Program Manual on Psychosocial Care and Support Services For Persons Living With HIV (PLHIV) and their Families

Department of Social Welfare & Development

with assistance from the
United Nations Development Programme

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Message from the Department of Social Welfare and Development

HIV/AIDS have an overwhelming and often devastating impact on families, communities, and even societies as a whole. The experience in other countries has shown that HIV infection can be prevented through increased attention on information dissemination and life skills development for its citizens, especially the younger people.

The *Program Manual for the Psychosocial Care and Support Services for People Living with HIV and their Families*, is a potent tool in order to guarantee that the people with HIV/AIDS will be directed to proper care. Furthermore, this manual introduces measure to reduce mother-to-child transmission, which is essential in the fight against HIV/AIDS.

Through the Republic Act 8504 "Philippine AIDS Prevention and Control Act of 1998" and the AIDS Medium Term Strategic Plan IV (2005-2010), we have recognized the importance of ensuring that people will have access to voluntary and confidential HIV counseling and testing services as well as to address the stigmatization and discrimination by creating an environment that is caring, supportive, and sensitive to the needs and condition of PLHIV.

It is also for this reason that I am glad that this Manual has been created, because in the case of HIV/AIDS, it does not only affect the lives of the individuals but also wipes out the development gains and opportunities for growth. Thus, something has to be done with greatest urgency. The contents of this Manual, geared towards effective case management of PLHIV is a good step towards increasing the scale and intensify of servicing Persons Living with HIV as well as their families and their communities.

Let us work together to combat and prevent the spread of HIV/AIDS in our society. That is the challenge that we have to face to ensure a better future for our children and the next generations.

Corazon Juliano-Soliman
Secretary

Message from United Nations Development Programme

The Philippines is at a critical moment in its response to HIV and AIDS with the rapidly accelerating rate of HIV infection in the past years. While one of the biggest challenges is scaling up effective HIV prevention strategies, equally important is improving care and support services for the increasing number of people infected and affected by HIV and AIDS.

To help mitigate the negative impact of HIV and AIDS, UNDP supported the establishment of the referral system for care and support services for people infected and affected by the disease and the development of its accompanying program manual. These manuals are products of the strategic partnership between the Department of Social Welfare and Development (DSWD) and UNDP towards successful achievement of the outcome of the joint project, "Mitigating the Economic and Psychosocial Impact of HIV and AIDS".

The first manual, ***"A Referral System for Care and Support Services for Persons Living with HIV (PLHIV) and their Families in the Community",*** provides a framework through which stakeholders fulfill their obligations to protect and promote the rights of PLHIV, their children and affected families. It presents an effective mechanism to ensure access of PLHIV to a quality and timely delivery of services, including those that will cater the needs of their families. It is intended to facilitate the convergence of various service providers from multi-sectoral agencies to respond to the emerging needs of PLHIV towards full enjoyment of their human rights, and fulfillment of a meaningful and productive life.

This accompanying document to the referral system, ***"Program Manual on Psychosocial Care and Support Services for Persons Living with HIV and AIDS and their Families",*** serves as the operations manual to guide implementers in the delivery of care and support services to PLHIV, their children, and their families. It is a tool that supports the prevention and management of problems associated with HIV and AIDS at all levels: individual, family, and community, particularly those that requires psychosocial interventions.

I am delighted that the referral system is now in place. In a way, this will help support the fulfillment of DSWD's mandate of mitigating the impact of HIV and AIDS on individuals, families and communities, and its effort to institutionalize care and support services by strengthening the role and capacities of social workers, community volunteers, and community leaders. I hope that this will also facilitate the successful implementation of the country's Fifth AIDS Medium-Term Plan (AMTP V) particularly in addressing the emerging challenges on HIV treatment, care and support. Moreover, I hope that this would, ultimately, assist the country in attaining its MDG 6 target of halting the spread of HIV and AIDS by 2015.

I wish to extend my sincerest appreciation to DSWD for the partnership, dedication, and commitment to develop these important tools. I look forward to the effective use of these tools towards enhanced HIV prevention, care and support services in the Philippines.

Renaud Meyer
UNDP Country Director

Acknowledgement

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- More importantly, to the People Living with HIV and their Families for allowing us to learn from them and inspiring us to be more sensitive, humane, and caring individual.

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Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
AMTP	-	AIDS Medium Term Plan
ARV	-	Anti-RetroViral
ASEAN	-	Association of South East Asian Nations
CBOs	-	Community Based Organizations
COC	-	Continuum of Care
DOC	-	Declaration of Commitment on HIV/AIDS
DOH	-	Department of Health
DILG	-	Department of Interior and Local Government
DSWD	-	Department of Social Welfare and Development
FBOs	-	Faith Based Organizations
FP	-	Focal Person
FLSW	-	Freelance Sex Workers
HACT	-	HIV/AIDS Core Teams
HIV	-	Human Immunodeficiency Virus
IDU	-	Injecting Drug Users
LAC	-	Local AIDS Council
LGU	-	Local Government Unit
MARCY	-	Most At Risk Children and Youth
MARYP	-	Most At Risk Young People
MARP	-	Most At Risk Population
MC	-	Memorandum Circular
MDG	-	Millennium Development Goals
MSM	-	Men who have Sex with Men or Males who have Sex with Males
NEC	-	National Epidemiology Center
NGOs	-	Non Government Organizations
OIs	-	Opportunistic Infections
OVC	-	Orphaned and Vulnerable Children
P/C/MHO	-	Provincial/City/Municipal Health Office
P/C/MSWDO	-	Provincial/City/Municipal Social Welfare and Development Office
PIP	-	Person/s In Prostitution
PLHIV	-	Person/People Living with HIV
PNAC	-	Philippine National AIDS Council
PWID	-	Persons Who Inject Drugs
RAATs	-	Regional AIDS Assistance Teams
RBA	-	Rights-Based Approach
RH	-	Reproductive Health
RS	-	Referral System
STI	-	Sexually Transmitted Infections
TESDA	-	Technical Education Skills and Development Authority
UNGASS	-	United Nations General Assembly Special Session

Part I. Background

Chapter 1. Introduction

Section 1. Rationale

The Department of Health-National Epidemiology Center has recorded a total of 6,015 cumulative cases of HIV and AIDS from January 1984- to December 10, 2010. Notably, December 2010 has increased by 38% compared to the same period last year (2009), which was only 126, and it was highest number of cases reported in a month since 1984.

With these data, HIV and AIDS cases is alarming and growing, by 2015, if HIV transmission will not be curbed it is estimated that the number of PLHIV will reached 46,000, and of these number, a total of 9,600 cases will be recorded per year.[1] This will mean a multiple burden amongst the PLHIV and their families because HIV/AIDS epidemic has become costly to families, communities, and nations. It has become one of the most devastating disease that mankind has encountered. HIV/AIDS is a silent bomb in action. In the Philippines, drugs for AIDS cost about PhP 360,000 a year, or PhP 30,000 a month. Laboratory tests, meanwhile, cost around PhP 50,000 a month. The cost for treatment of opportunistic infections varies according to type of infectious agent. Opportunity costs within the family are also lost because of the amount of time spent in taking care of PLHIV.

Socio-economic impact of HIV/AIDS is stark among the poor. PLHIV coming from poor families have higher susceptibility to infections since they are usually affected by malnutrition. Poor families also find it difficult to access information on HIV/AIDS prevention and treatment. High cost of AIDS is easily seen at the individual or household level, rather than in the country level. When it has reached epidemic proportions, households and communities are the first to be affected.[2]

Hence, to mitigate the economic and psychosocial brunt of HIV and AIDS on the individual, family, community, and society, the DSWD with support from the UNDP have taken a proactive steps inorder to respond to the pressing needs of the PLHIV and their families. The Department formulated a Referral System for Care and Support Services for Persons Living with HIV in the Community, and the significant and unprecedented document was launched last World AIDS Day Celebration (December 1, 2010). Series of orientations, seminars, and workshops on the Referral System were conducted amongst the service providers/social workers from the Local Social Welfare and Development Offices and DSWD-Regional AIDS Assistance Teams (RAATs) and Centers/Institutions.

However, the Referral System would be in vain and incomplete without corresponding concrete programs and services made available and accessible in the community level, and to bridge the gap, the Department had enhanced its existing Care and Support: A Self-Instructional Manual for Social Workers and eventually came up with this Program Manual for Psychosocial Care and Support Services for PLHIV and their Families. This manual is the complementary document of the Referral System as it contains certain **psychosocial care and support services** particularly focus on the promotion and protection of the rights and well-being of PLHIV and their affected families. More importantly, it guides social workers on the case management process, provides tips on counseling and confidentiality, illustrates case analysis of PLHIV, and presents the importance of referral system and/or registry to monitor the cases of PLHIV.

[1] Philippine MARP Size Estimates 2009 using 2007 NSO Census, 2009 IHBSS & review of literature
[2] Care and Support: A Self-Instructional Manual for Social Workers, DSWD & PNAC, 2002

Section 2. Guiding Principles

These guiding principles are based on the harmonized values of the social work profession and that of the Country Response[3] towards the Universal Access to HIV Prevention, AIDS Treatment, Care, and Support specifically embodied by the Continuum of Care (CoC) for Persons Living with HIV. These will also guide the social workers/service providers and agencies/organizations in the provision of services.

- **Respect for Dignity and Worth of PLHIV-** Social workers represent a profession that maintains a deep respect for dignity and worth of the individual. As human beings, PLHIV also deserve the same worth and dignity. They should be treated equally regardless of sex, age, race, gender, ethnicity, religion, social, and economic status.

- **Empowerment –** The process of increasing personal, interpersonal, or political power so that individuals, families, and communities can take action to improve their situation.[4] The focus is on enhancement of the innate strengths and capacities of the PLHIV to make decisions for her/himself, assist her/him to secure access to and control over needed resources and to acquire knowledge and skills to function independently. Social workers could help PLHIV realize that HIV/AIDS is a reality to deal with. At some point, PLHIV and their families become detached from society due to fear of what other people might say upon knowing their HIV status. They live in stigma and discrimination, affecting their daily functions in life. PLHIV must be reassured to continue living and to remain productive and healthy.

- **Meaningful and Greater Involvement of PLHIV** – refers to full participation of the PLHIV, their families and significant others throughout the helping process and that all actions that will affect their welfare should ensure the active and informed engagement of PLHIV. They can be effective partners in the promotion and protection of their rights and well-being, to include their families and children, when appropriate. Social workers are responsible in presenting available options to PLHIV relating to STI, HIV, and AIDS to help them decide. It is still the client, however, who decides on the option that suits her/his needs.

- **Confidentiality and Right to Privacy-** The management and handling of information relevant to the PLHIV and their families must conform to the highest ethical and professional standards in case management and referral. No identifying information should be released to the media and the public. Any disclosure of any information must be with the consent of the PLHIV and his/her privacy is protected. Social workers should put premium in the confidentially of matters their clients disclose to them. This way, they are able to build, maintain, and keep trust of the clients.

- **Accountability** – Ensures actions and decisions taken by public officials are subject to oversight so as to guarantee that government initiatives meet their stated objectives and respond to the needs of the community they are meant to be benefiting, thereby contributing to better governance and poverty reduction.[5]

- **Best Interest of the Child -** Means the totality of the circumstances and conditions are most congenial to the survival, protection and feelings of security of the child and most encouraging to his/her physical, psychological, and emotional development. It

[3] PNAC (2009) 4th AIDS Medium Term Plan: 2005-2010 and Operational Plan 2009-2010 Philippines. .
[4] Brenda DuBois & Karla Krogsrud Milley (1996) Social Work: An Empowering Profession. Mass.: Allen and Bacon
[5] http://siteresources.worldbank.org/PUBLICSECTORANDGOVERNANCE/Resources/AccountabilityGovernance.pdf

also means the least detrimental available alternative for safeguarding the growth and development of the child.[6]

- **Gender Equality**- Means that all human beings are free to develop their personal abilities and make choices without the limitations set by strict gender roles; that the different behavior, aspirations, and needs of women and men are considered, valued and favored equally.

- **Informed Consent-** Refers to the voluntary agreement of a person to undergo or be subjected to a procedure based on full information, whether such permission is written, conveyed verbally, or expressed indirectly.

- **Networking and Linkages** – A strong active inter-link with other components such as HIV and AIDS prevention and treatment and a vast coordinated network of service providers at all levels which are crucial to the effective achievement of the intervention goals for the well being of the PLHIV, their children, families, and communities.

- **Non-discrimination** – The equal treatment of an individual or group irrespective of their particular characteristics, and is used to assess apparently neutral criteria that may produce effects which systematically disadvantage persons possessing those characteristics.[7]

- **Rights-Based Approach-** is a conceptual framework for process of human development. It upholds human being as the subject and object of development. It is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It establishes the relationship between person and the State. Moreover, it seeks to develop a key capacity- the capacity to make claims and demand accountability- needed by the poor and marginalized to overcome poverty, marginalization, and vulnerability. Under the RBA, the state, as the principal duty-bearer, has primary obligations that it needs to perform to address violations (direct action or failure to act) and come up with preventive actions (no full enjoyment hence objectively prevented from enjoying the right) of the duty bearers.[8]

Section 3. Legal Bases

The Psychosocial Care and Support Services firmly draw its mandate from:

1) United Nations General Assembly Special Session (UNGASS) Declaration of Commitment (DoC) on HIV/AIDS which was adopted on 27th June 2001. The DoC "Global Crisis - Global Action" acknowledges that the HIV/AIDS pandemic constitutes a "global emergency and one of the most formidable challenges to human life and dignity" and calls for an urgent, coordinated and sustained response to HIV/AIDS. It stresses that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS," and covers broad areas including leadership, prevention, care, support and treatment, and human rights.

[6] Supreme Court (2000). Examination of a Child Witness. Manila
[7] http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/NONDISCRIMINATIONPRINCIPLE.htm
[8] Economic, Social and Cultural Rights – Asia. 2008 B. Beyond Informality, Claiming Dignity: A Training Course for Capability Building of Leaders and members of Informal Sector Organizations, Quezon City Philippines.

2) The Millennium Development Goals (MDG) adopted in 2000 has Goal 6 setting its corresponding target of halting and reversing the spread of HIV/AIDS by 2015 and to reduce the impact of the disease on infected and affected individuals, families, and communities. The Philippines is committed to prevent the spread of HIV/AIDS in the country by implementing the national law enacted in 1998.

3) ASEAN Declaration on HIV/AIDS was adopted during the 7th ASEAN Summit on 6 November 2001 at Brunei Darrussalam. The Leaders of the ten ASEAN countries agreed to lead and guide national responses to the increasing incidence of HIV/AIDS in the region and strengthen multisectoral and inter-ministerial collaboration at the international and national levels to implement HIV/AIDS programs, among others. An ASEAN Task Force on AIDS was created which formulated the ASEAN Work Program on HIV/AIDS to ensure the region's commitments to the UNGASS and the ASEAN Declaration by member countries.

4) The Philippine AIDS Prevention and Control Act of 1998 (RA 8504) was signed on February 13, 1998 instituting a nationwide HIV/AIDS information and educational programs, provision of services to PLHIV, establishing a comprehensive HIV/AIDS monitoring system and strengthening the Philippine National AIDS Council. To facilitate the development and scaling up of local AIDS responses, PNAC created the Regional AIDS Assistance Team (RAAT) by virtue of PNAC Resolution No. 3 dated 27 April 2007. RAATs are made up of focal points from three departments: Department of the Interior and Local Government (DILG), Department of Health (DOH) and Department of Social Welfare and Development (DSWD).

   Rule 5 – Section 34 – Community Based Services

   Community-based HIV/AIDS prevention, control and care services shall be integrated into the development plans of the province, city, municipality and barangay.

   Rule 5 – Section 35 – Livelihood Programs and Training

   Government agencies such as the Department of Social Welfare and Development (DSWD), DOLE, DECS, TESDA and DTI and private agencies, as well, shall provide opportunities for PLWHAs to participate in skills training, skills enhancement and livelihood programs.

   The DSWD with DOLE, DILG and private agencies and utilizing existing mechanism and strategies, shall jointly set up a referral system to assist PLWHAs in accessing skills training and livelihood assistance programs at the regional and provincial levels.

5) The Fourth AIDS Medium Term Plan (2005-2010) is the country's strategic plan which aims to prevent the further spread of HIV infection in the Philippines to meet the country's commitment to the MDG and other international and regional instruments. The goal of AMTP is to prevent the further spread of HIV/AIDS infection and reduce the impact of the disease on individuals, families and communities. Objective 2 is to increase the access of persons infected and affected with HIV/AIDS to quality information, treatment, care and support services, and Strategy 3 Scaling up and improving quality of treatment, care and support for persons infected and affected with HIV/AIDS.

