/NUMBER | OPERATING HOURS |
|---|---|---|---|
| Caloocan City | 1. Social Hygiene Clinic | Dr. Zenaida Calupaz – (Physician)<br><br>Mabini St., Caloocan Health Dept. / 2888811 local 2281 Mobile # 09176018331 | |
| Mandaluyong City | 2. Social Hygiene Clinic<br><br>3. Drop-in Center | Dr. Yolanda Tuaño - Social Hygiene Clinic Physician / Maysilo Circle, Mandaluyong City / 5467799; 2115336<br>Mobile #: 09178424298 | |
| Manila | 4. Social Hygiene Clinic | Dr. Diane Mendoza - Social Hygiene Clinic Physician / Quirricada St., Sta. Cruz, Manila / 7116942<br>Mobile #: 09205779074 | M-Sat: 8am-5pm; |
| Marikina City | 5. Social Hygiene Clinic / Satellite Treatment Hub | Dr. Honnielyn Fernando – Asst. City Health Officer, Social Hygiene Clinic Physician / Marikina City<br>Mobile #: 09178298862 | |
| Pasay | 6. Social Hygiene Clinic | Dr. Carlota Nan Ranieses - Social Hygiene Clinic Physician / Pasay City Health Office, F.B. Harrison St., Pasay City Tel: 5514180<br>Mobile: 09052599229 | M-F 8am-3pm |

[16] All information in this section have been placed as provided by NASPCP through Dr. Gerard Belimac, and includes both government facilities that offer VCT for free and accredited private clinics that offer VCT for a fee.

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| Pasig City | 7. Social Hygiene Clinic | Dr. Rocylene Roque - Social Hygiene Clinic Physician / Caruncho Avenue. Brgy. San Nicolas, Pasig City / 6400111 | |
| Pasig City | 8. St. Camillus Medical Center | 116 Amang Rodriguez Ave., Santolan, Pasig City / 645 3741<br>Mobile: 0905 259 9199 | M-F 9am-5pm |
| Quezon City, Batasan | 9. Batasan Social Hygiene Clinic | Dr. Dottie Mercado - Social Hygiene Clinic Physician / Batasan Hills, Quezon City / Mobile: 09053576353, 09052599245 | M-F 9am-3pm |
| Quezon City, Bernardo | 10. Klinika Bernardo Social Hygiene Clinic / Satellite Treatment Hub | Dr. Leonel John Ruiz – Social Hygiene Clinic Physician / EDSA across NEPA Q-Mart, Cubao, Quezon City<br>Mobile: 09052599211, 09164781607 | M-F 3pm-11pm |
| Quezon City, Bernardo | 11. Bernardo Social Hygiene Clinic | Dr. Suzette Encisa - Social Hygiene Clinic Physician / Bansalangin St., Project 7, Quezon City / Mobile: 09052599245 | M-F 9am-3pm |
| Quezon City, Project 7 | 12. Project 7 Social Hygiene Clinic | Dr. Monina Santos - Social Hygiene Clinic Physician / Project 7 , Quezon City /<br>Mobile: 09186184133; 09052599239 | M-F 9am-5pm |
| Quezon City, Varsity Hills | 13. Woodwater Center for Healing | Fr. Dan Vicente Cancino / Gerlita Enrera / 18 Nicanor Reyes St., Varsity Hills, Loyola Hts., Quezon City / 926 3147<br>local 17 / Mobile: 0915 960 1717 | M-F 9am-5pm |
| Sta. Cruz Manila | 14. Jose Reyes Memorial Medical Center | Dr. Ana Bañez<br>Quiricada St. Sta. Cruz, Manila | |

| | | | |
|---|---|---|---|
| Sta. Cruz Manila | 15. MEDI - Jose Reyes Memorial Medical Center | Dr. Ma. Luisa M. Date / Bldg. 14, DOH Compound Sta. Cruz, Manila / 7438301 local 1702 | |
| Quezon City | 16. AIDS Society of the Philippines | Ms. Cecilia C. Añonuevo / 2nd Flr., OTM Bldg., Sct. Tuazon St., Brgy. South Triangle, Quezon City / (02) 376 2546, 376 2541, 410 0204 | |
| Taguig City | 17. Social Hygiene Clinic | 3rd Floor LC Building, Gen. Luna St., Tuktukan, Taguig City<br>Contact Person: Rica Ana F. Magbalana (Nurse)<br>Contact No: 09267542917<br>Clinic Hours: Monday – Friday 8:00 – 5:00pm | |
| | 18. SHC Drop-in Center | Pateros District Hospital, East Service Road, Western Bicutan, Taguig<br>Contact Person: Renna Ocheda (Nurse Manager)<br>Contact No: 09752657466<br>Clinic Hours: Monday – Saturday 10:00 am to 6:00 pm | |

| SITE | INSTITUTION | CONTACT PERSON/NUMBER |
|---|---|---|
| Dasmarinas | 1. Dasmariñas Social Hygiene Clinic, City Health Office 1 | D. Mangubat St. Dasmarinas, Cavite<br>Contact Person: Dra. Sol Mendiola<br>Contact No.: 0922-8842553<br>Clinic Hours: 8 am- 5 pm |
| Bacoor | 2. Panapaan Health Center | Floraville Subdivision, Panapaan 1 Bacoor City<br>Contact Person: Dr. Mike Angelo Marquez / Contact No.: 0908-6144183<br>Clinic Hours: 8am-5pm |
| Antipolo | 3. Antipolo Social Hygiene Clinic | M. Santos St. Sitio Mulawin, Brgy. San Roque Antipolo City<br>Contact Person: Dra. Eleonor Javonillo<br>Contact No.: 0922-8423606<br>Clinic Hours: 8am - 5pm |
| Imus | 4. Imus Reproductive and Wellness Clinic | Velarde Health Center, Medicion, Velarde Subdivision, Imus City<br>Contact Person: Dr. Ferdinand P. Mina<br>Contact No.: 0926-7013539; 046-434-4057<br>0925-8787158<br>Clinic Hours- 2pm-4pm |
| Cainta | 5. Reproductive and Wellness Clinic | Cainta Health Office, Cainta, Rizal<br>Contact Person: Dra. Luzviminda Marcial / Contact No: 02-696-2607<br>Clinic Hours: 8am- 5pm |
| Sta. Rosa | City Health Office 1 | Rizal Blvd., Brgy. Market Area, Sta. Rosa City<br>Contact Person: Dra. Catherine Haynes<br>Contact No: 049-530-0015 local 5313<br>Clinic Hours: 8am-5pm |