Chapter 2. The Psychosocial Care and Support Program

Section 4. Theoretical Framework

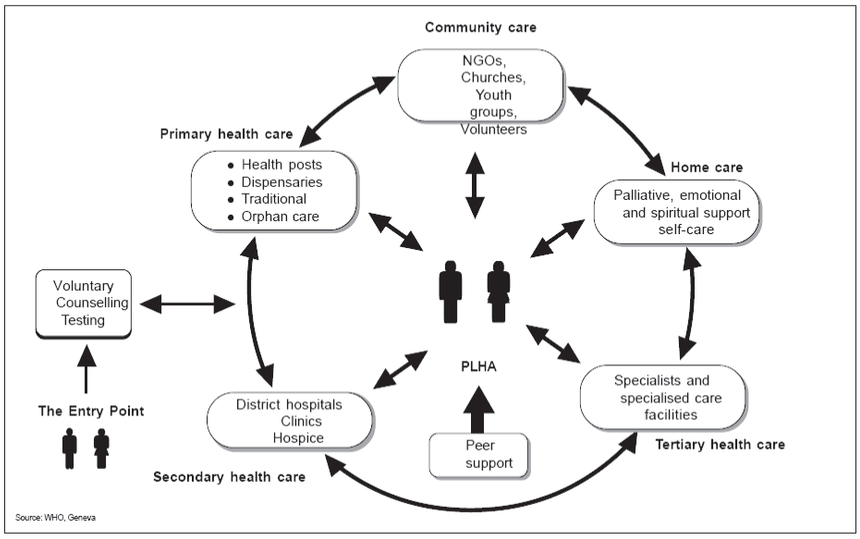
This section presents the two most fundamental and relevant theoretical frameworks used in this manual. The first Figure (1) is the internationally and widely accepted framework on HIV and AIDS while the second Figure (2), is the national framework for psychosocial care and support.

Section 4.1. The Continuum Of Care (CoC) Framework

The Continuum of Care and Referral System were used as frameworks, Persons Living with HIV (PLHIV) and their families have emotional, social, physical and spiritual needs that change over time. They often must cope with the effects of stigma and discrimination, poverty, loss, neglect and abandonment. On one hand, the purpose of the CoC is to address HIV as a chronic disease and develop systems that provide humane, effective, high-quality comprehensive and continuous care to PLHIV and their families. Continuum of Care creates an enabling environment of mutual trust and support between and among the PLHIV and the service providers that would help in the smooth facilitation and access to various support services.[9]

On the other hand, with the Referral System, the stakeholders fulfill their obligations to protect and promote the rights of PLHIV, their children, affected families, and significant others by coordinating strategic partnership with civil society. It ensures a relationship between all levels of the concerned stakeholders and guarantees that PLHIV, their children and affected families receive the best possible treatment, care and support services. Therefore, the main purpose of the referral system is the provision of an effective mechanism of ensuring access to a quality and timely delivery of services. [10]

Figure 1: The continuum of care

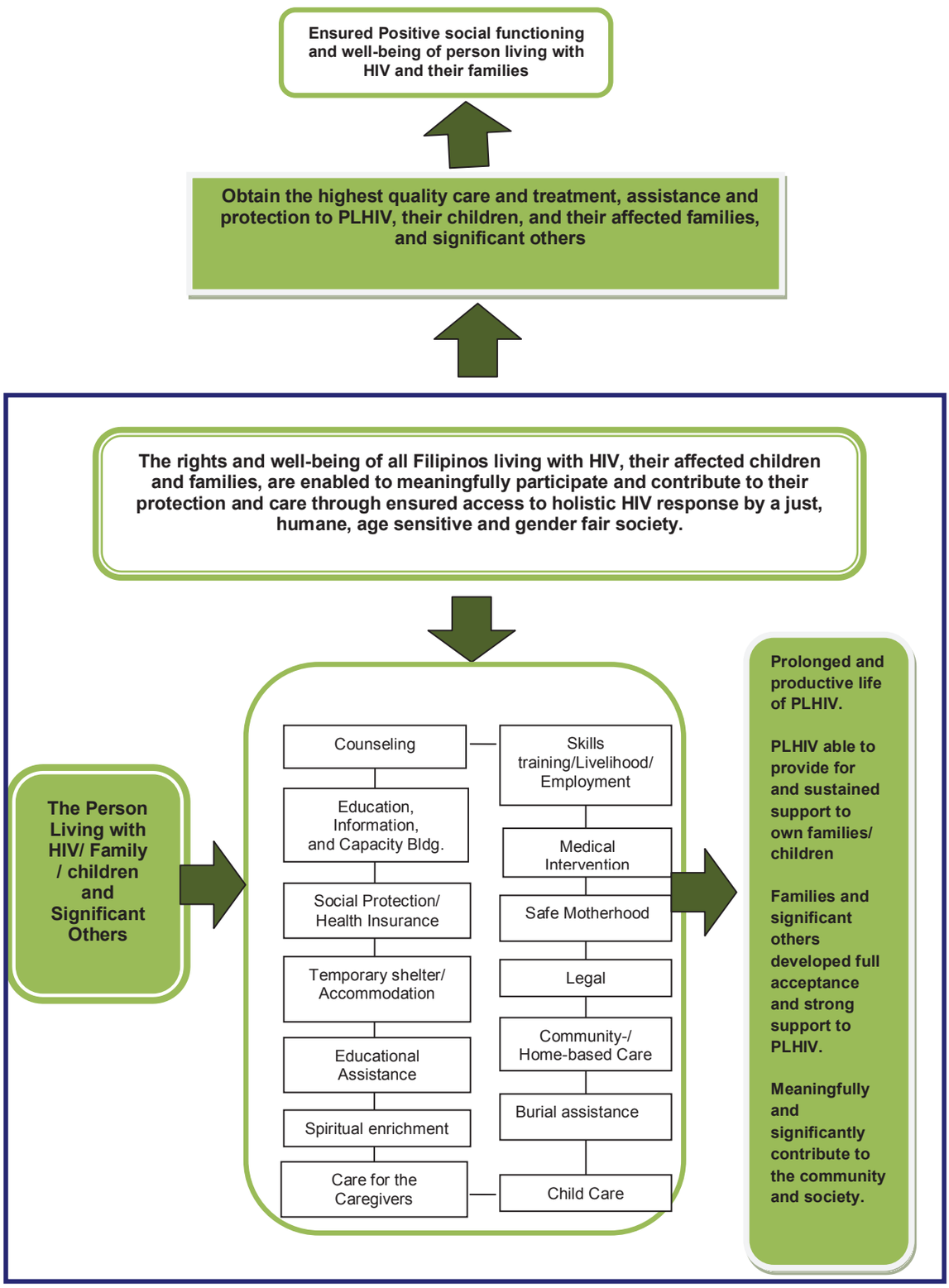


[9] Scaling Up the Continuum of Care for People Living with HIV in Asia and the Pacific: a Toolkit for Implementers

[10] Referral System for Care and Support for Persons Living with HIV in the Community, DSWD & UNDP, 2010

Section 4.2. National Referral System/Mechanism Framework

Figure 2 National Referral Mechanism for the Psychosocial Care and Support Program for PLHIV and their families



Section 5. Program Description

With the Continuum of Care (CoC) and the National Referral Mechanism, as the frameworks, the **Psychosocial Care and Support Program** is a community-based intervention for the prevention and management of the risks and related problems of HIV infection and the local collective response to those who are Persons Living with HIV and AIDS. It is geared towards the education and capability building of the individuals, family, and community in managing the impact of HIV and AIDS. It will make use of the established referral system[11] for accessing support services to the PLHIV and affected children and families in the community and in residential and hospital-based clientele.

Section 5.1. Objectives

1) General

To ensure the protection and promotion of the rights and well-being of the PLHIV and their families through provision of community-based psychosocial care and support services.

2) Specific Objectives

a. To build and/or strengthen the capabilities of PLHIV and their families to manage and cope with problems associated with HIV and AIDS.

b. To ensure that PLHIV and families have access to treatment, care and support services through a responsive referral system.

c. To support and strengthen community-based interventions strategies for the prevention, treatment, care, and support services for HIV and AIDS.

Section 5.2. Target Clientele/Beneficiaries

The primary target beneficiaries of the service are the following:

- Persons Living with HIV (PLHIV)
- Affected families
- Orphaned and Vulnerable Children (OVC)
- Significant others of PLHIV
- Affected, vulnerable, and high risk communities

Section 5.3. Program Components

1) Advocacy, Information, and Education Campaign

HIV/AIDS education and information dissemination to the public and community is necessary to control the spread of HIV and AIDS and to correct common misconceptions about the disease. This component will focus on prevention through public information and education, community education and policy advocacy.

[11] Referral System for Care and Support Services for Persons Living with HIV and their Families in the Community

The social worker must have basic information about HIV and AIDS and needs to coordinate with health authorities in these efforts. Advocacy activities in securing support and awareness on the plight of PLHIV and their families are conducted to result to adoption of policies, programs, and others.

2) Social Case Management: Access and provision of psychosocial care and support services

Social case management conducted by the social worker enables the PLHIV to access services provided by his/her agency or other agencies to promote the socio-economic and psychological well-being of PLHIV and their families. A multidisciplinary case management will facilitate the delivery of services through a referral system in place.

Aside from the discussion on the process of case management, psychosocial care and support services such as counseling, livelihood and skills training, among others, are also discussed.

3) Capability building of service providers and of support groups for PLHIV

This component focuses on the capability building of social workers, other partner agencies, and the community for a better understanding of HIV and AIDS and issues related to these, the referral system to access PLHIV and their families of available services in the community.

Support groups are important and their organization and capability building are to be conducted. If there are already existing support groups, these are strengthened and are mobilized for raising awareness and advocacy activities on HIV/AIDS. Support groups may consist of the infected and affected individuals and families as well as community volunteers.

4) Documentation and Research

Documentation of experiences in working with PLHIV and their families is necessary to improve delivery of services, identify effective strategies/approaches and keep data or statistics particularly related to the referral system.

The databank together with the actual case management experiences capturing the good practices of the referral network; social workers; and the PLHIV and their families, shall be the baseline for program review and evaluation workshops, further on, the results may be included in the research agenda of the Department for policy development and scaling-up of programs and services.

Part II. The Program Components

Chapter 3. Advocacy, Information, and Education Campaign

Public information and education campaigns are necessary since PLHIV face high levels of stigma and discrimination. Lack of knowledge regarding how HIV is transmitted contributes to discrimination among members of the general public and health workers alike. The link that many people make between HIV and "social evils" such as injecting drugs or participating in commercial sex may intensify the stigma and discrimination that is perceived and experienced by PLHIV.

Widespread stigma and discrimination against PLHIV continue to hamper care and prevention initiatives in most countries in the region. Many PLHIV practice illegal and highly stigmatized behaviors such as drug use and sex work and may not be welcome in health facilities. HIV prevention activities often have the undesirable effect of increasing stigma towards PLHIV and further marginalizing them, thus decreasing their access to care, treatment and support. [12]

Section 6. HIV and AIDS Information, Education, and Advocacy

The active participation and contribution of the community in the HIV prevention education campaign is the most cost-effective strategy to halt the spread of HIV. The myths surrounding HIV and AIDS should be corrected and rejected. Such strong belief that "Only sex workers are vulnerable of HIV and AIDS," must be rectified because it is misleading and dangerous, if construed as a fact. Everyone, regardless of age, status, gender, religion, and race, is vulnerable and susceptible of HIV infection.

Appropriate and accurate knowledge combined with safe and health seeking behavior could protect an individual against HIV and AIDS. Henceforth, HIV and AIDS information education campaign particularly, basic knowledge on HIV and AIDS (AIDS 101) should be intensified especially in the community. The saying "An ounce of preventions is a pound of cure" also applies to the issue of HIV/AIDS. Proper and sufficient information on HIV and AIDS spells significant protection. The following are the strategies or approaches in light of advocacy and information education campaign:

Section 6.1. Public Information and Education

This involves coordinated mass media campaigns (TV, print, and radio), e-media (mobile and internet /social networking sites), brochures, leaflets, etc., directed to specific audiences to raise awareness, promote public debate, increase support for needed programs and reduce stigma towards PLHIV and in vulnerable groups.

The social worker may be tapped as a resource person in TV/ radio programs or community assemblies. The social worker may discuss international, regional, and local instruments pertaining to HIV and AIDS and the programs and services for PLHIV and their families. As a reference, basic information is referred as AIDS 101 (Appendix B).

Moreover, the social worker may initiate and mobilize the involvement of the community that can be kicked-off during the two special events for HIV and AIDS.

[12] Scalling-Up the Continuum of Care for PLHIV in Asia and the Pacific, 2007

Firstly, is the celebration of "The International AIDS Candlelight Memorial", coordinated by the Global Network of People living with HIV, the world's oldest and largest grassroots mobilization campaigns for HIV/AIDS awareness in the world. Started in 1983, the Candlelight Memorial takes place every *third Sunday of May* and is led by a coalition of some 1,200 community organizations in 115 countries hosting local memorials to honor the lives lost and raise social consciousness about HIV. The Candlelight is also much more than just a memorial. It provides opportunities for leadership development, policy advocacy, partnerships, and improvement of community mobilization skills. With 33 million people living with HIV across the globe today, the Candlelight continues to serve as an important intervention for global solidarity, breaking down barriers, and giving hope to new generations.[13]

Secondly, is the World AIDS Day being celebrated on the *1st day of December every year*. It is dedicated to elevate the awareness of AIDS pandemic sources by spreading of HIV infectivity. It is ordinary to hold remembrance to respect persons who have expired from HIV/AIDS on this day. Health officials and government celebrate the event, often with forums or speeches on AIDS theme. The World AIDS Day was primary conceived in August 1987 by Thomas Netter and James W. Bunn, both were information officers for Global Program on AIDS at World Health Organization in Geneva, Switzerland. Netter and Bunn took their scheme to Dr. Jonathan Mann, Director of Global Program on AIDS (known as UNAIDS). Dr. Mann liked the idea, permitted it, and consented with the proposal that the initial ceremony of the World AIDS Day ought to be 1st December, 1988. Bunn recommended the date of 1st December to make sure reporting through western news media. He felt that since 1988 was a voting year in U.S. media passage would be tired of their post-election reporting and excited to get fresh news to cover. Netter and Bunn felt that 1st December was adequate after voting and early enough prior to Christmas holidays, in fact, it was a dead spot in news calendar and consequently perfect timing for the World AIDS Day. [14]

These two important events can also be participated by the support groups or peer educators of HIV and AIDS and they can serve as partners/resource persons in doing public information and education.

Section 6.2. Community Education

Everyone has a right to health information and services to promote health and wellness and avoid acquiring or transmitting HIV infection. In generalized epidemics, no section of society remains unaffected and the need for HIV prevention is universal. Addressing the general population in the community creates a framework/environment for more targeted HIV prevention measure to promote behavior change and stigma reduction[15].

The social worker has a significant role in educating the community on the prevention of HIV and AIDS. The social worker must work towards building community awareness on HIV-AIDS thru barangay/group assemblies, organizing volunteers, collaborating with the Sangguniang Kabataan, Barangay Council for the Protection of Children, Barangay VAWC desks, etc., to eliminate stigma and discrimination of PLHIV and their families.

[13] www.avert.org.ph
[14] http://www.altiusdirectory.com/Society/world-aids-day.php
[15] UNAIDS, Practical Guidelines for Intensifying HIV Prevention, Toward Universal Access, 2008

Section 6.3. Policy Advocacy

To support the prevention activities, the social worker, being advocate of social justice, should advocate and lobby with the Local Chief Executive and the Sanggunian the formulation and passage of ordinances/resolutions and other policies in support of HIV and AIDS programs and services. These advocacy efforts should be towards the creation of the Local AIDS Council, adoption of the referral network, and inclusion of HIV and AIDS as part of the Gender and Development (GAD) and/or the Local Development Plans.

Moreover, the social worker may also launch campaigns in a form of symposium, forum, roundtable discussion, etc., to address social and gender inequalities and sexual norms; support anti-discrimination legislation/policies for PLHIV; denounce stigma around sexuality; and advocate legal reform to remove barriers to prevention services.

The following are our Roles as Social Workers in the conduct of information education campaign:

1) *Social workers ensure that justice is given to all community members, including persons infected and affected by HIV/AIDS.*
2) *Social workers are agents of social change. Our advocacy should be able to influence public policies and legislation while working at the communities towards a healthy and supportive environment.*
3) *Social workers are also educators, especially on issues concerning sex and sexuality. In our country, sex is often viewed as personal and best discussed among close peers only. Schools only tackle its biological aspects, leaving behind its psychosocial dynamics. Such gap has to be bridged. Otherwise, STI, HIV, and AIDS cases would continue to increase in our society.*
4) *Social workers have roles in establishing linkages and networking to gain more support for PLHIV and their families. We must look at other social sectors whom we could network with, such as:*

- *Youth*
- *Women's groups*
- *Barangay health workers*
- *Parents*
- *Social workers*
- *Community leaders and volunteers*
- *Influential and respected individuals in the community*
- *Local government unit workers*

Chapter 4. Social Case Management

Section 7. Defining Social Case Management

Social case management is considered as both a skill and an approach. It is being used as a social worker's skills in the delivery of services, and in the same manner, an approach to service delivery that attempts to ensure that social welfare client with complex multiple problems and

disability receive all the services they need in a timely and appropriate fashion (De Guzman, 1992).[16]

Case management practice focuses on enabling individuals and primary groups to reach their full potential and on facilitating more effective interaction with the larger social environment. It is the function of linking PLHIV and their families with essential resources and empowering clients to function as independently as possible in securing the resources they need.

The social worker shall act as a case manager. As a case manager or a direct service provider, she/he shall link PLHIV and their families to needed resources that exist in complex service delivery networks and orchestrate the delivery of services in a timely manner. She/he may function as broker, facilitator, mediator, and advocate. She/he must have extensive knowledge of community resources, rights of clients, policies and procedures of various agencies, and must be skillful in mediation and advocacy. The case manager establishes helping relationships, assesses complex problems, selects problem-solving interventions, and helps PLHIV and his/her family functions effectively.

The need for self-awareness on the part of the social worker is perhaps nowhere as real as in working with PLHIV. Social workers should therefore, practice the principle of self-awareness, which involves bringing into their consciousness and examining their own attitudes, beliefs, and responses. [17] A non-judgmental attitude is also imperative.

The principle of individualization is of immense significance in working with PLHIV. Social workers should know that clients' adaptive tasks include maintaining a meaningful quality of life, retaining intimacy, coping with the loss of function, confronting existential and spiritual issues, and planning for survival of family and friends.

PLHIV who are gay men, injecting drug users (IDUs), women and children, as well as the families of these PLHIV, have different needs and adaptive tasks. For example, individuals with transfusion-related HIV infection have the additional adaptive tasks of "coping with feelings of victimization, sadness, anger, and isolation: decision-making concerning their medical treatment in the context of pre-existing medical condition; and rebuilding trust in relationship with health care professionals."

Most women with HIV are IDUs or the sexual partners of IDUs. Their needs are different from those of other groups. In many cases, children and adolescents with AIDS feel guilty about having the disease, about their past behavior and lifestyle, and about the possibility of having infected others. They experience sadness, hopelessness, helplessness, isolation, and depression.

Important Reminders

A Case Management is a:

- *A process wherein a client's issues and concerns are systematically tackled to obtain desired results.*
- *A process wherein both the social worker and the client have specific tasks and functions to achieve desired results.*

[16] Nunez, Consolacion, "Case Management". (2002). Philippine Encyclopedia of Social Work (2000 Edition). Quezon City: Megabooks Co.
[17] Care and support: A self-instructional manual for social workers, DSWD & PNAC, 2001

- *An interactive process wherein the client, care team and social workers collectively work.*
- *An empowerment process wherein clients are assisted in reintegrating into their families and communities.*
- *In social work, it is the process of enabling persons to mobilize resources (internal and external) to achieve a desired outcome (behavioral and/or environmental change).*
- *A process where the social worker and members of the team enable the client to perform specific tasks or activities and use the agency and other resources to reach or achieve desired results in a systematic way.*

Section 7.1. Case Management Framework

Figure 3 presents the interplay of approaches, goals and objectives, phases of case management, client system (PLHIV, family, and community) and access to referral system. It shall serve as a guide for social workers in managing cases of PLHIV.

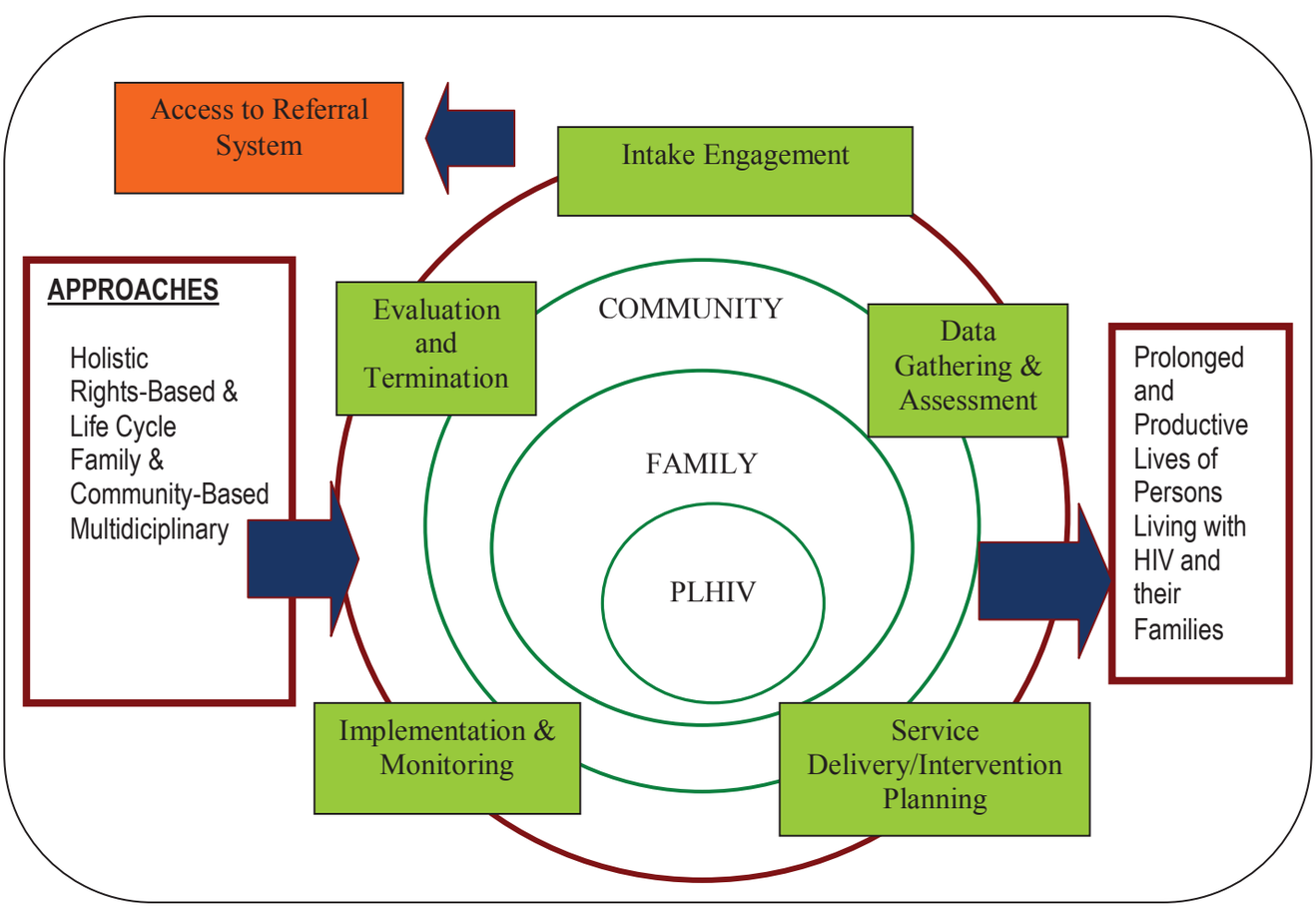


Figure 3 Case Management Framework for PLHIV

Section 7.2. Tips on Case Management

Below are the tips and to do list for social workers, it lays down certain and helpful techniques, strategies, and skills to successfully conduct each of the step involved in case management.

BASIC STEP	TO-DO LIST FOR SOCIAL WORKERS
1. Identifying and defining the problem or issue	• Prepare oneself emotionally and physically for the needs assessment interview. • Provide a safe and comfortable place to conduct interview, with client's full consent. • Prepare guide questions to aid smooth flow of interview. Tip: open-ended questions encourage clients to talk more. • Establish good rapport with client on the first interview. This is a gateway to access accurate information from client. • Ask your client's available time for initial and succeeding interviews. • Orient your client on the available services to address her/his problem as well as limitations to the situation to avoid raising too much expectations. • Always be in the "active" listening mode all throughout the interview. • Be keen on non-verbal responses of your client, as these would also help you in getting more data.
2. Data gathering	• Treat your client as main source of information. • Before gathering data, know the history of your client, especially his /her life situation. This helps you as you take note of her/his current behavior. • Understand your client's potentials and limitations, sources of strength and stress, resources for change and barriers to attain the desired change, and situations surrounding her/him.
3. Social diagnosis or diagnostic impression	• When making a case study report, seek support from representatives of established HIV/AIDS care and support teams such as local HIV/AIDS task forces, AIDS councils, or HACT core teams for more information that may benefit grasp situation and dynamics of the client. • Consult (or at least consider doing so) other experts or authorities on pressing concerns of your client. Remember: you as a social worker also have limitations. • Check on inconsistencies in the data obtained from your client, and verify these with her/him to arrive at a common goals to work on. • Practice case recording to track client's progress. • Be brief and clear when preparing your report.

4. Intervention planning	• *Level off with your client on the problem vis-à-vis expectations. Always consult your client in identifying gaps, priorities, available resources, and limitations.* • *Help your client in identifying doable alternatives and making sound decisions to contribute in the solution of the problem.* • *Encourage your client to make her/his own plan of action and establish monitoring and progress indicators. Remind her/him that action plans should be realistic in relation to available resources.* • *Institutionalize and maintain case conferences with the community care team or rehabilitation team.*
5. Implementation and evaluation of plan	• *Evaluate implementation of planned activities agreed upon by the community care team or rehabilitation team.* • *Monitor your client's progress. Consult her/him whether to continue current interventions.* • *Take note that your client's family may be part of the therapy, depending on her/his approval.* • *Always remember that your client has all the right to terminate intervention at any point whenever she/he feels it is not helping any further. When this happens, you could transfer the case to high- level institutions, or terminate if your client's needs are beyond the capacity of the community care team or rehabilitation team.*
6. Monitoring and review	• *Establish a system to keep track and measure whether objectives are met. This should involve your client, community care teams, and you.* • *Regularly evaluate your case; new data may help solve issues at hand.*
7. Termination or closure	• *Be conscious that case management process is time bound and the helping strategy and plan have corresponding outcomes within a defined period.* • *Be prepared in resolving issues concerning termination or closure of the relationship. The client has to be prepared as well.* • *Don't forget to discuss accomplishment of the interventions made.* • *Discuss possible follow up schedules.*

Section 8. Phases of Case Management

Section 8.1. Assessment Phase

The assessment phase of case management lays the foundation for the development of an individual plan for intervention/service of a client. It starts at initial contact or intake where application for services is assessed based on the problem/s presented and the agency's policies and resources. The social worker uses her skills in interviewing to gather information about the client's situation, identify his/her strengths and determine client's level of economic and social well-being. The assessment of the social workers at the end of this phase is the basis for a decision whether client will be accepted or not by the agency for services.

Section 8.1.1. Initial Contact / Intake of PLHIV

Intake is the process by which a potential client achieves the status of a client. On the client's part this involves presentation of the self and the problem or need as he or she is experiencing it. On the social worker's part, this involves some assessment of the client and the problem and whether or not the agency is in a position to help. A good intake interview should provide the client with adequate understanding of the agency and its policy and program in relation to the need or problem, as well as the responsibilities and obligations from both client and worker[18].

As prescribed by the Referral System for PLHIV, the initial engagement or entry of the PLHIV on the case management process starts when a PLHIV was referred for psychosocial care and support services either by DOH Treatment Hubs, hospitals, clinics, or LGU (P/C/MHO). The initial interview is usually conducted at the office of the Local Social Welfare and Development Office. Preferably, the intake interview should be conducted in a separate room, to ensure the privacy and confidentiality. At the onset, the Social Worker may ask the need or condition of the PLHIV before proceeding to the intake interview, because the PLHIV might be taking Anti-Retroviral (ARV) medicines that may have drastic side effects on the body and mood of the PLHIV. The social worker must ensure that the client is comfortable and ready for interview.

Further on, it must be explained to the client the importance of providing true and accurate information and that all the information are kept confidential. It is imperative that the verbal consent of the client must be obtained prior to the intake interview. If the client has given his/ her permission, the social worker shall conduct the intake interview using the prescribed Intake Form (see Appendix E) and shall ask the client to sign the consent form found at the last page of the document.

Section 8.1.2. Data Collection and Assessment

Assessment is the first phase of case management, it is a dynamic process that provides comprehensive understanding of client psychosocial functioning, environment, resources, goals, and expectations for community integration in order to optimize client care.

After the intake, the social worker must be prepared to assess and provide effective psychosocial interventions for individual clients. When the social worker was able to collect the significant data, these can be used in formulating assessment. Assessment is a professional opinion of the social worker based on the intake interview, documents presented, homevisits, and other collateral interviews. With the consent and participation of the PLHIV, the circumstances of problem and his/her presenting immediate problems versus underlying problems to be worked are identified. Consequently, through the interviewing skills combined with assessment tools, the social worker shall have an idea of the impact of the problem to the

[18] Mendoza, 2002

PLHIV's welfare (effects to psychosocial, social, physical, etc.). Thus, the PLHIV's motivation and capacity to relate and utilize help is also being explored and strengthened by the social worker. More importantly, the social worker must to do appraisal in what ways and for what reasons the Persons Living with HIV's motivation, capacity, and opportunities are inadequate to support his/her functioning and to cope with the problem (past, present and planned), and these shall also be the central focus of case management or the helping process.

In doing data collection and assessment, the social worker should:

- *Gather relevant information to coming up with assessment*
- *Client as the main source of information; collateral sources*
- *History of client (current behavior in line with the interview and his life situation)*
- *Understanding client potentials and limitations; sources of strength, resources for change and barriers to desired change, situations surrounding the client.*

Section 8.2. Intervention Planning

Planning is the process of determining future service delivery in an organized way. The result will be a service/intervention plan with the active participation of the client. Services which are not available in the agency will be may be accessed through with other agencies through the referral network. The plan identifies what services are needed, who will provide them and when they will be given.

Section 8.2.1. Planning and Contracting

Based on the assessment and the informed consent of the PLHIV the social worker with the PLHIV shall formulate a intervention and/or treatment indicating the treatment goals, objectives, activities and strategies, person responsible, time frame and the expected output. Specific activities to be undertaken by the PLHIV, their family members and the social worker are agreed upon, whether this be done verbally or written as a "contract".

The intervention/treatment plan maybe modified in the course of the implementation and shall be implemented in coordination with the PLHIV, their family/children/significant others, and other stakeholders concerned.

In the intervention planning the following are the actions needed:

- *Formulation of a goal that refers to some type of improvement in social functioning or change in client's life situation or problem at hand;*

- *The choice of goal is influenced by what the client wants; what the worker thinks is desirable and possible/ realistic or attainable within a given period of time in consideration of the social agency and social environment.*

Section 8.2.2. Arranging/Coordinating for Service Provision - Referral Network

As case manager, and to implement the agreed upon intervention plan, the social worker coordinates the provision of services either through his/her own agency or access these from other agencies. Consequently, the social worker shall utilize the existing Referral System for Care and Support Services for PLHIV and their Families[19] . The PLHIV when referred to other agencies the prescribed process and forms of the referral system. In so doing, the social worker must explain and acquire the consent of the PLHIV before the referral and guarantee the confidentiality of the case.

Section 8.3. Implementation of Interventions

Based on the agreed plan between the PLHIV and the social worker, all the strategies/interventions shall now be put into action. Below are the sets of services for the PLHIV and their families:

Section 8.3.1. Service Provision

The following services maybe provided and/or accessed to address the specific needs of the PLHIV and their families.

a) Counseling

Part and parcel of the implementation of intervention plan is counseling. Counseling is the art of providing options to clients to choose from Social workers should use counseling skills in meeting differential needs of PLHIV and their families. To counteract the pervasive helplessness, hopelessness, and isolation, the techniques of empowerment should be built into the work done with these clients. Some of these techniques can focus on the positive and less fatalistic aspects of AIDS, connect patients with sources of support, and help them regain and retain power and control over their lives and illness.

The focus of counseling is to provide emotional/psychological support to PLHIV and their families specially the children in stressful situations by assisting them in relieving their anxieties and enhancing their capability to make appropriate decisions to resolve their problems. PLHIV and their affected family/children may undergo counseling session during the helping process (case management principles and procedures shall apply).

Counseling HIV/AIDS clients is a complicated task. Skills are not acquired overnight, but are developed through actual experiences and insight. Social workers have to be aware of and understand the clients' needs. This initial and small step will help the social workers to complete our goal to provide and enabling, supportive and compassionate community for PLHIV.

[19] Launched and distributed last December 1, 2010

a.1.) What makes an effective counselor?