| SITE | INSTITUTION | CONTACT PERSON/NUMBER |
|---|---|---|
| Angeles | 1. Social Hygiene Clinic | Ms. Rosalinda Velasco - Social Hygiene Clinic HCT Counselor / Add: 1-20 Cristina Drive, Villa Teresa Subd. Angeles City / (045) 3222979 |

| | | |
|---|---|---|
| Laoag | 2. Social Hygiene Clinic | Dr. Imelda Tamayo - Social Hygiene Clinic Physician / Add: Brgy. 10, City Health Office, Tupaz, Laoag City / (077) 7720289 Mobile # 09189797491 |
| Taytay, Rizal | 3. Taytay Doctors Multispecialty Hospital | Ms. Jazzy Jane C. Pantaleon, RN, MANc, HIV Counselor, Nurse Supervisor, HACT Manager, 3rd Flr. Rm. 301, #6 Rizal Ave., Brgy. San Isidro, Taytay, Rizal |
| Puerto Galera | 4. Social Hygiene Clinic | Dr. Ma. Teresa Wycoco - Social Hygiene Clinic Physician / Add: Rural Health Clinic, Puerto Galera, Oriental Mindoro / (043) 4420182 Mobile #: 09178252929 |
| Puerto Princesa | 5. Social Hygiene Clinic | Dr. Eunice Herrera - Social Hygiene Clinic Physician / Add: City Health Office, Valencia St., Brgy Model, Puerto Princesa City / (048) 434 6581 / Mobile #: 09272383989 |
| Calapan City | 6. Social Hygiene Clinic | Dr. Maria Mencee Escalona – Social Hygiene Clinic Physician / Add: City Health Office, Calapan City / Mobile #: 0908 529 9183 |
| Mamburao, Occidental Mindoro | 7. Social Hygiene Clinic | |
| Santiago | 8. Social Hygiene Clinic | Dr. Robelyn Vera Go - Social Hygiene Clinic Physician Add: City Health Office, San Andres, Santiago City / (078) 6827687; 3052775/ Mobile #: 09194626389 |
| Tuguegarao | 9. Social Hygiene Clinic | Dr. James Guzman – City Health Officer / Add: City Health Office, Tugegarao City / (078) 8462197 Mobile 09175745050 |
| Olongapo City | 10. James L. Gordon Memorial Hospital | Mr. Archimedes Domdoma, HACT Nurse, New Asinan, Olongapo City, (047) 222 4120 |

**VISAYAS**

| SITE | INSTITUTION | CONTACT PERSON/NUMBER |
|---|---|---|
| B. Rodriguez St., Cebu City 6000 | 11. Vicente Sotto, Sr. Memorial Medical Center (VSSMC) | Dr. Gerardo M. Aquino - Chief of Hospital; Dr. Regina Melodia - HIV AIDS Core Team Leader / Add: B. Rodriguez, Cebu City / (032) 2539882; 2539982; 2537564; 2532592 Mobile #: 09193473658 |
| Cebu City | 12. Social Hygiene Clinic | Dr. Ilya Tac –an - Social Hygiene Clinic Physician / Add: Gen. Maxilano St. Cebu City / (022 3659962 Mobile #: 09173291663 |
| Iloilo | 13. Social Hygiene Clinic | Dr. Odetta Villaruel - Social Hygiene Clinic Physician Address: Iloilo City (033) 3208151 Mobile #: 09215694450 |
| Lapu-Lapu Ciy | 14. Social Hygiene Clinic | Dr. Rodolfo C. Berame - Social Hygiene Clinic Physician |
| Mandaue City | 15. Social Hygiene Clinic | Dr. Edna Seno and Dr. Debra Maria Catulong - Social Hygiene Clinic Physician / (6332) 346-0110 |

**MINDANAO**

| SITE | INSTITUTION | CONTACT PERSON/NUMBER |
|---|---|---|
| Butuan | 16. Social Hygiene Clinic | Dr. Jesus Chin- Chui - Social Hygiene Clinic Physician / Add: City Health Office, Butuan City / (085) 3423432; 815111 local 1039 |
| Davao City | 17. Social Hygiene Clinic | Dr. Jordana Ramiterre - Social Hygiene Clinic Physician / Add: City Health Office, Magallanes St. Davao City / (082) 222 4187 Mobile #: 09209102718 |
| Davao City | 18. Davao Regional Hospital | Ms. Telesfora A Hinay - Add: Apokon, Tagum City / (082) 2218593;2279536; 4003653; |
| General Santos | 19. Social Hygiene Clinic | Dr. Mely Lastimoso - Social Hygiene Clinic Physician / Add: General Santos City Health Office / (083) 3028115 Mobile #: 09088877512 |

| | | |
|---|---|---|
| Zamboanga | 20. Social Hygiene Clinic | Add: Petit Barracks, Zone 4C, Cty Health Office, Zamboanga City / Mobile #: 09274836672 |
| Davao City | 21. Alagad – Mindanao | 557 Kamuning St., Juna Subd., Matina, Davao City / (082) 297 3394 |

**List of DOH Treatment Hubs *****
(for people living with HIV including pregnant women)

| No. | REGION | TREATMENT HUB | ADDRESS | CONTACT NO. | HACT Chair |
|---|---|---|---|---|---|
| 1 | CAR | BAGUIO GENERAL HOSPITAL AND MEDICAL CENTER | Gov. Pack Rd., Baguio City | (074) 442-4216 loc 381 09155816480 | Dr. Maria Lorena L. Santos |
| 2 | 1 | ILOCOS TRAINING AND REGIONAL MEDICAL CENTER | San Fernando City, La Union | (072) 6076413 loc 124 | Dr. Jimmy Mynardo Mendigo |
| 3 | 2 | CAGAYAN VALLEY MEDICAL CENTER | Carig, Tuguegarao, Cagayan | (078) 304-1410 | Dr. Karina Domingo |
| 4 | 3 | JOSE B. LINGAD MEDICAL CENTER | Brgy. San Dolores, San Fernando, Pampanga | (045) 961-3989 (Medicine Department) | Dr. Edwin Pasumbal |
| 5 | NCR | SAN LAZARO HOSPITAL | Quiricada St., Sta. Cruz, Manila | 732-3125 732-3125 723-3776 to 79 732-3106 loc 218 (H4 OPD) loc 212 (H4 ward) | Dr. Rosario Jessica Tactacan-Abrenica |
| 6 | | PHILIPPINE GENERAL HOSPITAL | Taft Ave., Manila | 554-8400 loc 3249 09205031104 | Dr. Jodor Lim |
| 7 | | RESEARCH INSTITUTE FOR TROPICAL MEDICINE | Filinvest Corporate City, Alabang, Muntinlupa City | 807-2628 loc 332 | Dr. Manolito Chua |
| 8 | | MAKATI MEDICAL CENTER | #2 Amorsolo St., Legaspi Village, Makati City | 888-8999 loc 2336 | Dr. Ma. Tarcela Gler |
| 9 | | | | THE MEDICAL CITY | Ortigas Ave., Pasig City |

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|---|---|---|---|---|---|
| 10 | 5 | BICOL REGIONAL TRAINING AND TEACHING HOSPITAL | Rizal St., Legazpi City | (052) 4830017 | Dr. Anna Lynda Bellen |
| 11 | 6 | WESTERN VISAYAS MEDICAL CENTER | Q. Abeto St., Mandurriao, Iloilo City | (033) 3212841 | Dr. Ray Celis |
| 12 | | CORAZON LOCSIN MONTELIBANO MEMORIAL REGIONAL HOSPITAL | Dept. of Internal Medicine, 3rd Flr. OPD Bldg., CLMMRH, Lacson St., Bacolod City | (034) 709-0244<br>09222903710<br>09228608756 | Dr. Joann Cerrada |
| 13 | 7 | VICENTE SOTTO MEMORIAL MEDICAL CENTER | B. Rodriguez, Sambag II, Cebu City | (032) 2539891 - 96 | Dr. Abelardo Alera |
| 14 | | GOV. CELESTINO GALLARES MEMORIAL HOSPITAL | M. Parras St., Tagbilaran City | (038) 4114868 | Dr. Wilnilia Causing |
| 15 | 9 | ZAMBOANGA CITY MEDICAL CENTER | Ligaya Center for Healing, Zamboanga City Medical Center, Sta. Catalina, Zamboanga City | (062) 991-2934 | Dr. Maribel O. Felisario |
| 16 | 11 | SOUTHERN PHILIPPINES MEDICAL CENTER | J. P. Laurel St., Bajada, Davao City | (082) 2272731 loc 4205 | Dr. Alicia Layug |
| 17 | NCR | MAKATI MEDICAL CENTER | #2 Amorsolo St., Legaspi Village, Makati City | 0917 801 4314<br>(632) 216 6253 | |

*** These are also HCT Facilities

**LIST OF SOCIAL HYGIENE CLINICS/ REPRODUCTIVE HEALTH AND WELLNESS CENTER ****
**PROVINCE: BULACAN**

| **Name of Facility (If integrated, include RHU number)** | **Type of Facility** -RHU Integrated - Independent -CHO/ MHO Based - Hospital -Based | **Complete Address** | **Clinic Days and Consultation Hours** | **Facility Contact Number** | **Head of Facility** | **Official E-Mail Address** |
|---|---|---|---|---|---|---|
| RHU II – Guiguinto, Bulacan | -RHU Integrated | Tiaong, Guiguinto, Bulacan | Monday to Friday 8am-5:00pm | 0925 802 0960 | Dr. Prima Lea Chua | dra_chua@yahoo.com |
| RHU I – Pulilan, Bulacan | -RHU Integrated | Poblacion, Pulilan, Bulacan | Monday to Friday 8am-5:00pm | 0942 274 6195 | Dr. Concepcion Antonino | ma.concepcion@gmail.com |
| RHU II – CSJDM, Bulacan | -RHU Integrated | Sta. Cruz III, CSJDM, Bulacan | Monday to Friday 8am-5:00pm | 0905 335 5339 | Dr. Earl Bryan Borillo | betzaida50@yahoo.com.ph |
| Meycauayan City RHWC | Independent | St. Michael's Subd., Pandayan, Meycauayan City | Monday to Friday 8am-5:00pm | | Dr. Abelardo Bordador | doktora_s@yahoo.com |

**Also HCT Facilities

Contact Details of HCT Facilities in Region IV-B

| No. | SHC | SHC Physician/Nurse | Contact Number |
|---|---|---|---|
| 1. | Calapan Social Hygiene Clinic<br>Address:<br>Calapan City, Oriental Mindoro | Dr. Maria Mencee Escalona | 0908-529-9183 |

| | | | |
|---|---|---|---|
| 2. | Mamburao Social Hygiene Clinic<br>Address:<br>Mamburao , Occidental Mindoro | † Dr. Edison Tan<br>Ms. Chona Cuasay (PHN) | 0932-877-7011 |
| 3. | San Jose Social Hygiene Clinic<br>Address:<br>San Jose, Occidental Mindoro | Dr. Enid Asuncion | 0920-931-9336 |
| 4. | Sta. Cruz Social Hygiene Clinic<br>Address:<br>Sta Cruz, Marinduque | Dr. Teodolfo Rejano | 0917-552-4912 |
| 5. | Boac Social Hygiene Clinic<br>Address:<br>Boac, Marinduque | Dr. Honesto Marquez | 0998-196-2489 |
| 6. | Odiongan Social Hygiene Clinic<br>Address:<br>Odiongan, Romblon | Dr. Maria Aida Atienza | 0918-959-1565 |
| 7. | Palawan PHO - Social Hygiene Clinic<br>Address:<br>Bancao-Bancao, Palawan | Dr. Louie Ocampo | 0917-577-7518 |
| 8. | PPC Social Hygiene Clinic<br>Address:<br>Puerto Princesa City, Palawan | Dr. Eunice Rina Herrera | 0918-946-6686 |
| 9. | Coron Social Hygiene Clinic<br>Address:<br>Coron, Palawan | Dr. Alan Guintapan | 0908-893-7202 |
| 10. | El Nido Social Hygiene Clinic<br>Address:<br>El Nido, Palawan | Dr. Cesar Rivera | 0917-801-1925 |
| 11. | Narra Social Hygiene Clinic<br>Address: Narra, Palawan | Dr. Gina Tagyab | 0920-414-8050 |