An effective counselor has the following personal qualities:

- *Respects dignity and rights of PLHIV.*
- *Respects the PLHIV right to confidentiality.*
- *Is emotionally stable.*
- *Is non-judgmental.*
- *Is an active listener.*
- *Is well equipped with knowledge in HIV/AIDS and STI.*

a.2.) Benefits of Effective Counseling

Counseling skills enable a counselor to:

- *Explain facts clearly and simply, and provide accurate information*
- *Listen and give the client time to talk.*
- *Ask questions that may prompt the PLHIV to say more about her/his feelings, giving the client the opportunity to think about her/his own life and relationship with others.*
- *Emphasize or understand how your client feels about her/his situation.*
- *Give psychological support, thus enabling the client to identify and explore her/his reactions, feelings, and emotions.*
- *Help the client make realistic decisions and find ways to adjust to changes by drawing on her/his own resources.*
- *Establish trust and maintain confidentiality.*

a.3.) Below are some of the counseling issues that may be handled by the social worker **:**

CLIENT	*COUNSELING ISSUES*
Orphaned children who are under the custody of their grandmother.	• *Disclosure of parent's HIV status. Is the child ready to know what happened to her/his parent/s?* • *Dealing/coping with death of a parent/s. Is there a way for the child to deviate his/her attention after the lost of his/her parents? Any relatives willing to support the child?* • *Discrimination and stigma. How will the child cope at school or community upon knowing cause of her/his parent's death?* • *Educational plan for the orphaned child. Have there been preparations for the child's education needs? If not what mechanism is available to ensure the child's education sponsorship from family members, government scholarship, or private support?* • *Livelihood, both for the child and her/his guardian.* • *Support from relatives and friends, be it technical, financial, psychosocial support. How will this be articulated or worked out among the family members?*
HIV positives who are as follows: • *Men who have sex with men*	• *Disclosure of status to partner and family. The client will have the last say whether to disclosure her/his status with anyone.* • *Lifestyle and behavior such as safer sex responsibility and substance use/abuse. It is important to reiterate values of a healthy lifestyle and behavioral practice to further enhance the well being of the client.*

• *Sex Worker* • *Injecting drug user or Person Who Injects Drugs*	• *Plan for a productive life after HIV status has been known. Help the client to plan her/his future.* • *Medical check up, insurances and medical follow-ups. Ensure that the client is referred to medical service groups.* • *Dealing with Stigma and discrimination. Help client how to handle such issues and where to go to for assistance.* • *Access to support groups. Client may wish to join peer support groups to cope up with her/his situation.*
OFW who is HIV positive	• *Disclosure of status to partner and family members. The client has the right whether or not he/she feels the need to disclose.*
Monogamous person who contracted HIV from her/his partner	• *Stigma and discrimination: Help her/him how to handle such issues and where to go to for assistance.* • *Economic concerns: A primary concern among couples especially those with children is financial stability.* • *Couple counseling on plans, sex and pleasure and other issues that matter in how to maintain a "productive" life after HIV status has been known.* • *Dealing with depression: Clients may have already been established (especially on careers) when they learn their HIV status, thereby affecting their outlook in life. Help them cope with the present and redirect plans.* • *Medical check up, insurances and medical follow-ups. Ensure clients' access to medical service groups.* • *Access to support groups in the community.*

Important Reminders

Below are the requisites in terms of skills and tasks vis-à-vis Counseling:

SKILL	*TASKS*
Active Listening	• *Pay attention to your client's verbal and non-verbal experiences.* • *Express your active involvement with your client through listening to both verbal and non-verbal cues of your client*
Paraphrasing	• *Restate in your own words what your client says to let her/him know and understand what she/he has previously said. This applies to non-verbal and underlying feelings, to help client express herself/himself further.*
Asking effective questions	• *Use questions that would help your client express herself/himself clearly, and to further encourage her/him to explore her/his thoughts. Open-ended questions encourage deeper discussion.*
Identifying and reflecting feelings	• *Help your client identify her/his feelings and reactions by taking nopte of her/his descriptions.* • *Help your client reflect on such emotions or responses to situations. Reflecting gives you the opportunity to interpret what your client has*

	previously said.
Problem solving	• *Allow your client to state and define problems.* • *Facilitate your client's exploitation of potential solutions to identified problems, and possible consequences of such.* • *Suggest possible solutions too.*
Assuming and reassuring	• *Apply these using verbal and non-verbal cues, without raising false hopes on the part of your client.*
Universalizing and normalizing	• *Inform your client that her/his responses to the situation are just normal, typical, and even "universal." This helps her/him in dealing with her/his situation.*
Acknowledging and validating	• *Let your client know that you are aware of her/his feelings and experiences.* • *Validate your client's responses occasionally since this contributes to he/his openness to discuss.*
Confirming realities	• *Confirm realities in your client's feelings and experiences, even when you may want to "protect" or cushion her/him from the pains of reality.*
Probing	• *Apply thorough questioning to enhance your client's capacity to explore and investigate her/his situation.*
Confronting	• *Apply this when your client denies her/his situation or has not come out in the open.*
Focusing	• *Help your client maintain her/his focus on more important issues at hand as many issues emerge during counseling.*
Appropriate use of silence	• *Apply this to allow your client to reflect, integrate feelings, think through an idea thoroughly or absorb new information. It is not always comfortable, however, to allow silence to continue for too long. On one hand, never interrupt silence prematurely during counseling session.*
Supporting and modeling behaviors	• *Support and reinforce certain behaviors to your client to achieve objectives. For instance, if counseling aims to improve her/his communication skills, apply clear and direct communication when interacting. When your client responds in a similar way, commend and support such type of dialogue.*
Providing information	• *Present – but do not overload – information in a clear and understandable manner.* • *Use this technique at the middle or end of a session, to allow your client to reflect on what has been previously discussed and to propose similar directions for discussion.*

a.4.) Helping HIV/AIDS Clients Deal with Emerging Issues and Concerns

- Social workers have a role in helping your client identify immediate concerns.
- Social workers have a role in helping PLHIV disclose her/his status.
- Social workers have a role in helping PLHIV deal with stigma and discrimination from others.

a.5.) Social workers role in helping PLHIV identify immediate concerns:

- Discuss whether your client wishes to inform any one of her/his HIV test results and how that particular person or persons could help.
- Identify difficulties which PLHIV foresees and possible ways of dealing with them.
- Help the PLHIV identify other support mechanisms.
- Encourage the PLHIV to ask questions.
- Discuss healthy behavioral practices such as safer sex, good diet, sleep, and exercise.
- Assure the PLHIV that shock, anger, or disbeliefs are common reactions of people to a crisis situation.
- Discuss medical follow-up procedures and expected results as well prompt identification and treatment of symptoms.
- Inform the PLHIV of local support organizations.
- Always offer a follow-up appointment.[20]

Important Reminders

The following are some of the practical guides on what social workers can say and/or suggest to PLHIV in disclosing her/his status:

- *Be selective. Disclose only to people who would surely be supportive.*
- *Disclose your status in a secure and comfortable place, since this would surely be an emotional process.*
- *Prepare yourself for most commonly asked questions after you disclose. Think of the most difficult questions, and feel free to tell them that you need them to primarily "listen" to you.*
- *Maintain realistic expectations.*
- *Not everyone understands and is supportive of the PLHIV. Some may react negatively, due to lack of knowledge on HIV/AIDS and some unfounded fears, aside from the fear of losing you. If the person or people you disclosed to want to leave, just let them.*
- *Both you and I (the PLHIV and the social worker) should not feel responsible for other peoples' reactions after disclosure. We are not required to make others feel better.*

a.6.) Types of Counseling

[20] Modified from the Care and Support: A self-instructional manual for social workers

Depending on the assessment of social worker, there are several forms of counseling that may be applied in handling PLHIV and their families and these are as follow:

a.6.1.) **Couple Counseling**

- Provided to couples or partners (regardless of marital status and sexual orientation)
- Usually centers on a common issue and carries an end goal of coming up with options or decisions suitable for the couple to address a pressing issue.
- Could be done in terms of disclosing one's HIV status, contact tracing such as in STI cases, and counseling on infertility.

a.6.2.) **Group Counseling**

- Provide to more than two persons.
- Usually centers on very broad issues common to all counselees.
- Usually conducted in post-counseling sessions for people with HIV-negative results.

a.6.3.) **Peer to Peer Counseling**

- Provided by a person or group of persons coming from the same background or orientation as the counselee. Example: a youth counseling fellow youth; former sex worker; a PLHIV to another PLHIV client.
- Has been proven to be effective in helping clients realize and accept their situations, after listening to credible sources of advice and service.
- Usually applies the experiential approach.
- Best form of counseling during disclosure of sensitive issues or situations.

a.6.4.) **Grief and Bereavement Counseling**

- One of the most tasking forms, since it involves death of a client.
- Is conducted among bereaved members of the family, friends, and relatives.
- Focuses on the process of "letting go" and helping each other cope from the passing away of a loved one.
- Usually leads to formation of peer support groups.

a.6.5.) **Task-Oriented Counseling**

- A strategy for counseling that has for its specific focus a particular behavior to be changed through assisting clients to find out and identify a range of possible problem solving actions with supportive and collaborative actions from others.
- Emphasizes active client participation in problem identification and definition; assessing and identifying possible solutions; and supportive and modeling role of caseworker.

- Social worker's roles include (a) obtaining of and assisting client to use resources; (b) finding out obstacles to resource provision; (c) helping clients prepare for carrying out their tasks; (d) doing anticipatory guidance or asking clients to think ahead of what should be done and how to react to certain situations in the future; (e) finding out obstacles to task performance and identifying solutions to overcome these obstacles; and (f) helping client revise agreement if tasks are poorly performed, situations change or new problems arise, and resources are ineffective.

a.6.6.) **Pre- and Post-Test Counseling**

In accordance with the provisions of RA 8504, the social worker trained on HIV and AIDS may provide counseling prior to and after HIV testing if the family and significant others of the PLHIV are on high risk of acquiring HIV and have agreed to undergo HIV anti body testing.

Below are the checklists before and after HIV testing:

PRE-TEST COUNSELING	*POST-TEST COUNSELING*
1. Identify and define your role in the community care team.	*1. Give the results*
2. Determine available time for counseling	*2. Check your client's comprehension of the results*
3. Value confidentiality	*3. If HIV is negative, proceed with risk reduction*
4. Ask about risk exposures that led your client to decide taking HIV test.	*4. Reinforce strategies for prevention of HIV/AIDS transmission and safer sex practices*
5. Identify risk activities and factors	
6. Provide information on transmission and prevention	
7. Discuss "window period" and check on client's last exposure	
8. Discuss on different aspects of the test – purpose, procedure, and probable implications	
9. Discuss how your client would protect sexual partners in the interim	
10. Talk with your client about list of people she/he wishes to and has to inform about the condition	
11. Identify available social support	
12. Provide contact persons while waiting for the test results	
13. Arrange for follow-up interview	

b) Educational Assistance to PLHIV and their Children

This refers to the provision of financial assistance for school tuition fee payment of the PLHIV or his/her beneficiary whether in public or private schools and learning institutions. Using the Referral for Service (Form 2) of the Referral System, the social worker shall access the PLHIV or his/her children to educational assistance from the LGUs, NGOs, CBOs, and other government

agencies' scholarship program. Depending on the agency, the following may be the requirements for the educational assistance:

- Birth certificate of the student or beneficiary of PLHIV.
- Certification from the school that he/she is currently enrolled.
- Enrolment Assessment Form of the student.
- For beneficiaries of the PLHIV who is/are out of school and have expressed the desire and commitment to go back to formal school, a social case study report from the local government social welfare services office shall be submitted.

c) Vocational/Skills Training

The PLHIV and/or members of the family may be accessed to the nearest Productivity Skills Capability Building for Women (PSCB) or various skills training offered by TESDA/DOLE that may suit their interest.

The social worker may also refer the PLHIV and/or members of the family to DSWD Regional Office who in return shall refer the client to the vocational/training school to TESDA, DOLE, or other agency for various skills training program that may suit their interest, subject to compliance to admission requirements by these learning institutions. This will prepare/enable the PLHIV and their family to venture in livelihood projects/activities that may generate income for the family. The LGU social worker shall prepare the following documents:

- Accomplished Referral Form (Form 2)
- Certificate of eligibility from the referring agency.
- For OSY beneficiary of the PLHIV, social case study report by the LGU C/MSWDO

d) Livelihood/ Income-Producing Activities/Self-Employment Assistance

The strategies and mechanism of the Self-Employment Assistance Kaunlaran (SEA-K) shall be applied in the provision of livelihood assistance to the PLHIV. The PLHIV together with his/her family/relative may be organized in order to avail of the seed capital. Note the following guidelines:

- Requisite documents may be determined by LGUs based on existing SEA-guidelines.
- In cases where funds are accessed from the DSWD Regional Office(s), this may require the preparation of a project proposal submitted to the DSWD Regional Office Focal Person for review/approval;

- As a form of investment, project proposals must have a component that facilitates recovery through a scheme that emphasizes social accountability and responsibility (e.g., Tulong Kapwa Concept).

- Social preparation is an important component of all grants and interest/ collateral free loans;

- PLHIV and their families with minimum skills and are interested in undertaking an enterprise or self-employment activities, are required to attend pre-employment/business management seminar/forum which aims to build/enhance their entrepreneurial skills and knowledge;

- Loan/grants applicants must have the capacity to manage a micro enterprise/project per social worker's /PEO assessment/recommendation.

e) Crisis Intervention Services; food/material assistance, temporary shelter, transportation, financial, and burial assistance.

Referrals (for other social services and assistance) for the PLHIVs, families and children to avail of these needed/additional services (including but not limited to legal, psychological, medical and transportation) may require financial assistance as well.

PLHIV their families/ children may request financial assistance (i.e., but not limited to transportation assistance) from their nearest M/CSWDO/DSWD Crisis Intervention Units. Provision of needed financial assistance is based on the social worker's assessment/recommendation and the client's compliance to the following requirements:

- Any valid ID of the requesting party;
- Referral letter from legislator if funding is chargeable against their PDAF if managed by DSWD;
- Eligibility requirement if necessary from the referring agency

The social worker shall assist the PLHIV and his/her family avail of burial assistance from the P/M/CSWDO or other stakeholders. The requirements for burial assistance may not be limited to the following:

- Any proof of hospitalization or death (medical or death certificate) if such is the reason for requesting assistance;
- Copy of the funeral contract and registered death certificate of the deceased PLHIV;
- Any valid ID of the claimant from the funeral service provider.

f) Medical and Psychological services

The LGUs social workers shall access the PLHIV and his/her family to their respective PhilHealth Indigent Program, subject to their local guidelines. Likewise, refer the PLHIV to proper agencies for medical services.

g) Alternative Care for Children- Early Childhood Care/Day Care, Respite care, foster care adoption and residential care, and after care services

- Day care and other early childhood care arrangements- Children of PLHIV aged 3-6 or 0-6 years old may be accessed to early childhood/day care services for temporary substitute care and respite care.

- Foster care or adoption- Should circumstances warrant, the Department or any of the licensed child caring agency may provide the Orphaned and Vulnerable Children (OVC) of HIV and AIDS alternative family care through adoption, foster care, residential, and after care services whichever is appropriate to the child's needs. The residential care facility shall abide and comply on the Department's Guidelines on HIV/AIDS Testing of Children Under the Care and Custody of DSWD, Administrative Order No. 159, Series of 2002, signed by Sec. Corazon Juliano-Soliman (see Appendix C).

  The referral shall be accompanied by the following:

  - Referral for Service (Form 2)
  - Case Study Report form the referring agency
  - Picture of the child
  - Birth Certificate of the child
  - Medical Certificate/ Abstract of the child

h) Home-Based Care

It is estimated that up to 90 percent of illness care is provided in the home by untrained family and associates, and up to 80 percent of AIDS related deaths occur in the home. This location of care is determined greatly by the scale of the epidemic.[21] A potential benefit of home based care is that sick people are continually surrounded by people they love and are familiar with, so they can also receive more flexible and nurturing care. They will also not be exposed to hospital-based infectious diseases. As people with terminal illness generally spend their final moments at home, strengthening the capacity to be cared for also removes the cost and distress of traveling to and from the hospital when they are weakest.

The family of PLHIV must also be empowered to overcome the crisis and be able to carry out their social functioning. The family members shall be provided education and support services to enable them to provide appropriate Home/Bedside care to HIV patient at home.

i) Legal Assistance

The PLHIV and their families may be discriminated by their own family, school, community, and workplace. The provisions under RA 8504, pertaining to the rights of the PLHIV must be explained by the social worker. Once the PLHIV know their rights, they will be empowered to seek either legal or extra-legal redress. In this case, the social worker shall link the PLHIV to government, non-government, and faith-based organizations for legal assistance.

[21] www.avert.org.com,February 2, 2011

j) Respite Care

This pertains to services for caregivers of PLHIV and their affected families may be availed of. Such respite care services include, Critical Incidence Stress Debriefing (CISD), stress management workshops/activities, alternative therapy, or other appropriate services. The need for respite care will be based on the assessment and continued monitoring by the social worker and doctors.

k) Family Orientation/Sessions

Programs such as peer education and peer counseling among the children and youth, women and fathers (ERPAT) will also be utilized to effectively reach out to the target population.

Likewise, the issue on HIV/AIDS shall integrated into existing programs/services available in the community such as Women in Especially Difficult Circumstances (WEDC), Parent Effectiveness Service (PES), and the Special Drug Education Center (SDEC).

Section 8.3.2. Monitoring and Evaluation

Evaluation is an ongoing part of the helping case management process, hence, the word "periodic" or "regular" evaluation. Periodic evaluation allows the worker and the client to review and, if necessary, revise the goals and objectives, assess gains and/or failures negotiate conflicts, and so on. It is a very important phase to ensure efficient and effective service delivery[22].
Thus, a quarterly case conference shall be scheduled by the social worker in coordination with the team from partner agencies (referral network) providing treatment, psychosocial care, and support services. The progress in attaining the goals of the intervention plan is both monitored and evaluated.