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|---|---|---|---|
| 12. | Ospital ng Palawan (ONP)<br>Address: 220 Malvar St., Puerto Princesa, Palawan, 5300<br>Open Monday to Sat 24 hours;<br>Sunday 8AM – 12NN | Dr. Jose Coloma, Jr. | 0920-440-8720 |
| 13. | Agape Rural Program Inc.<br>Address: Puerto Gen.. Malvar St.,<br>Puerto Princesa City, Palawan<br>Open at 9AM-12NN , 3PM-6PM | Dr. Editha Miguel | 0917-543-2150 |
| 14. | MMG Coop Hospital<br>Address:<br>Puerto Princesa City, Palawan | Dr. Paul Castillo | 0917-928-5379 |
| 15. | Adventist Hospital Palawan<br>Address:<br>Puerto Princesa City, Palawan | | |
| 16. | Southern Palawan Provincial Hospital (SPPH)<br>Address:<br>Puerto Princesa City, Palawan | | |
| 17. | Northern Palawan Provincial Hospital (NPPH)<br>Address:<br>Puerto Princesa City, Palawan | | |

**Also HCT Facilities

## HCT FACILITIES - ZAMBOANGA PENINSULA REGION IX

| NAME OF FACILITY | ADDRESS | CONTACT PERSON | CONTACT DETAILS |
|---|---|---|---|
| 1. RHWC | City Health Office Pettit Barracks, Zamboanga City | **Dr. Kibtiya Uddin** Asst City Health Officer & RHWC Physician In-Charge | 0917 483 6672 |
| | | **Ms. Rosalie Mendoza** City Program Coordinator | 0917 802 4581 |
| | | **Ms. Josephine S. Mangila** HIV Proficient RMT | 0936 907 5721 |
| 2. RHWC | City Health Office Pagadian City | **Dr. Noel Ceniza** City Health Officer | |
| | | **Ms. Carleen J. Tolentino** City Program Coordinator | 0922 812 7405 |
| | | **Ms. Genevieve Dablo** HIV Proficient RMT | 0921 820 9814 |
| 3. RHWC | City Health Office Dipolog City | **Dr. Cecilio Siglos** City Health Officer | 0920 891 6531 |
| | | **Ms. Liberty Sybico** City Program Coordinator | 0922 856 5947 |
| | | **Ms. Rachel Otud** HIV Proficient RMT | 0936 751 2175 |
| 4. AGAPE Health Clinic | Dipolog City | **Mr. Ramil Daarol** Owner & HIV Proficient RMT | 0917 838 6893 |
| 5. Ipil RHU | Ipil, Zamboanga Sibugay | **Dr. Adnilre Verzon** Municipal Health Officer | 0917 322 8386 |
| | | **Ms. Bernadette Combista** HIV Proficient RMT | 0928 344 0048 |
| 6. Integrated Provincial Health Office | Old Provincial Hospital Bldg., BiasongDipolog City | **Ms. Abigail B. Khio** Provincial Program Coordinator & HIV Proficient RMT | 0922 8040 560 |

Note: Isabela City & Dapitan City - CHO still needs to identify a RMT for HIV Proficiency (HIV testing referred to CHO, ZC & Dipolog)