Case monitoring may also be done through home visitation scheduled within the first month and as needed. A home visit or progress report shall be prepared every visit or contact with clients. Collateral contacts with the other significant partners involved in the intervention plan shall also be undertaken.

Section 8.3.3. Termination and Closure

During the termination phase, "terminal evaluation" is particularly important, it is the time for the worker and the client - but particularly the worker who has been helping person, to appraise what have transpired, to focus on the goal or goals formulated during the Planning phase, and of course, on the problem that was identified during the Assessment phase.[23]

The social worker should note the changes in the client's behavior and attitudes, the knowledge gained, and the process involved in reaching the goal.

In some cases, the following are the parameters in closing a case:

[22] Social Welfare and Social Work, Mendoza, 2012
[23] Ibid

- Client and worker decide that the goal has been reached or cannot be reached and it is not desirable to continue;
- When the helping goals have been achieved;
- When the client terminates the helping relationship;
- When the helping process can no longer address the problems/ issues.
- When the PLHIV dies.

Follow up and/or after care shall be provided to the clients by the social worker and proper referral and turn over within the next 6 months or as necessary based on the social worker's assessment. Closure of the case is done after an exit interview with the client.

Chapter 5. Capability Building

Section 9. Institutional Strengthening or Capability Building

Learning is an on-going and dynamic process. Knowledge, skills, techniques, and attitude on HIV and AIDS cannot be learned overnight. Hence, it is essential to conduct capacity building to all stakeholders of HIV and AIDS.

Section 9.1. Capability Building of Social Workers

Technical assistance as well as institutional strengthening and/or conduct of capability building activities would be provided to social workers directly handling services to PLHIV and their families in the community, particularly in the high risk areas identified by Department of Health (DOH). They should also be knowledgeable about the international and national laws such as RA 8504, AIDS 101 (Basic Concepts of STI, HIV, and AIDS), Gender Sensitivity, Case Management, working with volunteers, and support group, This Manual and that of the Referral system shall be their main reference.

The stakeholders such as City Health Offices, Social Hygiene Clinics, the community particularly those at risk shall be oriented with the Referral System for Psychosocial Care and Support Services for PLHIV and their Families in the Community for them to realize their roles in the case management in relation to the referral system.

Section 9.2. Community Organization of Community Based Action Team

The community in general, the Most at Risk Populations (MARPs) and the Most at Risk Children and Young People (MARCY) in particular, shall be provided with basic proper and accurate knowledge on HIV and AIDS prevention and management (AIDS 101) , R.A. 8504, Referral System, and other relevant topics that will capacitate them to access treatment, care and support services with concerned agencies be it government, non-government, or faith-based organizations. These will be done in collaboration with the DOH and the LGUs.

The social worker's significant task is to organize Community Based Action Team in the Barangay level. Existing Barangay structures such as BCPC, VAWC Desk, SK, Barangay Council, Senior Citizens and the likes, can be organized as partners and advocates on programs and services pertaining to HIV and AIDS.

The team will be responsible in the conduct of the following:

a) Information and education campaign
b) Peer education/peer counseling
c) Family and community life enrichment
d) Initial intervention and referral for appropriate needs of PLHIV
e) After care and follow-up

The social worker trained on HIV and AIDS shall facilitate the conduct training of community volunteers on AIDS 101, RA 8504, Psychosocial Care Values Formation, etc., as well as social mobilization in the identification and training of formal and Indigenous leaders/volunteers to be members of Stop HIV and AIDS organization or movement.

The recruitment of volunteers shall be made in coordination with the local government units in communities where there is high incidence of STI, HIV, and AIDS. Volunteers shall be selected based on leadership skills and willingness to be an advocate or champions of HIV and AIDS preferably members of existing organization or support groups such as Empowerment and Reaffirmation of Paternal Abilities (ERPAT), Men Oppose to Violence Everywhere (MOVE), etc.

The members of the Stop HIV and AIDS organization or movement may report to Local Social Welfare Office who shall serve as the central advisory of the said organization. Their reports may include nature and scope of their activities, numbers of members, etc.

Section 9.3. Organizing, Strengthening, and Training of PLHIV and their Family Support Group (i.e., affected families and children)

Equally important is the organizing and/or mobilizing of support groups or peer educators, community volunteers, and networks of group of the positive community (including affected families) who may serve as partners in providing emotional support, home-based/bedside, and substitute care in times of crisis for PLHIV and their families particularly children when necessary.

Section 9.3.1. Strengthening Family Support System of PLHIV

A vital part of the helping process is integrating the PLHIV with her/his family. Actual experiences of social workers show that achieving this state is not easy as one may think, in spite of the strong sense of family ties among Filipinos. Social workers play key roles in helping PLHIV integrate with their families.

The following notes, taken from the 1997 book Social Work in Health Care in the 21st Century, could serve as our guide in successfully helping PLHIV as well as other special groups needing similar help from their families:

a.1.) Principles of Achieving Family-Centered Care

- Recognize that the family is the constant in your client's life, whereas service systems and their personnel fluctuate.
- Facilitate family/professional collaboration at all levels of hospital, home, and community care: (a) care of the individual; (b) program development, implementation and evaluation; (c) policy formation.
- Provide families complete and unbiased information in a supportive manner at all times.

- Incorporate into policy and practice the recognition and honouring of cultural diversity
- Recognize and respect different methods of coping and implementing comprehensive policies and programs for meeting the diverse needs of families.
- Encourage and facilitate family-to-family support and networking.
- Ensure that hospital, home and community service and support systems are flexible, accessible, and comprehensive in responding to diverse family-identified needs.
- Appreciate families as families and clients as clients, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for health services and support.

a.2.) Importance of Family Support System

- While working with PLHIV, social workers must define families as more than families of origin and families of procreation and include a "functional family," a group marked by committed relationships among individuals that fulfill the functions of family.

- The emotional and tangible effects of AIDS on families varies by the type of family and such factors as social stigma and isolation, fear of contagion on the part of family members, fear of infecting loved ones, fear of abandonment, guilt and physical fatigue.

- Social workers should know that the family's ability to be involved in the care of the PLHIV also depends on such factors as coping characteristics and resources, perceptions of self-efficacy, perceived adequacy of social support, familial obligation and affection, fears of being infected, the degree to which the patient is held responsible for the illness, and acceptable of homosexuality.

Recognizing that the impact of HIV and AIDS is not only biological, but also psychosocial and economic, HIV programs must respond holistically to the needs and rights of People Living with HIV (PLHIV). [24] This is why there should be a paradigm shift of involving peer educators/ support groups in the treatment, and provision of psychosocial care for PLHIV.

Section 9.3.2. Organizing and Strengthening Support Groups

This is where the role of the social workers as community organizers begins. The social worker shall strengthen linkage between health facilities (Social Hygiene Clinics, Treatment Hubs, Provincial/Municipal/City Health Offices) and community by mobilizing, organizing, and training PLHIV and their families (including their children) to form support group and/or peer educators. There are two levels of organizing support group, one is the infected level (PLHIV themselves) and the other is the affected level.

On the first level, the social worker shall conduct capability building amongst PLHIV in terms of creating support group. In peer support groups, members help each other to improve and better manage their situation, share challenges and discuss solutions. Members support each other to implement decisions made in order to meet their psychological, social,

[24] Strategies for Integrating Psychosocial Support Interventions into HIV Prevention, Care, and Treatment Services 2010 by Elizabeth Glaser Pediatric AIDS Foundation, 2010

physical and medical needs. Support groups are usually a group of HIV-positive laypeople trained to provide various services within communities.[25] Their scope of work includes providing emotional support, escorting PLHIV to clinics for antiretroviral medicines, and caring PLHIV through bedside care and pain management. The participation of support group in HIV programs provides an opportunity for the meaningful involvement of PLHIV in the provision of HIV services.

At the second level, the families and/or significant others of PLHIV may also be organized and train to be support group or peer educator. It is imperative to formulate Family Enrichment sessions to process the feelings of the family towards the PLHIV and their fears of infection.

Likewise, the families shall be also given training or orientation on adherence counseling, psychosocial care values formation and home-based care/pain management of PLHIV. Families play a critical role in encouraging PLHIV to adhere with their duty to take their ARV on a regular/daily basis. If they are ready and willing, they can also serve as resource persons by giving of testimonial sharing on the impact of HIV and AIDS to their beloved PLHIV and their whole family, during conferences, dialogues, fora, and symposia, and this can help instigate the support of the local government unit and other stakeholders.

Chapter 6. Documentation and Research

Continuing research and documentation shall be done to improve the service delivery and ensure responsiveness on the evolving issues surrounding HIV and AIDS, likewise, be abreast with the dynamics of the PLHIV and their families. In terms of documenting and reporting, the following should be noted and considered in line with risk assessment and/or vulnerabilities on HIV and AIDS and psychosocial support services provided.

Types of clients served [26]	Sex and Gender Disaggregate	Services provided
Orphaned children by HIV/AIDS Most at Risk Children and Young People	Gender 0-17 years old 17-24 years old	Indicate whether the client is Living with HIV Referral to treatment Provision / access to psychosocial care and support services (indicate specific services provided)
Filipinos with behaviors at risk for and living with HIV MSM and transgenders Female sex workers Male clients of FSWs Low-risk partners of at-risk	Gender At-birth males and females Female and pregnant Age 14 years and below 15 to 24 years 25 years and above	Indicate whether the client is Living with HIV Referral to treatment Provision / access to psychosocial care and support services (indicate specific services provided)
Locally employed Filipinos vulnerable to and living with HIV Formal or informal sector Male, female non-spousal sex Spousal relations Substance use Living with HIV*	Gender At-birth males and females Female and pregnant Age 14 years and below 15 to 24 years 25 years and above	

[25] www.avert.org.com
[26] Modified from PNAC AMTP V Planning Workshop, 2011

▪ Overseas employed Filipinos vulnerable to and living with HIV ▪ Land-based or sea-based OFW ▪ Documented or undocumented ▪ Repatriated	▪ Gender ▪ At-birth males and females ▪ Female and pregnant ▪ Age ▪ 14 years and below ▪ 15 to 24 years ▪ 25 years and above	▪ Contextual vulnerability ▪ Male, female non-spousal sex ▪ Spousal relations ▪ Substance use ▪ Living with HIV*

Documentation and/or data banking shall be done through a secured Referral Registry which shall only be accessed by the trained focal persons social workers from the DSWD Central Office, Regional Office, Local Social Welfare and Development Offices, and Non-Government Organization, Faith-Based Organizations, and other stakeholders.

Chapter 7. Institutional Arrangement

The following are the particular agencies involved in this program and their corresponding roles, responsibilities, and duties to perform:

The Department of Social Welfare and Development

- Spearheads the implementation of the Psychosocial Care and Support Services for PLHIV, their Families Program
- Prepare guidelines for the Psychosocial Care and Support Services for Persons with HIV and AIDS their Families
- Disseminate the printed the Referral System for Care and Support Services for Persons Living with HIV/AIDS and their Families in the Community
- Disseminate the Program Manual for the Psychosocial Care and Support Services.
- Conduct consultation, workshops, and dialogue with positive community, and other stakeholders / partner agencies
- Facilitate the conduct of capability building of implementers.
- Allocate funds for the conduct of capability building activities such as but not limited to orientation to Social Workers, community leaders and Volunteers and for direct services to persons with HIV and AIDS for the period of three (3) years.
- Establish linkages with GOs/NGOs to access PLHIV their families and children to available resources
- Provide technical assistance in the implementation of the program
- Document the entire program implementation
- Conduct monitoring and evaluation of the program.
- Performs other necessary functions.

DSWD Field Office

- Assist in the implementation of the Psychosocial Care and Support Services for PLHIV, their Families Program.
- Supports and promotes the Referral System for Care and Support Services for Persons Living with HIV and AIDS in the Community.
- Designate a focal person to directly coordinate with the program implementer
- Identify, manages, and monitors program beneficiaries/partners in coordination with NGO / LGU partner

- Assist in the conduct of information dissemination and advocacy activities on HIV and AIDS
- Assist in establishing linkages with GOs/NGOs to access PLHIV their families and children to available resources
- Disburse support services funds to program beneficiaries
- Assist in the conduct of monitoring and provide technical assistance to implementing LGUs/ NGO partners.
- Submit quarterly accomplishment and fund liquidation report to the DSWD
- Performs other functions necessary to carry out the above responsibilities.

NGO Partners

- Assist in the identification of target beneficiaries
- Designates a focal person to directly coordinate with the program implementer
- Conducts regular consultation with the program beneficiaries/partners/ families and help identify and resolve program issues/concerns in coordination with program partners
- Ensure active involvement of the program beneficiaries/partners in the program implementation
- Identifies/formulates mechanisms in sustaining the gains and processes involved in the program implementation
- Provide counterpart during program implementation:
  - Act as resource person to capability building activities
  - Provide technical assistance on care and support
  - Participate in the advocacy on HIV and AIDS

Local Government Unit

- Establish the Local AIDS Council (LAC) per DILG MC 99-223.
- Institutionalize the Care and Support Program within the P/M/CSWDO.
- Follows and supports the Referral System for Care and Support Services for Persons Living with HIV and AIDS in the Community.
- Designates a social worker as focal /alternate person from the local social welfare and development office to implement the program and coordinate with concerned agencies.
- Identify target beneficiaries to include formulation of criteria for the identification of beneficiaries/partners.
- Identify community leaders and volunteers for the Care and Support Program
- Ensure confidentiality of the cases of PLHIV, their Families and Children as stipulated in RA 8504.
- Conduct regular consultation with the program beneficiaries/partners families and help identify and resolve program issues/concerns in coordination with program partners.
- Ensure active involvement of the beneficiaries/partners in program implementation.
- Identifies/formulates mechanism in sustaining the gains and process involved in the program implementation;
- Propose funds for program implementation.
- Provide logistic support if available.
- Provides basic services to the clients.
- Submit periodic report.

Appendices

Appendix A. Terminologies

The following are the terminologies used adopted from HIV Media Guide: International Federation of Journalist (IFJ) Media Guide and Research Report on HIV/AIDS, 2006.

A

Abstinence
Refraining from sexual activity or delaying the age of first sexual experience. Also used as part of the term ABC – abstaining from sex, being faithful and using condoms.

Affected community
People living with HIV/AIDS and other related individuals, including their families and friends, whose lives are directly influenced by HIV infection and its physical, social and emotional effects.

AIDS
Acquired Immunodeficiency Syndrome (AIDS) occurs when an individual's immune system is weakened by HIV to the point where they develop any number of specific diseases or cancers.

Antibodies
Molecules in the body that identify and destroy foreign substances such as bacteria and viruses. Standard HIV tests identify whether or not HIV antibodies are present in the blood.

Antiretroviral Therapy (ART)
ART refers to any of a range of treatments that include antiretroviral medications. These drugs are designed to destroy HIV, or interfere with its ability to replicate. If successful, the onset of AIDS can be delayed for years.

Asymptomatic
A person with HIV is asymptomatic if they do not show signs and symptoms of the disease. The virus can be transmitted during this stage, which can last for many years after infection.

C

Care and treatment
Care and treatment encompass the range of interventions necessary to take care of people living with HIV/AIDS, including antiretroviral therapy, treatment and prevention of opportunistic infections, nutrition support, psychological and community support.

CD4 (T4) cell
These cells control the body's immune response against infections and are the primary targets for HIV. HIV multiplies within these cells and eventually destroys them. CD4 cell count is used as one measure of HIV disease progression. The lower a person's CD4 cell count, the more progressive the HIV disease is.

Clinical trial
A scientific study designed to evaluate the safety, efficacy and medical effects of a treatment. A treatment must proceed through several PLHIV of clinical trials before it is approved for use in humans.

Complementary and alternative therapies
Treatments that are outside the scope of conventional Western medicine. The effectiveness of these therapies in combating HIV infection has not been proven.

Condoms
A latex sheath worn over the penis during sexual intercourse, viewed by scientists and medical experts as the most effective way of preventing the transmission of HIV and other sexually transmitted infections.

E

Efficacy
The measurement of a drug's or treatment's ability to heal, regardless of dose. For example, the efficacy of an antiretroviral drug is the most benefit that the drug can cause without considering how much of the drug is taken.

Epidemic

The occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.

- Low-level: HIV prevalence is low across the general population and is still low among higher-risk sub-populations
- Concentrated: HIV prevalence does not exceed one per cent in the general population but does exceed 5 per cent in some sub-populations (e.g., among sex workers, injecting drug users, men who have sex with men).
- Generalized: HIV prevalence exceeds one per cent in the general population

F

Female condoms
The female condom is a lubricated polyurethane sheath with a ring on either end that is inserted into the vagina before sex. It can be inserted up to eight hours before intercourse and does not necessarily have to be removed immediately after ejaculation, offering the possibility of a woman-controlled method of HIV prevention.

G

Generic
A drug that is identical, or bioequivalent, to a brand name drug in dosage, safety, strength, how it is taken, quality, performance and intended use.

Global Fund
The Global Fund to Fight AIDS, Tuberculosis and Malaria was created in 2002 and is a partnership among governments, the private sector and affected communities. It makes grants to help developing countries fight AIDS, tuberculosis and malaria.

H

Human Immunodeficiency virus (HIV)
The virus that causes AIDS. HIV is transmitted through infected blood, semen, vaginal secretions, breastmilk, and during pregnancy and childbirth.

HIV test
HIV tests are used to identify the presence of HIV antibodies in the blood. Antibodies are produced by the body once it detects the presence of HIV.

I

IDU
Injecting drug users.

Immune system
The body's system of defense against foreign organisms such as bacteria, virus and fungi.

Immunodeficiency
When the immune system cannot defend itself against infection. HIV progressively weakens it and causes immunodeficiency.

Incidence
The number of new cases of a disease in a population over a specific period of time, usually annually.

Incubation period
The period of time between HIV infection and the onset of symptoms.

M

Microbicides
Microbicides are designed to reduce the transmission of microbes. Research is underway to determine whether microbicides can be developed to successfully reduce the transmission of sexually transmitted diseases, including HIV. Microbicides would be applied topically, either in the vagina or anus.

Mother-to-child transmission (MTCT)
This refers to transmission of HIV from mother to child during pregnancy, labour and delivery or breastfeeding. Also referred to as perinatal and vertical transmission.

MSM
MSM stands for Men who have Sex with Men. For assessing disease risk, use of the term "MSM" is often used instead of "gay", "homosexual" or "bisexual" because it refers to a behaviour, rather than an identity.

O

Opportunistic Infection (OI)
Diseases that rarely occur in healthy people but cause infections in individuals whose immune systems are compromised as a result of HIV infection. These organisms are frequently present in the body but are generally kept under control by a healthy immune system. When a person infected with HIV develops an OI, they are considered to have progressed to an AIDS diagnosis.

P

Pandemic
A worldwide epidemic occurring over a wide geographic area and affecting an exceptionally high proportion of the population.

Prevalence
Prevalence is a measure of the proportion of the population that has a disease at a specific period in time.

Prevention
Prevention activities are designed to reduce the risk of becoming infected (primary prevention) and the risk of transmitting the disease to others (secondary prevention). Prevention services include safe-sex education, condom distribution, voluntary counseling and testing, disease surveillance, outreach and education, and blood supply safety.

Prophylaxis
Refers to the prevention or protective treatment of a disease. Primary prophylaxis refers to medical treatment that is given to prevent the onset of infection. Secondary prophylaxis refers to medications given to prevent the symptoms of an existing infection.

PLHIV
Person/People Living with HIV/AIDS.

R

Risky behavior
Any behavior or action that increases an individual's probability of acquiring or transmitting HIV. Examples include having unprotected sex, having sex with multiple partners and injecting drugs.

S

Safe sex
Safe sex is any sexual activity that does not allow semen, vaginal fluid, mucus from the lining of the vagina or anus, or blood to pass from one person into the bloodstream of another person. Many sexual activities are therefore safe as they don't allow these fluids to transfer from one person to another. Being safe for HIV does no necessarily mean an activity is safe for some other sexually transmitted infections including gonorrhea, syphilis, chlamydia or herpes.

Sexually transmitted infection (STI)
Any disease or infection that is spread through sexual contact.

T

Tuberculosis
A bacterial infection caused by Mycobacterium tuberculosis. It usually affects the lungs but can spread to other parts of the body.

U

UNAIDS
This acronym refers to the Joint United Nations Programme on HIV/AIDS. It is a part of the UN and is a collaboration among 10 organizations and the UNAIDS Secretariat.

Unprotected sex
Sex without a condom.

V

VCT
Voluntary Counseling and Testing programs enable people to learn their HIV status and receive counseling about risk reduction and referral to care if they are HIV positive.

Viral load
The amount or concentration of HIV in the blood. There is a correlation between the amount of virus in the blood and the severity of disease – the higher the viral load, the more progressive the HIV disease. A viral load test is an important tool for doctors in monitoring illness and determining treatment decisions.

Vulnerable populations
Populations that are at increased risk of exposure to HIV due to socioeconomic, cultural or behavioral factors. Vulnerable populations include refugees, poor people, men who have sex with men, injecting drug users, sex workers and females, particularly in countries or communities where gender inequality is pronounced.

W

World Health Organization (WHO)
WHO is the United Nations agency for health. It is governed by 192 member states, and aims to help all individuals achieve the highest possible level of health.

Appendix B. Basic Knowledge on STI, HIV, and AIDS (AIDS 101)

Gender and Sexuality in the Context of HIV and AIDS

In dealing with PLHIV it is very important that the social worker is gender sensitive. Knowledge and application of basic information on gender and sexuality can serve as practical tools in addressing gender issues along their community work; remove gender-based barriers in counseling; and develop openness and comfortability in discussing issues on gender and sexuality. The following are the points to be considered by the social worker:

- The terms SEX and GENDER are usually considered synonymous. They have, however, different meanings.
- Sex refers to the distinction between male and female, or that property or character by which an animal is male or female. Example; penis for males, vagina for females.
- Gender refers to the way a community defines a man or a woman. Society expect women and men to look, think, feel and behave in specific ways.
- Worker's Gender may also include ideas about "typical characteristics " of women and men. Gender could vary according to culture and social norms.
- Concept of gender could be learned from family, friends, schools, opinion leaders, religious and cultural institutions, workplace and media.
- Gender roles are passed from parents to children. Society further perpetuates these roles. Gender roles, however, change as the world changes.

GENDER DICTIONARY AT A GLANCE:

- **Heterosexual:** sexual orientation in which a person is physically attracted to a person of the opposite sex.
- **Homosexual:** sexual orientation in which a person is physically attracted to a person on the same sex.
- **Gay:** male homosexual.
- **Lesbian:** female homosexual.
- Men who have sex with men: men who have sex relations with other men.
- **Bisexual:** sexual orientation in which a person is physically attracted to both sexes.
- **Transvestite:** a person who dresses, uses cosmetics and acts like a person of the opposite sex.
- **Transsexual:** a person who changes her/his physical characteristics to completely resemble the sex to which she/he feels she/he belongs to Example: taking hormones and undergoing sex change orientation to have a penis removed or constructed.
- **Transgender :** a person who has the characteristics of the opposite sex, Example: a person dressing like the opposite sex and perhaps taking hormones, but refuses to undergo sex change operation.

Sexually Transmitted Infections (STI)

The saying "An ounce of prevention is a pound if cure" already captures what should be our attitude when it comes to STI. Proper education and measures could mean our protection from STI.

STI response

- Just like HIV/AIDS, STI are also considered one of the most crucial health concerns of our society since these result from persons' sexual behavior and practices. Prevention and cure of STI remain a challenge in developing countries like the Philippines despite access to antibiotics.
- Encounters with persons willing to disclose their STI problems require adequate and immediate responses. Social workers are advised to know nearest health centers for referrals since prompt treatment of STI prevents further complications.

STI defined

- STI refers to infections passed from one person to another during sex.
- Any type of sex act could cause STI vaginal sex, anal sex, or oral sex. It could also occur from just rubbing an infected sex organ against another's organ.

- STI could be passed from a pregnant woman to her baby before or during childbirth.

STI signs and symptoms

- Abnormal discharge in the genital area, anus or mouth. D
  is charge may be yellowish, pus-like, whitish, cheesy, foul smelling.
- Ulcers or wounds in the genital area, anus or mouth.
- Abnormal growth of skin lesions in the genital areas or any part of the body.
- Pain at the lower abdomen.
- Frequent episodes of urination.
- Pain in the male's scrotum.
- Itchiness in the genital area.
- History of unprotected sex.
- History of having multiple sex partners.

STI red alert

Noting just one of STI's known signs and symptoms is enough to refer one's client to the nearest health center or clinic for medical evaluation and eventual treatment.

STI Complications

- Infertility/sterility. Failure to immediately treat STI causes scarring of normal tissues of the reproductive tract.
- Ectopic pregnancy
- Pelvic inflammatory disease (PID). This usually occurs to women. STI such as Chlamydia and gonorrhea affects a woman's upper reproductive e tract (cervix, uterus, ovaries, or uterine tubes). Symptoms include pain in the lower abdomen, lower back, and vaginal discharge.
- Effects on the baby. STI could lead to premature births, birth of underweight babies with eye defects.
- Other STI resistant to drugs, resulting from under treatment, self-medication, or poor compliance with drug dosage. Drug-resistant organisms are more difficult and expensive to treat.
- Recurrence of infections, especially when a client (a) has a partner who is a symptomatic for STI; (B) Applies self-medication; (c) fails to complete dosage requirement or fails to have follow up checks; and (d) has a partner who is yet to be treated from STI.

STI STICK-ONS

Always remember!

1. STI and HIV are co-factors. One is susceptible to HIV if he/she is detected to have STI, and vice-versa.
2. STI treatment needs holistic approach. Presence of just one STI may lead to or indicate another STI.
3. Self-medication complicates treatment of STI as it causes drug resistance and recurrence of infections

HIV/AIDS

What is HIV?

- It is Human Immunodeficiency Virus, which causes AIDS. It thrives on living human cell.
- It attacks one's immune system by making her/his body susceptible to infections such as pneumonia, tuberculosis and cancer. A person susceptible to infections is said to have AIDS.
- It does not have any specific sign or symptom. An HIV-Positive individual may feel and look healthy, but could learn her/his status only through HIV antibody testing.
- It could infect anybody male or female; Men who have Sex with Men (MSM) or heterosexuals; Filipinos, Chinese, or Americans; Protestants or Catholics; rich or poor.

What is AIDS?

- It is Acquired Immune Deficiency Syndrome. It is the last stage of HIV infection.
- It is when opportunistic infections are common, eventually leading to the carrier's death.
- It is a syndrome. It carries a constellation of non-specific signs and symptoms as a result of overwhelming infection.

How does HIV affect one's body?

- A person is affected by HIV if she/he has exposure with an HIV-positive patient (through sex, blood transfusion).
- In the early stages of HIV, the body shows no symptoms until later part of infection.
- These symptoms will be resolved until the immune system becomes too weak to fight overwhelming infection, as in the case of AIDS.
- Not all signs and symptoms may occur to HIV positive individuals. These are called opportunistic infections, since they happen when the immune system could no longer fight the disease.
- OIs usually occur to persons with AIDS; they succumb to death due to complications from AIDS.

Seeing the Code: non-specific signs and symptoms of HIV

- Intermittent or persistent fever
- Fatigue
- Weakness
- Diarrhea
- Malaise
- Loss of weight
- Generalized swelling of lymph nodes in neck, arm pits, or groin
- Skin infections
- Whitish patches in the mouth and tongue
- Sores in the genital area, buttocks, or mouth; athlete's foot, etc.

How is HIV detected?

- In the Philippines, HIV screening is done through blood test. Blood tests determine presence of HIV antibodies in one's blood. This is an indirect test of the virus wherein the body produces antibodies against HIV.
- The body usually produces HIV antibodies six (6) months after the time one has been exposed to an HIV-infected person.
- The HIV antibody test involves two (2) steps. First step is the screening test that uses either the ELIZA Test, or enzyme-linked immunosorbent assay or the PA Test, or the Particle Agglutination test. The second step is the confirmatory test, which uses Western Blot or immunoflourescence test. Only those whom yield positive results in the ELIZA or PA tests undergo the confirmatory test.
- HIV antigen test is a direct test of the virus itself. It is usually used for research purposes only, such as the Polymerase chain reaction or PCR.

What is the window period?

- At the time a person's body develops antibodies against the virus, usually 3 to 6 months from the time of exposure to HIV.

TRANSMISSION NOTES: HOW HIV COULD BE TRANSMITTED OR NOT

HIV could be transmitted:

- When body fluids with high concentration of virus successfully enters the bloodstream of an individual.
- Transmission through blood and blood products is 95 percent high-risk to an uninfected partner. This includes blood transfusion, organ transplant, and sharing of contaminated needles and syringes during drug use.
- Perinatal transmission (mother to child) has only 20 to 40 percent chance to successfully transfer HIV from mother to child. Using anti-retrovirals during pregnancy further lowers risk by 8 percent. Transmission happens during last trimester of pregnancy, labor and delivery, or during breastfeeding. Absence of anti retroviral therapy during breastfeeding increases risk of HIV infection to the child by 25 percent.
- During unprotected sexual penetrative sexual intercourse anal, vagina, and oral sex.
- Body fluids known to have high concentrations of the virus include blood, seminal fluid or semen, vaginal or cervical secretions, and breast milk of a HIV-infected mother.

HIV is not transmitted through:

- Air
- Saliva, urine, feces
- Mosquito bites
- Talking with persons with HIV/AIDS
- Borrowing clothes from an HIV person
- Sharing of utensils, drinking from the same glass with the person with HIV/AIDS
- Shaking of hands, embracing, kissing

- Coughing or sneezing
- Sharing swimming pools or toilets with PLHIV
- Sharing instruments used in barber shops or parlors, such as shaver, razor, nipper and all cutter.

Factors for "successful" HIV transmission:
- High concentration of HIV at the time of exposure
- Mode of transmission
- Route of transmission
- Virus has successfully entered the bloodstream.

How is HIV prevented?

For blood:
- Screen blood for donations and transfusions.
- Avoid sharing of contaminated needles and syringes during intravenous drug use.
- Observe standard precautions in handling body fluids. Health care workers should use protective materials such as gloves, goggles, lab gowns and masks when exposed to body fluids. Protective materials should be properly disposed of after use.

For seminal fluid, semen and cervical/vaginal secretions:
- Abstain from any sexual activity; or
- Be faithful to one partner; or
- Use condoms consistently during sexual intercourse.
- Observe safer sex practices

For Breast Milk:
- Deciding whether to breastfeed or not a child is crucial, the mother has to weigh risks and benefits.
- HIV positive mother should be informed the breastfeeding may transmit virus in her baby. In situation, however where milk supplements or potable water are not available, breastfeeding should still be practiced.

BREAKING MYTHS ABOUT HIV/AIDS

- Body fluids such as saliva, urine, tears, and sweat have low concentration of HIV and are said not to be transmit the virus effectively
- One needs eight (8) gallons or 35 liters of saliva to infect the individual with HIV. If this involves a kissing act, it has to be done in one session to transmit the virus!
- HIV is not easily transmitted. The virus does not live outside the body of a human being, since it needs human cell to live and multiply;
- Casual contact (holding hands) does not transmit HIV.

Is there a cure for AIDS?
- There is still no cure for AIDS until today.
- Current anti-retroviral could only slow down HIV progression. Known as reverse transcriptase and protease inhibitors, these medications slow down replication of HIV in the body.
- Known as "cocktail therapy", medications are combined to produce synergistic effects against HIV as well as lower side effects from anti-retroviral medications;
- Research still goes on regarding long term effects of these medications to man.

What are other vital issues in treating AIDS?
- Cost of drugs. Taking anti-retroviral drugs is very expensive because it has to be maintained once taken.
- Quality of life. Standard of living may be affected since most resources go to purchase of expensive medications. Other family needs such as education may be sacrificed.
- Compliance with the intake of retroviral medications. This refers to client's regular check ups and consistent intake of prescribed medicines.
- Drug resistance. This may be due to failure to follow proper dosage. PLHIV need to be monitored during anti-retroviral intake to determine response of the body.
- Treatment failure. Sometimes, the body no longer responds to cocktail therapies.

It is important to note that HIV prevalence in the Philippines is still low at 0.03% (UNAIDS 2000) but this does not mean that we have to be complacent but yet be very vigilant for an explosive HIV/AIDS epidemic might occur.

The Psychosocial Cost of AIDS

Most PLHIV face psychosocial issues such as uncertainty and adjustment to communities they belong to. This is a result of whether or not they will be accepted once again just like any ordinary member of the community. Knowing their status usually threatens their dreams and aspirations and this is brought about by the compounding fear of having HIV surfaces.

Common psychosocial concerns that PLHIV experience include the following:

- Self denial or self stigma as a result of once HIV status
- Denial/Stigma of partner, family members/relatives, members of society/community
- Isolation from the community as a result of stigma/discrimination
- Depression/Loneliness
- Revenging/Avenging HIV client which is as a result of anger/rage or denial
- Loss of relationship as a result of HIV stigma
- Disclosure of one's HIV status – how soon to partners / family members
- Rights to disclose one's HIV status- the best time to do so by the doctor/social worker if it is for the medical improvement/interest of the client and disclosed among members of the care team
- Discrimination from work, travel, education, access to information and services as a result of knowing one's HIV status

Social workers must know and recognize these issues when we deliver our care and support services at the community.

- In general, PLHIV may think of different priorities and these depends on how PLHIV has readily accept the realities in their lives. In case when their families accept their status, PLHIV tend to wish helping their families achieve a better life. In cases where there is no disclosure yet, PLHIV concentrate on this goal, expecting full acceptance and support later on.
- Some PLHIV hope that cure for AIDS would soon be developed. Unfortunately, very few PLHIV have access to antiretroviral therapies. The reason for this is that it is very costly and could not readily be afforded. It would cost PhP 30,000/month on ARV treatment alone and that does not include hospitalization or other laboratory needs of the client.
- Quality of life among PLHIV varies accordingly. The social worker's sensitivity to her/his client is key to helping the client develop and nurture concept of quality of life.