**LIST OF FACILITIES THAT OFFER HIV COUNSELING AND TESTING (HCT)**

| NO. | Classification | HIV Counselors | POSITION | E-MAIL ADDRESS | HI-PRECISION BRANCH | BRANCH LANDLINE | BRANCH CELLPHONE NO. |
|---|---|---|---|---|---|---|---|
| 1 | Private Diagnostic Clinic | Arlyn Luna | Supervisor | arlyncluna@uyahoo.com | Hi-Precision Diagnostics, Del Monte | 02741-7777 | 9228906664 |
| 2 | Private Diagnostic Clinic | Francis Paolo Estoesta | Phlebotomist | paolo_estoesta@yahoo.com | Hi-Precision Diagnostics, Del Monte | 02741-7777 | 9228906664 |
| 3 | Private Diagnostic Clinic | Carolyn Torres | RMT | torres22ca@yahoo.com | Hi-Precision Diagnostics, Del Monte | 02741-7777 | 9228906664 |
| 4 | Private Diagnostic Clinic | Jam Winstrol Cabaltera | Phlebotomist | jwdcabatera@yahoo.com | Hi-Precision Diagnostics, Del Monte | 02741-7777 | 9228906664 |
| 5 | Private Diagnostic Clinic | Earle Sapelino, Jr. | Supervisor | iamearle@gmail.com | Hi-Precision Diagnostics, Del Monte | 02741-7777 | 9228906664 |
| 6 | Private Diagnostic Clinic | Queen PJ Salcedo | CS Officer | **danica_0319@yahoo.com** | Hi-Precision Diagnostics, Rockwell | 02899-8820 | 9228906667 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 7 | Private Diagnostic Clinic | Mila Salcedo | Supervisor | milesbillionesyahoo.com | Hi-Precision Diagnostics, Rockwell | 02899-8820 | 9228906667 |
| 8 | Private Diagnostic Clinic | Brian Christian Marin | Phlebotomist | **brianmarin12@yahoo.com.ph** | Hi-Precision Diagnostics, Pasig | 02628-3277 | 9228906683 |
| 9 | Private Diagnostic Clinic | Kathleen Gaite | Phlebotomist | katheenxuxa@yahoo | Hi-Precision Diagnostics, Pasig | 02628-3277 | 9228906683 |
| 10 | Private Diagnostic Clinic | Anna Lizza Trinidad | Laboratory Processor | onepiece_gomagoma26@yahoo.com | Hi-Precision Diagnostics, Baliuag | 044766-0280 | 9328656597 |
| 11 | Private Diagnostic Clinic | Peachy Pedrajita | CS Officer | sweetpeach100805@yahoo.com | Hi-Precision Diagnostics, V.Luna. | 02433-8637 | 9228906680 |
| 12 | Private Diagnostic Clinic | Mary Grace Zuñiga | RMT | grc.zuñiga@gmail.com | Hi-Precision Diagnostics, East Ave. | 02435-8228 | 9228906688 |
| 13 | Private Diagnostic Clinic | Aaron Joseph Morden | 2D-Echo Tech. | ajmorden@yahoo.com | Hi-Precision Diagnostics, East Ave. | 02435-8228 | 9228906688 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14 | Private Diagnostic Clinic | Mary Ann Magtubo | Registered Nurse | maryann_magtubo21@yahoo.com | Hi-Precision Diagnostics, Angeles | 045624-6227 | 9228966724 |
| 15 | Private Diagnostic Clinic | Ralph Benjamin Basilio | Phlebotomist | bass_1737@yahoo.com | Hi-Precision Diagnostics, Angeles | 045624-6227 | 9228966724 |
| 16 | Private Diagnostic Clinic | Rialyn Valencia | RMT | tiavalencia12@yahoo.com | Hi-Precision Diagnostics, San Fernando | | 9228906705 |
| 17 | Private Diagnostic Clinic | Sally Batang | Supervisor | jeimar_0610@yahoo.com | Hi-Precision Diangnostics, Alabang | 02659-2673 | 9228906678 |
| 18 | Private Diagnostic Clinic | Gladys Pagaduan | Phlebotomist | gop_29@yahoo.com | Hi-Precision Diangnostics, Sucat | 02774-4887 | 9228966722 |
| 19 | Private Diagnostic Clinic | Lemy Montanes | Supervisor | montanes.lemy@yahoo.com | Hi-Precision Diangnostics, Sucat | 02774-4887 | 9228966722 |
| 20 | Private Diagnostic Clinic | Imelda Trinindad | Supervisor | imelda_trinidad@ymail.com | Hi-Precision Diagnostics, East Ave. | 02435-8228 | 9228906688 |

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|---|---|---|---|---|---|---|---|
| 21 | Private Diagnostic Clinic | Mary Grace Zuñiga | RMT | grc.zuñiga@gmail.com | Hi-Precision Diagnostics, East Ave. | 02435-8228 | 9228906688 |
| 22 | Private Diagnostic Clinic | Nestor Ocba | Phlebotomist | nocturnal_nast@yahoo.com | Hi-Precision Diagnostics, Retiro | 02415-2622 | 9228906663 |
| 23 | Private Diagnostic Clinic | Cristina Sitjar | RMT | delch_17@yahoo.com | Hi-Precision Diagnostics, Retiro | 02415-2622 | 9228906663 |
| 24 | Private Diagnostic Clinic | Dominique Emmanuelle Lumaque | Psychologist | nikki_lumaque@yahoo.com | HPD International - Taft Branch | 02405-0039 | 9328908921 |
| 25 | Private Diagnostic Clinic | Guia Reyes | Supervisor | guia_78@yahoo.com | Hi-Precision Diagnostics, Las Piñas | 02875-0597 | 9228906686 |
| 26 | Private Diagnostic Clinic | Cecilia Pena | RMT | cecillepena425@yahoo.com | Hi-Precision Diagnostics, Las Piñas | 02875-0597 | 9228906686 |
| 27 | Private Diagnostic Clinic | Carolyne Barot | CS Officer | carolynebarot@yahoo.com | Hi-Precision Diagnostics, Las Piñas | 02875-0597 | 9228906686 |
| 28 | Private Diagnostic Clinic | Erwin Ditan | Encoder/IT | erwin14_032000@yahoo.com | Hi-Precision Diagnostics, Kalaw | 02526-2329 | 9228906687 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 29 | Private Diagnostic Clinic | Princess Manreza | Phlebotomist | Iceko2@yahoo.com | Hi-Precision Diagnostics, Kalaw | 02526-2329 | 9228906687 |
| 30 | Private Diagnostic Clinic | Miashmen Tesaluna | Phlebotomist | tenshi_mahal_24@yahoo.com | Hi-Precision Diagnostics, Cavite | 046424-1796 | 9328908920 |
| 31 | Private Diagnostic Clinic | Alma Alger | Supervisor | almager@yahoo.com | Hi-Precision Diagnostics, Cavite | 046424-1796 | 9328908920 |
| 32 | Private Diagnostic Clinic | Mabel Naguit | CS Officer | cutie_mabz@yahoo.com | Hi-Precision Diagnostics, Cebu | 032255-4131/255-4133 | 9228284136 |
| 33 | Private Diagnostic Clinic | Heracel Bantasan | Supervisor | herazelbantasan@yahoo.com | Hi-Precision Diagnostics, Cebu | 032255-4136 | 9328813163 |
| 34 | Private Diagnostic Clinic | Leah Livelo | Supervisor | leahlivelo@yahoo.com | Hi-Precision Diagnostics, Cebu | 0322560151/54 | 9228284136 |
| 35 | Private Diagnostic Clinic | Anna Liza Lado | Phlebotomist | analizabladdo@yahoo.com.ph | Megaclinic - ALS | 02633-5907 | 9228906710 |
| 36 | Private Diagnostic Clinic | Marites Tabalanza | RMT | tekla_tabalanza@yahoo.com | Megaclinic - ALS | 02633-5907 | 9228906710 |
| 37 | Private Diagnostic Clinic | Armando Jose Arribas, Jr. | RMT | jr_arribas7@yahoo.com | Megaclinic- ALS | 02633-5907 | 9228906710 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 38 | Private Diagnostic Clinic | Jennifer Enar | Phlebotomist | jennyear@yahoo.com | Megaclinic-ALS | 02633-5907 | 9228906710 |

# ANNEX D: HIGHLIGHTS OF FGD WITH GOVERNMENT AND NON-GOVERNMENT ACTORS

**Focus Group Discussions with Government and Traditional and Non-Traditional Workplace Actors**
16 December 2015, 9:30 am - 4:00 p.m.
Occupational Safety and Health Center, Quezon City

## 1. Note about these discussion highlights.

The Researcher scheduled two FGDs — one with the non-government actors and another, with national and local government actors as discussants. The FGDs pushed through, and both were attended by representatives from the Occupational Safety and Health Center (OSHC) and the Bureau of Working Conditions (BWC), both of the Department of Labor and Employment (DOLE).