To ensure success in addressing the client's needs, the social worker should be able to understand and level off with the client's definition of quality of life, and means of achieving it. This is a big challenge to us.

Appendix C. Guidelines on HIV/AIDS Testing of Children Under the Care and Custody of DSWD

PHILIPPINES 2000

July 15, 2002

Administrative Order No. 159
Series of 2002

SUBJECT: **Guidelines on HIV/AIDS Testing of Children Under the Care and Custody of DSWD**

I. Rationale

Republic Act 8504 otherwise known as, "The Philippine AIDS Prevention and Control Act of 1998" specifically Article III, Section 15, prohibits compulsory Human Immuno-deficiency Virus (HIV) testing on any individual. Compulsory HIV testing refers to "HIV testing imposed upon a person attended or characterized by the lack of vitiated consent, use of physical force, intimidation or any form of compulsion".

The AIDS Registry which is the official record of reported HIV positive and AIDS cases and deaths in the country shows that from January 1984 to January 2002 there were 1,622 recorded cases of HIV infection. Of the total number infected, 1,076 are asymptomatic and 546 are AIDS cases. Thus so far, there have been 239 deaths due to AIDS complication.

Regardless of age and sex, a child under the care of DSWD and its licensed/ accredited agencies is at risk with HIV infection when he/she is under the following circumstances: sexually abused by someone with multiple partners or being born to a woman with HIV.

The DSWD as the legal guardian of abandoned/neglected children who are under their care shall act accordingly in instances wherein an informed consent shall be obtained for a child in need to undergo HIV testing.

In view of the above, the policies and guidelines provided henceforth, shall be adopted by the DSWD Field Offices and its licensed/accredited child caring/placing agencies to ensure that every child under their care and custody is protected of their rights relative to compulsory HIV/AIDS testing in response towards the global concern of HIV/AIDS infection.

II. Legal Base

A. International Global Instruments

1. The Declaration of commitment on HIV/AIDS adopted during the United Nations 26th Special Session of the General Assembly last June 2001 confirms the commitment of all countries to take the necessary steps to implement the present Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges.

1

2. The United Nations Commission on Human Rights in its Resolution 1995/44 adopted on 3 March 1995/44 confirmed "that discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term or other status in non-discrimination provisions in international human rights tests can be interpreted to cover health status, including HIV/AIDS.

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

Article 2

State parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interest of the child shall be the paramount consideration and shall:

c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption.

B. Local Laws

1. Republic Act 8504, "The Philippine AIDS Prevention and Control Act of 1998"

Section 2 ***(b) Declaration of Policies*** - The State shall extend to every person suspected or known to be inflicted with HIV/AIDS full protection of his/her human rights and civil liberties. Towards this end,

- Compulsory HIV testing shall be considered unlawful unless otherwise provided in this Act;
- The right to privacy of individuals with HIV shall be guaranteed;
- Discrimination in all its forms and subtleties of having HIV shall be considered inimical to individual and national interest; and
- Provisions of basic health and social services for individual with HIV shall be assured.

Section 15. ***Consent as a Requisite for HIV Testing*** - No compulsory HIV testing shall be allowed. However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV: Provided, that written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual.

Section 17. ***Exception to the Prohibition on Compulsory Testing*** - Compulsory HIV testing may be allowed only in the following instances:

(b) When the determination of the HIV status is necessary to resolve the relevant issues under Executive Order No. 309, otherwise known as the "Family Code of the Philippines".

III. Implementing Guidelines

A. Purpose

Children who are considered to be high risk of contracting HIV/AIDS and are under the custody of the DSWD or its licensed/accredited child caring/placing agencies may be recommended for HIV testing to ascertain his/her health status for medical care and appropriate treatment.

In the same manner, the child may be recommended to undergo HIV testing when he/she is being considered for permanent placement either thru local or intercountry adoption and upon the written request of the prospective adoptive parents. It is to be understood, however, that in no way should the child be deprived of the right to alternative family care on the basis on his/her perceived HIV status.

B. Coverage

The following children shall be covered by these guidelines, to wit:

- Children whose legal custody are voluntarily or involuntarily committed to DSWD;
- Children who are under the protective custody of the DSWD in the center or in the community; and
- Children who are under the care of the DSWD and its licensed/ accredited child caring agencies for temporary shelter.

C. General Policies

1. An in-depth study on the child's situation is necessary to determine whether the child needs to undergo HIV testing for his/her best interest and welfare. The social worker may only recommend for HIV testing when it is beneficial to the child and is based on the following conditions:

    1.1 The mother is known to be HIV positive or have engaged in high risk behaviors (e.g. drug dependent, active sex life with multiple partners, etc.);

    1.2 The child is a victim of sexual abuse, especially if the alleged perpetrator is suspected to have engaged in high risk behavior; or

    1.3 The child is manifesting symptoms of HIV infection.

2. The primary consideration in submitting the child for HIV/AIDS testing should be for his/her best interest so as to take necessary precautions and to give him/her proper medication and appropriate care if the test turns out positive.

3. In cases of adoption, the prospective adoptive parents should have an official request for HIV testing once matched to a child indicating the reason for such request.

4. The fees/cost for the HIV testing shall be chargeable to the DSWD Field Office/child caring/placing agency responsible for the care and custody of the child or the prospective adoptive parents matched to a child if they requested for such test.

5. The HIV status of a child should not be treated any differently from any other analogous medical condition in making decisions regarding care, support, custody, fostering or adoption.

6. Children found to be HIV positive must be ensured/guaranteed of their right to privacy and the right against discrimination considering that children with HIV/AIDS are victims due to their vulnerability which should not be taken against them.

7. The DSWD shall be responsible to coordinate with the concerned agency or the adoptive parents caring for the child who has been found to be HIV positive to ensure that appropriate care and medical treatment are provided for. The Department of Health (DOH) shall be tapped to provide support to the medical needs of the child.

8. The Department shall maintain linkage with the Department of Health (DOH) or NGOs at the national/regional level to ensure that social workers are trained on HIV/AIDS prevention and case management.

D. Procedures

The general procedure to be strictly adhered to prior to the HIV testing of a child whose case is handled by the DSWD either center-based or community-based and its licensed/accredited child caring/placing agencies are as follows:

1. Pre-requisite for HIV Testing

1.1 Maintaining Confidentiality and Privacy

Confidentiality encompasses all information that directly or indirectly lead to the disclosure of the identity of the child recommended for HIV testing. This information includes, but is not limited to the name, age/date of birth, address, picture, physical characteristics or any other similar identifying characteristics.

The child's right to privacy shall at all times be protected and guaranteed by the Social Worker handling the particular case. In so doing, the Social Worker must ensure confidentiality through the following:

- The child to be tested or is diagnosed to have symptoms of HIV infection shall be given an assumed name or code name instead of the real name;

- The member of the inter-disciplinary team who are critical for the care of the child and management of his/her case has a need to know the child's medical status. This also include the Court which has jurisdiction over the petition of adoption in case one is filed in Court. Provided, further, that the judicial proceedings be held in executive session pursuant to Article VI, Section 31 of R.A. 8504; and

- The result of the HIV testing must be kept in a separate folder from the medical records of the child. Except for a valid medical or legal need for this record, no access shall be allowed to any individual or agency.

Penalties for violating medical confidentiality, as provided in Section 33, Article VI of R.A. 8504 shall be applied.

1.2 Pre-test Counselling

Pre-test counselling is necessary for an individual who shall undergo HIV/AIDS testing. Notwithstanding the age/maturity of the child, he/she must be prepared both physically and emotionally before undergoing the HIV test by the Social Worker who is trained to handle HIV/AIDS cases of children. When the child is of age to understand the situation, the pre-test counselling shall include:

- Purpose of HIV testing.
- What the test is, and what it is not.
- Procedure i.e., how long he/she will wait for the result.
- Implications of the test and the meaning of the result, both negative and positive.
- Informed consent and prohibition of compulsory testing.
- Guarantees of confidentiality and risk-free disclosure.
- Basic information on HIV/AIDS infection.

1.3 Informed Consent

Informed consent as a requisite for HIV testing under RA 8504 refers to the voluntary agreement of a person to undergo or be subjected to a procedure based on full information. 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 child or a mentally incapacitated individual.

- In case of children voluntarily or involuntarily committed to the Department, the Director of DSWD Field Office shall decide upon the recommendation of the Social Worker handling the case if it is deemed necessary for the child to undergo HIV testing. Consequently, the approval for the issuance of a written informed consent of the child shall be the responsibility of the DSWD Field Office Director in their respective regions;

- In instances of children who are under the care of the DSWD but whose biological parent/s has/have not relinquished their parental authority, the Social Worker must consult the parent/s and seek their decision whether to give consent for the HIV testing of the child. The written informed consent shall be obtained from the parent/s once they are agreeable to it; and

- In the event wherein the parent/s of a child can no longer be found, the consent of the nearest kin shall be sought or a petition for involuntary commitment of the child to DSWD shall be filed at the appropriate Court. A Declaration of Abandonment committing the child to the care and custody of the DSWD must be obtained from the Court before the DSWD Field Director can give consent for the child to undergo HIV testing.

  The written informed consent to be used shall be in conformity to the prescribed format (Annex A) developed by the DOH as provided for in the Implementing Rules and Regulations of RA 8504.

2. *Post-test Counselling*

Counselling at this stage is provided to children and prospective adoptive parents for emotional support in case of a positive HIV antibody test.

- It is important that the Social Worker explains the implications of the test result and be able to address psychological reactions to it.

- The Social Worker must identify other medical and social support system needed by the child; and

- The Social Worker must recommend the need for follow-up and appropriate care for the child.

  In case of a negative HIV antibody test result, the Social Worker must explain the meaning of a negative HIV test and initiate preventive and continuing care for the child.

IV. Procedural Safeguards

To ensure that rights of children are protected:

1. Testing should only be undertaken to enable prospective adoptive parents to make an informed decision to ensure that the child receive optimal care and NOT to discriminate a child.

2. Disclosure of the test results should only be limited to a selected group which shall include members of the interdisciplinary team in charge of the child's care and management of his/her case and of the committee tasked with matching the child to parents, and the Court which has jurisdiction over the petition of adoption in case one is filed.

3. Custodians of the test results should be bounded by the provision on medical confidentiality under RA 8504.

4. Security measures such as having identification codes on file covers rather than names; separating medical form from administrative files; enforcing a clean desk policy and locking filing cabinets with only authorized personnel to have access should be strictly observed.

5. Any breach of confidentiality involving disclosure should be penalized in accordance with R.A. 8504 and other existing rules and regulations.

V. Monitoring and Reporting

The Field Office shall monitor the strict implementation of these guidelines for HIV testing of children under the care of DSWD and its licensed/accredited child caring agencies.

Likewise, the Field Office is responsible in reporting to the DOH AIDSWATCH in the region any HIV/AIDS related health data for statistical and monitoring purposes without divulging the identity of the child tested and ensure that the result is not traced or linked to him/her.

VI. Effectivity

This Order shall take effect immediately.

CORAZON JULIANO–SOLIMAN
Secretary
Department of Social Welfare and Development

Appendix D. Assessment Guide in Handling PLHIV

PSYCHOSOCIAL ASSESSMENT OF PLHIV

Introduction

It has been realized that psychosocial intervention is integral to the comprehensive Care, Support and Treatment services for PLHIV. Though psychosocial needs are identified as corner stones of quality services, it is often undermined. A lot of human resource issues are contributing to the lacunae of present interventions like lack of professional and component specific training, research, refresher courses, etc. in addressing specific psychosocial issues of PLHIV. The present counseling services or psychosocial interventions are limited to mere information sharing only.

Psychosocial Assessment

Social workers working with people living with HIV/AIDS must be prepared to assess and provide effective psychosocial interventions for individual clients. Assessment is an ongoing (dynamic) process. It provides comprehensive understanding of client/caregiver psychosocial functioning, environment, resources, goals, and expectations for community integration in order to optimize client care. Prime tool for assessment is relationship.

Psychosocial intervention

Psychosocial intervention is dealing with all the social phenomena which have direct impact on the individual and vice versa.

FAMILY ASSESSMENT

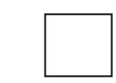
Genogram

A genogram is a graphic representation of a family tree that displays the interaction of generations within a family. It goes beyond a traditional family tree by allowing the user to analyze family's emotional and social relationships. It is used to identify repetitive patterns of behavior and to recognize hereditary tendencies.

In social work, genograms are used to display emotional bond between individuals composing a family or social unit. A genogram will help social workers to make an assessment of the level of cohesiveness within a family or a group and to evaluate if proper care is available within that unit. Genogram displays social relationships that illustrate the places people attend such as schools, churches, youth facilities, associations or retirement homes. Here are some of the basic components of a genogram.

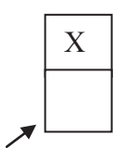
It should be identified whether anybody else in the family is HIV positive. (i.e., the spouse and children of the client)

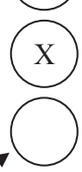
Male-



Female

Death





Infected with HIV

Family vulnerability/ Life Cycle

Here we asses other problems which the family is facing. The family life cycle is the emotional and intellectual stages a person passes through from childhood to the retirement years as a member of a family. We asses the stage in which the family is in and developmental lag in each stage of family life cycle.

- Number of children
- Challenges in the family
- Relationship with parents and moved out children

- Major life events (death, birth, illness and treatment,) (Significant points from life events)
- (e.g., marriage of adult girl. (Most felt need)
- Excessive loans.
- Constant fight with neighbors, siblings.

The Family Life Cycle

Family Life cycle Stage	Emotional Process of Transition: Key Principles	Changes in family status required to proceed developmentally
Leaving home: Single young adult	Accepting financial and emotional responsibility for self	▪ Differentiation of self in relation to family of origin ▪ Development of intimate peer relationships ▪ Establishment of self in relation to work and financial independence
The joining of families through marriage: the new couple	Commitment to the new system	▪ Formation of marital system ▪ Realignment of relationships with extended families and friends to include spouse
Becoming parents and families with children	Accepting new members into the system	▪ Adjusting marital system to make space for child(ren) ▪ Joining in child rearing, financial and household tasks ▪ Realignment of relationships with extended family to include parenting and grand parenting roles
The family with adolescents	Increasing flexibility of family boundaries to include children's independence and grandparents' frailties Accepting a multitude of exits from and entries into the system	▪ Shifting of parent-child relationships to permit adolescents to move in and out of system ▪ Refocus on mid-life marital and career issues ▪ Beginning shift toward joint caring for older generation ▪ Renegotiation of marital system as a dyad ▪ Development of adult to adult relationships between grown children and their parents ▪ Realignment of relationships to include in-laws and grandchildren ▪ Dealing with disabilities and death of grandparents
Families in later life	Accepting the shifting of generational roles	▪ Maintaining own and/or couple functioning and interests in the face of physiological decline; exploration of new familial and social role options ▪ Support for a more central role of middle generation ▪ Making room in the system for the wisdom and experience of the elderly, supporting the older generation without over-functioning for them ▪ Dealing with the loss of spouse, siblings, and peers and preparation for own death Life review and integration

Family Type/ Dynamics

Social Worker assesses the type of family and how comfortable the family is. In family dynamics, we assess mainly cohesion / relationship in the family, whether the family members are dependent/ interdependent/independent on each other. This assessment helps to find out the possible resources from the family.

Communication

The way of talking of the family members is assessed here. It is imperative to determine how and with whom the family members express their positive and negative feelings. Here we asses: How do people make a request, give reinforcement, express negative comments and how open they are.

Role

One of the greatest challenges in HIV/AIDS pandemic is the role change in the family. In vast regions of the world this disease has disrupted the basic family structure. A family member with HIV/AIDS increases the pressures on a family. Can that family respond adequately to the problems? There is both physical and emotional damage. Women and elderly family members are overburdened with the painful duty of providing care for HIV infected and orphans. Women first and then children become the heads of families. Children's role changes from the cared to the caring person.

Social workers have to assess the pattern of role change because of the HIV infection and burden with multiple roles (strain).We also have to find out what all possible ways are there to address this strain.

Leadership

We have to assess the leadership pattern in the family before and after the occurrence of the illness

Reacting / Responding

Here we assess how family members reacted to the HIV diagnosis and how they are reacting to the current situation. We also assess how they are providing support to the HIV infected.

Decision Making and Problem Solving

We assess decision making and problem solving process in the family by asking major life events like death, birth, loss of job, illness etc. Some of the areas to be probed are: Who took the major life decisions, how was it taken, were decisions taken against the will of others in the family? Does the client regret or feel depressed about any of the decisions taken earlier in his/ her life and how were the problems in the family solved?

Family Resources

A resource is that which is restored to, relied upon, or made available for aid or support. In family resources, we assess all material and non-material resources which family has such as the following:

- Good relationship with relatives (support)
- Material resources (property)
- Membership in a community or religious group, (e.g., Muslim)
- Networks which the family is part of (e.g., Self Help Groups, Positive Networks etc)
- Possible place of resources (church in that place, lions club, youth club, rotary club etc)

This assessment helps to utilize the community resources to be able to provide effective support to the infected and their family.

Family Appraisal of stressors /Expectation

Here we assess**:**

- Meaning of stress to the family
- How does the family look at the issue? (Responsible, feels disgrace, extra expense, contagious.)
- How does the client look at the infection?
- What is the immediate concern of the family?, etc.

PSYCHOLOGICAL ISSUES

Individual's Appraisal

This is done to figure out how the individual looks at the particular infection. Whether he/ she views it as means for social discrimination, if it causes worries, tensions, whether the client is hopeful about his/her future, whether there is a pessimistic attitude, whether he/she is deeply troubled by any other related issues (family, job, finance etc. e.g., I am worried about the social discrimination; I am more worried about economical part; any way I am going to die)

The Emotional status of the client can also be determined. The following aspects have to be covered while checking the emotional status of the client.

- Whether the client is very active or not?
- Whether the client has good sleep?
- Is he/ she very anxious?
- Whether the client is depressed?
- Does he/she have any hope in life?

- The appetite of the client should also be assessed.

Expectations

It is significant to identify what the client expects from social worker or the system? Unrealistic, high expectations need to be rectified/ modified or else this may lead to other emotional issues.

Strengths and Weakness

Identify what all are the strengths of the person. Also assess if the client has any weaknesses like substance abuse (smoking, drinking alcohol), any extra marital affairs etc

Habits / Recreational patterns

How does the client keep himself occupied?

Individual Feelings and Reactions

[Cognitive distortion]
Attitude towards his/her problem [Analyze the thought process]

COGNITIVE DISTORTION

Overgeneralization - Taking isolated cases and using them to make wide generalizations.

This type of distortion causes you to think that because a negative event has happened, it represents a never-ending pattern in your life. Over-Generalization thinkers often over-exaggerate the event and make self-critical statement about themselves and their lives with defining words like “never” “nothing” “everything” “always” “every time” “completely” “totally” “forever” “nobody” and “everybody”, “Bad things always happen to me.” “I can never win.” “Nothing good has ever happened to me in my life and nothing good will ever happen.” This negative type of self-talk often leads to self-defeat and depression. The pain of rejection is generated mostly from over-generalization.

Mental filter - Focusing exclusively on certain, usually negative or upsetting aspects of something while ignoring the rest, like a tiny imperfection in a piece of clothing.

This type of distortion causes you to ignore or filter out all positive things and focus exclusively on the negative. Depressed people are not aware that they are filtering out everything positive; they tend to focus or dwell only on negative details or experiences. The best way of describing the mental filter is to imagine putting one drop of ink into a glass of water. At first, it just creates a few small discolored streams, and then almost instantly, the entire glass of water is discolored. To overcome mental filters you must force yourself to look for positive potential or possibilities in situations that you feel are overwhelmingly negative.

Magnification (also known as *Catastrophizing)* and **Minimization** - Inappropriately understating or exaggerating the way people or situations truly are. Often the positive characteristics of *other people* are exaggerated and negative characteristics are understated. There is one subtype of magnification:

- *Catastrophizing* - Focusing on the worst possible outcome, however unlikely, or thinking that a situation is unbearable or impossible when it is really just uncomfortable.

Magnification causes you to look at yourself and your problems through a magnifying lens which grossly magnifies all your mistakes, faults, or problems. Then you turn the binocular around and minimize anything good you see in yourself.

With this faulty thinking pattern, there is a tendency to magnify or exaggerate the importance of your problems. You either blow things out of all proportion or deny facing things the way they really are. This type of thinking destroys your self-esteem and sets you up for feeling overwhelmed by every situation that happens.

Some people use minimization to point out the weakness, flaws or shortcomings of others. They always insert a “but” into every evaluation. The problem with the “but” is that it negates anything good that may have been said before it.

All or Nothing Thinking:

This type of distortion causes you to think in extremes. You see things as either black or white; or totally good or totally bad. You tend to evaluate yourself as a winner if something goes right or as a total loser or a complete failure if something doesn't go as expected. All or Nothing thinkers often use words like: always or never when describing things. Example: "I always pick the worst checkout line at the grocery" "I never get a break." "Nobody likes me." With All or Nothing thinking, if your performance falls short of perfect, you see yourself as a total failure.

Disqualifying the positive

This type of distortion causes you to discount any compliments or praise you receive from others. You feel that what they are saying doesn't count. For example, say you work really hard on a project and do a good job, but when you start to receive attention for it you negate all your effort by implying that anyone could have done it or you tell yourself it wasn't good enough. Some people erroneously think they are being modest and shunning pride by doing this. Discounting the positive thinkers often use words or phrases like: "it was nothing" "anyone could have done it" "it was just dumb luck" "you're just saying that" or "they're just trying to be nice." Unfortunately this type of thinking robs them of any joy or satisfaction and always leaves them feeling inadequate and unfulfilled.

Jumping To Conclusions:

This type of distorted thinking pattern causes you to make negative assumptions or interpret events with no evidence or facts to support your thoughts. In other words: You jump to conclusions without knowing all the facts or giving the other person a chance to explain. It usually manifests itself in two very interesting ways: mind reading and fortune telling.

Mind reading

In mind reading, you decide that someone is reacting negatively to you, and assume that you know what they are thinking, feeling and/or why they are acting the way they are. This is a dangerous thinking pattern because it can lead to erroneous thoughts, groundless negative feelings, anger, resentment and bitterness.

Fortune telling

In fortune telling, you anticipate that things are going to turn out badly before they have begun or that an event will go from bad to worse. This fatalistic mind-set makes you feel like your thoughts and feelings are a fact and that nothing will ever change.

Labeling and Mislabeling:

This type of distortion causes you to attach a label to yourself, your behavior and your experiences, as well as applying labels to others that you believe to be true. Note: a label is a classifying name or phrase usually applied to a person or thing that is generally demeaning, all-encompassing and restrictive.

When you apply personal self-defeating labels to yourself — you create a negative self-image. Instead of describing an error or mistake you made as an experience ("I made a mistake"), you label or classify yourself as "I'm an idiot" or "I'm such a loser." It is like all-or-nothing thinking, blown out of proportion.

Mislabeling is when you apply negatively charged labels to others. Mislabeling is generally used when describing a person or event when you are experiencing intense emotions. The descriptions and language used is highly colored and emotionally loaded.

Emotional Reasoning:

This type of distortion causes you to reason with your emotions or feelings. In other words, you assume that your emotions reflect the truth or things the way they really are. However, negative feelings or emotions can color your thoughts, and you may not be thinking objectively or rationally.

This is very apparent in people who are depressed. Sometimes, when a person is very down or very upset, they will think, "My family would be better off if I were dead." They think this would be true because they are viewing everything from their upset emotions. If they were thinking rationally or objectively, they would realize that nothing good could ever come from doing something like that.

We should never make decisions based on how we are feeling emotionally, especially if those emotions are very negative or we are very upset. Rule of thumb: Feelings cannot be trusted; they do not always reflect the truth. Do not let your emotions or feelings determine how you behave or react

"Should", Statements:

This type of distortion causes your self-talk or inner voice to be very self-critical of yourself and often very critical of others. Your internal conversations are filled with "I should" "I must" and "I ought to" towards yourself and "They should" "They must" and "They ought to" towards others. You generally have a list of rules that you feel you or others must live up to. However, these "ironclad rules" leave you feeling guilty when you don't measure up to them and angry, frustrated and resentful of others when they don't meet your expectations.

Do not try to motivate yourself or others with these words. It does not work. In fact, these words usually have the exact opposite effect and cause yourself and others to resist and/or retaliate against you — the "messenger" and the "message."

Use better words to express your desires. Use exact expressions like: would like to, want or need. These are not critical or demanding nor controlling; they simply state what you want to express.

Personalization and Blame

This type of distortion causes you assume responsibility for things that are out of your control. You feel personally responsible for the happiness or unhappiness of others. You take everything that people say or do as a personal reaction to you. This type of thinking, personalization and blaming, leads to chronic feelings of failure and false guilt. Personalization leads to guilt, shame and feelings of inadequacy.

For example, when a woman received a note that her child was having difficulty in school, she told herself, "This shows what a bad mother I am," instead of trying to pinpoint the cause of the problem so that she could be helpful to her child.

Some people do the opposite. They blame other people or their circumstances for their problems, and they overlook ways they might be contributing to the problem:

For example, "The reason my marriage is so lousy is because my spouse is totally unreasonable."

Remember, you can only have an influence on others; you cannot control anyone else, nor should you want to. Blaming yourself for what others do causes you to fall into the victim role. This makes you vulnerable to how you perceive the way people treat you. The rule of thumb is: It's not the event that causes your emotions, feeling or mood, but how you interpret the event. Stop taking responsibility for everyone else. You're only responsible for yourself! That's it! It's not your job to carry the weight of the world on your shoulders.

Effort towards addressing the problem

What all steps /effort the client has taken to address financial problems, Stigma etc can be figured out.

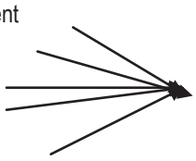
BRIEF MEDICAL HISTORY:-

The Social Worker can look into the past and present medical history of the person. What is the chief complaint of the person when he/she is admitted. Some of the other aspects to be probed into are:

- If HIV Testing has been done or not
- If yes, when was it done and where (which Hospital)
- Whether the client is on ATT
- If yes, which type?
- Whether the client is taking ATT from any PHC
- Whether the client is on ART.
- If yes, from which hospital he/she is taking ART?
- If the CD4 count testing has been done or not?
- *The Social Worker has to ask questions to identify whether the person is suffering from any Opportunistic Infections.*
- Whether the client has any other illness apart from HIV and OIs, i.e. Cardiac problems, BP, cholesterol
- Identify the treatment given earlier and the duration of medications.

PERSONAL DEVELOPMENT HISTORY

- Early development
- Childhood
- Adolescence
- Adulthood
- Current phase.



any challenges or blocks in this phase.

SOCIO-ECONOMIC CONDITIONS

Economical

Here the Social Worker has to assess the monthly income of the family, number of earning members, assets of the family and debts. The nature of employment of the family members including that of the client can be identified, whether it is seasonal employment, unemployment etc. The skills of the person and his educational background also be identified. This will prove effective at instances when rehabilitation of the person has to be considered.

Social

Here we try to assess the interaction pattern of the person with others before and after diagnosis, how well he involved in social activities, was he a recluse or an extrovert, how well he/she initiates activities etc. We can also identify the person's membership in any social networks, political organizations, sangams etc.

CULTURAL AND SPIRITUAL

This is to get an idea regarding the cultural and spiritual background of the person. It is necessary to probe into the rituals, beliefs and values the person used to conform to in his life. It is important to note how spiritual is the person before and after the diagnosis. A significant variation in the same, calls for a need to intervene. All interventions made in this aspect should be culturally sensitive.

Scope of Medical Social work in Case Management of PLHIV

The methods of social work such as Social case work, group work, community organization, social work research and social action are highly potential in addressing multidimensional felt needs of PLHIV comprehensively. The assumptions of social work have special reservation on quality of life of Individuals, Groups and Communities. The guiding principles of social work interventions are framed in right based approach. The scientific methods, techniques and strategies could be used optimally to respond to the various needs of PLHIV.

Role of Medical Social Worker

- Psychosocial assessment and interventions with Individuals, groups and families infected and affected by HIV/AIDS
- Creating an enabling environment through linkage and leverage activities with potential service providers
- Scaling up of programme and strategies by working with a multidisciplinary team
- Research and development of best practices/interventions

Break up of Tasks Work with Individuals:-

- Social case work,
- Counseling (Pre and post test counseling, follow up and in-patient counseling, etc)
- Crisis intervention
- Livelihood counseling,
- Positive prevention counseling
- Nutritional counseling,
- Spiritual counseling
- De-addiction counseling
- End of life counseling
- Bereavement counseling
- Life skill education
- Treatment education and drug adherence
- Care giver education

Work with Groups/Families:-

- Social group work
- Group therapy
- Support group meeting/Follow up meeting
- Work with families, life skill education
- Care giver training
- Vocational training for PLHIV and care givers

Work with Orphaned and Vulnerable Children:-

- Provide child counseling services
- Adoption Services
- Educate family on child rights
- Encourage child participation in the programme
- Ensure the comprehensive growth and development of children through psycho-social intervention

Other areas:

- Coordination of Admission procedures
- Referrals and linkage to various service providers
- Transportation arrangements
- Leverage social welfare services
- Legal Aid
- Funeral arrangements
- Maintaining client case load

Appendix E. Intake Form (Form 1)

INTAKE FORM (Form 1)	CONFIDENTIAL

Instructions	This form should be completed by *fully trained and designated staff* of the implementing agency. Original copy shall be maintained by implementing agency and shall form part of the client's records. Any information contained herein and the rest of the records of the client shall be considered classified information. No information from this Form shall be shared to anyone except when needed and as may be authorized. Attach additional pages with continued narrative, if needed. Information must be encoded in the Referral Registry system.

Date of Intake: _____ Case No. _____

I. Identifying Information

Name: _____ (AKA, if any): _____
Sex:_____ Age: _____ Civil Status:_____ Date of Birth: _____
Place of Birth: _____
Complete Permanent Address: _____
Provincial: _____
City Address (zone number, if any): _____
Highest Educational Attainment: _____
Last school attended by the client:_____
Address of school: _____
Date/Year_____ Status in school (Pls. check): _____OSY _____ ISY
Occupation: _____ Employer: _____
Religious Affiliation: _____ Ethnicity: _____
Skills: _____
Contact No/s: Mobile Phone:_____ Landline: _____
Email Address (if any) : _____
If the client is minor, name of parent/guardian/custodian: _____
Relationship to the client: _____

II. Family / Household Composition

Name	Age	Sex	Civil status	Address	Relationship to Client	Religious affiliation	Educational attainment	Occupation/ Employer	Income	Remarks

III. Problem Presented

_____
_____
_____
_____
_____
_____

IV. Background of the Case

_____
_____
_____
_____
_____
_____

VI. Initial Assessment/Impression

_____
_____
_____
_____
_____
_____

VII. Intervention Plan

(Use additional sheet if needed)

Objective	Plan (activities)	Time Frame	Funding Requirements/ Source	Responsible service provider	Action taken	Expected output

V. Evaluation/Recommendation

_____
_____
_____
_____
_____
_____
_____

PAHINTULOT NG KLIYENTE*(INFORMED CONSENT)*

Ang mga nabanggit na impormasyon ay pawang katotoohanan at kusang loob kong ibinigay, at ito ay maaring maibahagi sa ibang ahensya na makakatulong sa ikabubuti ng aking kasalukuyang kalagayan o kondisyon.

Nilagdaan ko ngayong _____, sa tanggapan ng _____
_____

_____
Pangalan at Lagda

Prepared by:

_____
Name of Service Provider and Signature

_____
Designation

Appendix F. Referral Form (Form 2)

REFERRAL FORM (Form 2)	CONFIDENTIAL
Instructions	This form should be accomplished when referring client for services not provided by own agency. Be specific on what types of services are requested.
Note	For Referring Agency (RefA) - Please be reminded to attach appropriate documents to complete the referral. Seal the envelope containing this form and the documents, and then give it to the client and instruct him/her to give bring it to Receiving Agency (RecA). After completing this form, fill up the Referral Registry (Form 4).

Date of referral								
Receiving Agency								
Contact person/Focal person of receiving agency								
Client's Name		Age		Sex		F		M
Occupation of the client		If married, number of children						
Civil status		Educational attainment						
Address of client								
Name of Guardian (if minor/child)								
Client's Address								
Client's Landline		Permanent Address						
Reason/s for Referral								
Specific Support Service/s Requested								
Referring Agency								
Address of the Referring Agency								
Contact number/s of Referring agency								
Referred by: (Signature over printed name of worker)								
Position/designation								
Documents accompanying referral								
Noted by: (Signature over printed name)								
Position/designation								

Appendix G Feedback Form (Form 3)

FEEDBACK FORM (Form 3)	**CONFIDENTIAL**
Instructions	This form should be completed by the Receiving Agency (RecA) after provision of requested services which must be forwarded to the Referring Agency (RefA).The inclusive dates of provision are needed both at the initial contact and succeeding services. The last column is to be filled up only by the case manager of client. This form may be given to the client in a sealed envelope or sent to the RefA through courier or other means.
Note	The information on this form will be part of the National Care and Support Services Databank (NCSSD), particularly in the Services Provided field, thus accuracy of information is imperative.

Case no. _____ **Date:** _____

Name of Client	Age:	Sex:	Address:
TO: (Referring Agency):			
Name of Focal Person/Contact Person:			
Address:			
FROM: (Receiving Agency):			
Name of Focal Person/Contact Person:			
Address:			
Name of client:			
Date referred			

Services requested	Services provided	Name of Service Provider/s and Designation	Inclusive Dates of Provision		Other Pertinent Information such as Problems Encountered	Client's satisfaction feedback (Only for case managers)
			Initial	Update		

Appendix H. Referral Registry (Form 4)

REFERRAL REGISTRY	CONFIDENTIAL			
Name of client			Case no.	
Receiving Agency (RecA)	Type of services provided	Date of Referral	Date of monitoring (follow up) and Progress notes (Status of the case)	Remarks