The first was well attended while the other only had three discussants in attendance, the third being the representative from DOLE - Bureau of Workers with Special Concerns (BWSC). It is noted here that the unfavorable weather on the date the FGD was conducted and the tight notice may have hindered some of the invitees from participating in the FGDs. However, it is worthy of note that focus interviews with three out of the four Local Government Units (LGU) invited have already been completed prior to the FGD; interviews have likewise been completed with three of four non-government actors, which include Pinoy Plus, Pilipinas Shell Foundation, Inc. and Standard Chartered Bank, prior to the FGD; and, by the time the FGD was conducted, focus interviews have been confirmed with the Department of Interior and Local Government (DILG) and the Philippine National AIDS Council (PNAC).

These highlights therefore will be best conveyed by combining the proceedings from both FGDs.

## 2. Attendees

The meeting was facilitated by Margaux Diaz-Sanguyo, Writer and Researcher for a situational analysis study on the workplace response to HIV and AIDS, commissioned by the International Labour Organization (ILO) and conducted in collaboration with the Occupational Safety and Health Center (OSHC) of the Department of Labor and Employment (DOLE).

2.1. Discussants in attendance include:
- 2.1.1. Dr. Ma. Teresita Cucueco, DOLE-OSHC
- 2.1.2. Dr. Maria Beatriz Villanueva, DOLE-OSHC
- 2.1.3. Dr. Marco Antonio Valeros, DOLE-BWC
- 2.1.4. Mr. Cielo Cabalatungan[17], DOLE-BWSC
- 2.1.5. Dr. Kate Leyritana, Medical Director, Sustained Health Initiatives of the Philippines Foundation (SHIP)
- 2.1.6. Mr. Danvic Rosadiño, The Love Yourself Foundation (TLY)
- 2.1.7. Mr. Rafael Mapalo, HIV and AIDS Focal Point, Trade Union Congress of the Philippines (TUCP)
- 2.1.8. Dr. Marie Yvette Jaramillo, National PRO, Philippine College of Occupational Medicine (PCOM)
- 2.1.9. Ms. Mercy Castillo, RN, Occupational Health Nurses Association of the Philippines (OHNAP)
- 2.1.10. Mr. Noel Quinto, Representative, Pinoy Plus Foundation, Inc. (Pinoy Plus)

2.2. Others invited but were not represented include:

[17] Present only in discussion with DOLE-OSHC and DOLE-BWC.

*Non-Government Actors:*

2.2.1. Alliance of Progressive Labor (APL) -SENTRO
2.2.2. Associated Labor Unions (ALU)
2.2.3. Employer' Confederation of the Philippines (ECOP)
2.2.4. Federation of Free Workers (FFW)
2.2.5. Philippine Financial Industry Pride (PFIP)
2.2.6. Pilipinas Shell Foundation, Inc. (PSFI)
2.2.7. Standard Chartered Bank

*Government Actors:*

2.2.8. Department of Health (DOH)-National AIDS / STD Prevention and Control Program (NASPCP)
2.2.9. Philippine National AIDS Council (PNAC)
2.2.10. DOH-Health Promotion and Communication Service
2.2.11. Department of Interior and Local Government (DILG) - Local Government Academy (LGA)
2.2.12. Makati City Health Department
2.2.13. Quezon City Health Department
2.2.14. Pasay City Health Department
2.2.15. Manila Health Department

**3. Involvement of organizations in the workplace response to HIV, and the most pressing issue that must be prioritized in the workplace response**.

3.1. OHNAP, currently has an estimated 3,000 active members, mostly working as company nurses under direct hire or hired by third-party OSH providers. OHNAP provides trainings to its members, including HIV and AIDS which includes discussions and hands-on activities on workplace policy and program development.

For Ms. Castillo, more attention must be put into increasing compliance of enterprises to RA 8504 and DOLE DO 102-10.

3.2. Pinoy Plus, Members composed of Persons Living with HIV (PLHIV) has provided training to various groups which include private enterprises and hospital workplace settings. Mr Quinto thinks that correcting employers' and workers' misconceptions about HIV remains to be the biggest challenge for the workplace response.

3.3. BWC, the primary DOLE agency in-charge of checking, monitoring and evaluating the compliance of private enterprises to all labor requirements, including instituting workplace policies on HIV and AIDS and ensuring that these are translated into programs that work. For Dr. Valeros, more priority should be poured into increasing and improving the quality of business sector compliance to DO 102-10.

3.4. OSHC, the training arm of the DOLE on occupational safety and health standards which chairs the Inter-Agency Coalition on HIV and AIDS. Dr Villanueva is concerned about gathering more evidence to serve as inputs to inform future strategies for the workplace response. She stresses on the need to deliver impact while ensuring that strategies are practical.

Dr. Cucueco is interested to find out where the workplace response is falling short and how these program weaknesses / limitations may be improved.

3.5. SHIP, serves as a quasi-satellite office of the Department of Health (DOH) which runs a non-profit arm with the objective of filling in gaps in the public health system. SHIP reaches out to medical societies and schools as even doctors are not aware of the real, pressing issues around HIV and AIDS, according to Dr. Leyritana.

For her, the workplace response should look into broadening the health benefits / HMO coverage for PLHIVs, particularly in making sure that periodic lab tests required for PLHIVs to take are covered while at the same time encouraging employed PLHIVs to disclose their status to their respective employers so that they may be able to access medical benefits.

In a separate discussion, the DOLE representatives clarified that employers are only required to offer PhilHealth and SSS benefits. HMOs are an additional health benefit offered by employers.

3.6. TLY, run by 700 volunteers, focuses its efforts in broadening and increasing HIV and AIDS awareness among MSMs. TLY regularly runs the "Love Yourself Caravan" in schools and private enterprises, with the strategy of delivering HIV 101 and Onsite VCCT whenever resources and facilities are available. TLY has supported a number of companies in developing workplace policies and programs on HIV and AIDS.

Mr. Rosadiño, like Dr. Leyritana, also feels that the workplace response should give more attention to expanding HMO coverage for treatment and lab tests for HIV and HIV-related illnesses.

3.7. Mr. Mapalo opined that so many programs on the workplace response to HIV and AIDS have been launched and completed in the past with poor sustainability. For him, the workplace response must prioritize labor inspection. He adds that the Government must lead the response most especially because non-government actors like workers' unions and other NGOs do not have resources available regularly and on continuous basis to make the workplace response happen. Besides, he says further, with so many concerns and issues in the labor sector, HIV and AIDS does not fall under the first tier of priorities for the sector.

**4. On the extent which the workplace response is expected to reach**. DOLE-OSHC and BWC representatives shared the following information concerning the size of the business sector and labor inspection standards in relation to DOLE DO 102-10:

4.1. There are an estimated 760,000 total number of private business establishments all over the country. Approximately 90-92% of which are micro-, small- and medium- sized enterprised (MSME).

4.2. Using the latest labor inspection procedures of DOLE, the most current data[18] available regarding business sector compliance to DOLE DO 102-10, 79.03% of all establishments surveyed are compliant to the policy. The survey covered only some estimated 38,000 small-, medium-, and large- scale enterprises employing at least 10 people, roughly 5% of the total number of all business establishments nationwide.

4.3. The current compliance rate, however, cannot be used to determine any improvement in business sector compliance to DO 102-10 from previous years as both parameters being measured and the data gathering procedures are different.

Dr. Villanueva and Dr. Valeros stressed how it is unrealistic for the DOLE to reach all of the business establishments given the current strategies employed by the agency and the other players present during the discussion.

[18] January-October 2015; data provided by BWC.

Both further offered insights as to how various tracks may be explored to achieve a multiplier effect for the workplace response to reach a larger chunk of the private sector:

4.4. Labor Law Compliance Officers (LLCO) may be tapped to support business sector compliance to DOLE's requirement of instituting workplace policies and programs on HIV and AIDS. After all, she adds, the thrust of LLCOs has shifted from a regulatory to a more developmental role, which means that rather than penalizing non-compliant enterprises, the LLCOs help companies comply with all labor requirements through remediation.

4.5. Safety training organizations like PCOM and OHNAP, an accreditation mechanism for which is already in place and is being managed by OSHC, may be tapped to help cover large enterprises consisting of some 8-10% of all enterprises only.

Safety training organizations and related professional associations are either directly hired or employed as third-party service providers of large enterprises, while MSMEs are unserved or underserved, often due to enterprise's resource limitations. This strategy then still leaves out 90% of enterprises, and another strategy is called for.

4.6. There may be advantages in targeting specific groups to be prioritized, whether these be industry-specific or sector-specific or based on workplace location.

**5. On how the workplace can tap partners and services available outside of the workplace to improve workers' access to HIV and AIDS prevention, testing, treatment, care and support services**. The discussants were in agreement of two points: (1) that the workplace actors — Government, workers, employers — have limited capabilities and can only do so much to bring the full spectrum of HIV and AIDS services to the workplace; and, (2) that the workplace response needs to look beyond the workplace to be able to provide workplace actors with access to the full spectrum of HIV and AIDS services.

In line with this discussion, the discussants shared the following information:

5.1. Dr. Leyritana shared that the Department of Health (DOH) regularly offers a one week training cum certification program for HIV counselors. The discussants want to explore further the possibility for DOLE or the employers to send / fund OSH professionals to participate in the program.

Mr. Mapalo recommended that the suggestion be raised at the level of the Inter-Agency Committee (IAC) on HIV and AIDS and explore further the possibility of issuing Guidelines for HIV Counseling at the Workplace.

5.2. The discussants were also keen on developing a 'Protocol for Managing HIV Cases in the Workplace' which shall include necessary steps for employers or any of its delegated officers to carry out if and when an HIV positive employee discloses his HIV status. Some of the information it should include are: how to uphold confidentiality and non-discrimination; what information should the employer make known to the infected or affected employee, including treatment services like PhilHealth's Out-Patient HIV and AIDS Treatment (OHAT) Package; if enterprises should report this instance, what to report, and who to report it to; who employers should contact in case the company needs further support in managing the case; and, who the infected or affected employee may contact in case s/he needs more information or, further help and support.

5.3. Dr. Villanueva insists that enterprises must continue to be given two options when it comes to making available HIV and AIDS services in the workplace:

5.3.1. Enterprises that have resources to allocate must continue to be encouraged to bring HIV and AIDS services onsite.

5.3.2. Enterprises that have limited resources must be capacitated to provide referral services.

The minimum requirement for referral service available in all workplaces is the capability at the enterprise-level to connect or link the infected or affected employee/s to external providers which was suggested, must be made available via the DOH website, to which the websites of OSHC, BWC and DOLE Central Office can link back to so as to ensure that the information are kept up-to-date as per the latest information available to the DOH.

6. **On introducing standards for the workplace response**. The discussion particularly focused on introducing certain standards in the conduct of HIV 101, Onsite VCCT, and in formulating workplace HIV policy and program on HIV and AIDS.

Dr. Villanueva pointed out that, even through the IAC, all participating entities that do not fall under the purview of the DOLE remain independent and cannot be compelled by the DOLE to follow specific instructions from the agency. The DOLE, however, will take a recommendatory role to better orchestrate the workplace response, particularly in mapping out the existing efforts and keeping informed both tradition and non-traditional workplace actors involved in the response.

The final agreement then was for all organizations involved to continue doing what they are doing in the way they think these are best carried out. However, DOLE may have to request the players to help DOLE reach out to the business sector in terms of increasing enterprise awareness of DOLE DO 102-10, key principles that must be embodied in workplace policies on HIV and AIDS, sample workplace HIV and AIDS programs that may be introduced / conducted by the company, and a list of workers' rights in relation to HIV and AIDS. As all organizations' efforts in reaching workplaces is perceived as an opportunity to advocate for these information, all organizations conducting HIV-related activities in workplaces shall be enjoined to help extend these advocacies to their enterprise partners.

7. **On strategies that must be pursued to improve the reach, coverage and impact of the workplace response**.

7.1. *Inviting greater business sector participation.* Mr. Mapalo stressed for the second time how HIV and AIDS is one of many concerns that businesses have to deal with and, in many ways, pale in comparison to the immediacy of other labor issues. However, he says, with the proper logic and a business case, employers will realize that they have everything to gain in making HIV and AIDS services available to their workers.

7.2. *Focusing the thrust of the workplace response.* Mr. Rosadiño stressed that the workplace response must continue to reach out to everybody — workers and employers alike. The workplace response, to him, must continue to be driven by the objective to raise and improve people's awareness and knowledge of HIV and AIDS. By so doing, he says, the workplace will have already taken the first step which hopefully will lead to behavior change, and to people's enlightenment such that stigma and discrimination are eliminated or less frequently experienced by people infected or affected, at the very least.

7.3. *Identifying workplace champions.* Dr. Leyritana highlighted the importance of identifying business sector champions and in-house champions at the enterprise-level as well to support the setting up and sustainability of workplace programs on HIV and AIDS. People who can drive the program from within, she says, are critical for the response to maximize the workplace potential to mass educate a captive population on HIV and AIDS. Otherwise, workplace HIV 101 orientations will continue to become poorly attended.

7.4. *Whether or not HIV and AIDS should be a stand alone policy or program or, if it should be lumped with other enterprise-level health and wellness initiatives*. Dr. Valeros favors a strategy that does not tackle HIV and AIDS in isolation with other workplace OSH programs. He says that, by putting HIV and AIDS at the same level as other OSH related concerns, this strategy contributes to the de-stigmatization of HIV and AIDS.

A company has three options in instituting a workplace policy on HIV and AIDS: (1) It can be integrated with the overall OSH policy; (2) it can be

7.5. *Combining HIV 101 and VCCT for onsite enterprise level engagements*. Mr. Quinto says that this strategy is very much welcome; though, he says, the availability of resources to perform VCCT may be a limiting factor for such strategy to be taken. Mr. Rosadiño also says that, sometimes, an enclosed facility or room is not available onsite which defeats the requirement for confidentiality during VCCT. This, he adds, can also be a limiting factor.

7.6. *Providing incentives for companies with good workplace programs on HIV and AIDS*. Dr. Jaramillo noted that companies like to be recognized for good labor practices and that it will be beneficial for the workplace response to identify mechanisms for awards, recognition and other incentives.

Dr. Villanueva informs discussants of the many enterprise incentives awarded by DOLE, including the regularly bestowed OSH Awards (Gawad Kaligtasan at Kalusugan) and, the ARROW Awards (ASEAN Red Ribbon Outstanding Workplace) which is currently in the pipeline. The ARROW Awards will be exclusively awarded for best workplace programs on HIV and AIDS. Each country in ASEAN will be requireed to nominate one company; all nominated companies will be judged at the regional level and the company with the best program will be bestowed the prestigious regional award.

TLY is also pushing to set up the Safe Space Program for each of their LGU partners. The award, according to Mr. Rosadiño, is intended to be bestowed to companies who have, not only created non-discriminatory workplaces with regards to HIV and AIDS but also, have outstanding health and wellness programs.

7.7. *Disseminating wider information as to DOLE support for workers discriminated by employers based on HIV status*. Dr. Valeros and Dr. Villanueva were in agreement that workplace actors must be better informed of the roles which the National Conciliation and Mediation Board (NCMB) and the Nationa Labor Relations Commission (NLRC) can play in cases of discrimination in employment in relation to an employee's HIV status.

Both institutions are administratively under the DOLE. Both have also been instructed to undertake a mandatory 30-day conciliation between the employer and the worker/s.

7.8. *Training PLHIVs on alternative livelihoods*. The BWSC provides livelihood training programs in general. Prior to actively offering these opportunities to PLHIVs, all three DOLE representatives agreed that trainers will have to undergo desensitization on HIV and AIDS.

7.9. *Partnering with LGUs*. Asked if DOLE has had experience partnering with LGUs on specific labor requirements, BWSC recalls a partnership involving the informal sector. According to Dr. Valeros, select (Chartered) LGUs are allowed to undertake technical safety inspections, such as those involving compliance to mechanical and electrical requirements, on enterprises located in their respective jurisdictions.

Dr. Villanueva said to explore the possibility of DOLE advocating for the workplace response to HIV and AIDS using the Metro Manila Council, which is made up of all local

chief executives from all cities of Metro Manila and serves as the policymaking body of the Metropolitan Manila Development Authority (MMDA). She further recommended the possible signing of either a MoA or an MoU between the DOLE and the LGU; with the important note of determining whether or not the DOLE Secretary and the Mayor are on equal footing to sign such an agreement, as per protocol. From there, she says, the DOLE will discern the need to partner individually with key LGUs in line with the workplace response to HIV and AIDS.

7.10. *Collaborating more closely with the DOH*. Dr. Valeros noted that the DOH implements a scorecard for all LGUs which establishes an incentives-based point system in evaluating the quality of health services offered by LGU-based health facilities.

**8. Next Steps**. DOLE will continue to explore the recommendations that surfaced from the discussions, beginning with the following:

8.1. OSHC and BWC will look more closely into issuing an Advisory to be issued by either agency, which will be Annexed to DO 102-10 with the primary objective of clarifying and updating its provisions. An Advisory is favored over a revised Department Order to improve efficiency of issuing the policy. Among the possible content of such an Advisory is outlining the key principles that should be present in workplace policies on HIV and AIDS.

8.2. Explore possible partnerships with LGUs.

8.3. Explore the possibility of entering into an agreement with the Philippine Economic Zone Authority (PEZA) to cover companies located in economic zones with HIV and AIDS orientations, and perhaps VCCT. DOLE will determine the effectivity of a previously signed MoU for Joint Inspection signed between DOLE and PEZA.