PHILIPPINES

SKPA-2 Baseline Assessment Report

March 2023

HEALTH EQUITY MATTERS

ACRONYMS AND ABBREVIATIONS

ACHIEVE	Action for Health Initiatives, Inc
AEM	AIDS Epidemic Model
AIDS	Acquired Immunodeficiency Syndrome
AIP	Annual Investment Program
AMTP	AIDS Medium Term Plan
APCOM	Asia Pacific Coalition on Male Sexual Health
ART	Antiretroviral Therapy
BIR	Bureau Internal Revenue
BPA	Budget Partnership Agreements
BTr	Bureau of Treasury
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CDP	Comprehensive Development Plan
CHD	Centers for Health Development
CHE	Current Health Expenditure
CLM	Community-Led Monitoring
COA	Commission on Audit
COVID-19	Coronavirus Disease 2019
CPA	Citizen Participatory Audit
CSO	Civil Society Organization
DBCC	Development Budget Coordination Committee
DBM	Department of Budget Management
DFAT	Australia's Department of Foreign Affairs and Trade
DIC	Drop-in Center
DICT	Department of Information and Communication Technology
DILG	Department of the Interior and Local Government
DOF	Department of Finance
DOH	Department of Health
DOH-EB	Department of Health – Epidemiology Bureau
DRDF	Demographic Research and Development Foundation
ELA	Executive and Legislative Agenda
FSW	Female Sex Workers
GAA	General Appropriations Act
GAAAO	GAA as an Allotment Order
GDP	Gross Domestic Product
GFI	Government Financial Institutions
GCG	Governance Commission for GOCCs
Global Fund	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOCCS	Government-Owned or-Controlled Corporations
GOP	Government of Philippines
HARP	HIV/AIDS & ART Registry of the Philippines
HASH	HIV & AIDS Support House

ACRONYMS AND ABBREVIATIONS

HFEP	Health Facilities Enhancement Program
HIPTTreA	High-impact prevention, testing, treatment and adherence (HIPTTreA)
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IHBSS	Integrated HIV Behavioural and Serologic Surveillance
IRR	Implementing Rules and Regulations
LAC	Local AIDS Council
KP	Key Populations
LCE	Local Chief Executive
LDIP	Local Development Investment Program
LEP	Local Expenditure Program
LGC	Local Government Code
LIPH	Local Investment Plan for Health
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
LGU	Local Government Unit
LTV	Long-Term Vision
LYS	The LoveYourself
M&E	Monitoring and Evaluation
MDS	Modified Disbursement Scheme
MSM	Men who have sex with men
N/A	Not Applicable
NASPCP	DOH National AIDS and STI Prevention and Control Programme
NCA	Notice of Cash Allocation
NEDA-ICC	National Economic Development Authority Investment Coordination Committee
NEP	National Expenditure Program
NGOS	Non-governmental Organizations
NIRT	National Internal Revenue Taxes
NSP	National Strategic Plan
OHASIS	One HIV and STI Information System
OSBPS	Online Submission of Budget Proposals System
PAFPI	Positive Action Foundation Philippines, Inc
PCNC	Philippines Council for the NGO Certification
PDP	Philippines Development Plan
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
Php	Philippines Pesos
PLHIV	People Living with HIV
PNAC	Philippines National AIDS Council
PPA	Projects, Programs, Activities
PPAPI	Pinoy Plus Advocacy Pilipinas (PPAPI)
PrEP	Pre-exposure Prophylaxis

ACRONYMS AND ABBREVIATIONS

PWID	People who inject drugs
RAATs	Regional AIDS Assistance Teams
(rHIVda)	Rapid HIV Diagnostic Algorithm
S&D	Stigma and Discrimination
SARO	Special Allotment Release Order
SKPA	Sustainability of HIV Services for Key Populations in South-East Asia
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TB	Tuberculosis
TLD	Tenofovir, Lamivudine, and Dolutegravir
TLF	The Library Foundation
TTT	Take the Test project
U=U	Undetectable=Untransmittable
UHC	Universal Health Care
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
USD	United States dollars
WHO	World Health Organization

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EXECUTIVE SUMMARY

Sustainability of HIV Services for Key Populations in South-East Asia (SKPA)-2 is a three-year (1 July 2022 to 30 June 2025) multi-country program funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund). The program aims to improve the sustainability of evidence-informed, prioritized HIV services for key populations in Bhutan, Mongolia, the Philippines and Sri Lanka. The program objectives are:

1. Accelerate financial sustainability
2. Improve strategic information availability and use
3. Promote programmatic sustainability
4. Remove human rights- and gender-related barriers to services

Between July and December 2022, SKPA-2 conducted a rapid baseline assessment in each of the four countries, to better understand the financial landscape, strategic information needs, policy and regulatory barriers, human rights and gender situation and country readiness for the sustainability of services for key populations. The assessments included a desk review and key informant interviews with government, civil society and key population stakeholders.

The following summarizes key findings for each of the SKPA-2 objectives, key issues and recommendations (in bold) from the baseline assessment in the Philippines. Detailed findings, issues and recommendations are included in the main report.

Key findings

Objective 1: **Accelerate financial sustainability**

- From 2007 to 2017, HIV spending in the Philippines progressively increased, with domestic funding comprising a larger share of total HIV financing. International funding for HIV declined in the same period. Despite the increase in domestic financing, overall funding remains insufficient.
- The Seventh AIDS Medium Term Plan (AMTP) 2023-2028 includes a commitment to increasing domestic financing for a sustainable HIV response. However, in the online sustainability pulse check survey, only one respondent saw government being in a position to expand HIV services for key populations without reliance on external donors within the next three years.
- The 1987 Philippine Constitution recognizes the important role of civil society organizations in decision making, including participation in national planning, budgeting and performance monitoring. The government is exploring the possibility of purchasing HIV services through social contracting. Many of the preconditions are in place including legal and regulatory frameworks promoting civil society organization participation in HIV service delivery and Department of Health rules governing accreditation of civil society organizations as implementing entities. Key challenges include realistic costing of and payment for services, and the inclusion of essential services in social health insurance.

Objective 2: Improve strategic information availability and use

- The Philippines has a mature second generation HIV surveillance system, which has helped the country to target services to key populations. There are some data gaps, including disaggregated data on men who have sex with men and transgender women, data on HIV prevalence among people who inject drugs, and gaps in HIV cascade data for female sex workers and transgender women.
- The national data collection system, the One HIV and STI Information System (OHASIS), is an electronic case-based surveillance system that can track clients across the HIV cascade. The system will be the main means for measuring HIV service coverage and key population performance across the HIV cascade.
- It is difficult to get an accurate sense of coverage of HIV services for key populations, but available data suggest that coverage is suboptimal. In addition, there are gaps in key population service data. For example, data on PrEP follow up and on community-based testing delivered through outreach by some organizations are not consistently captured by OHASIS.
- The Department of Health regularly shares epidemiological and cascade data, but OHASIS does not yet support availability of data in a dashboard format. Consequently, facilities view OHASIS as a reporting tool rather than as a platform to support improved service delivery. Development of data dashboards will be a priority for the Department's Epidemiology Bureau in the coming year.
- Measures are in place to ensure good quality data, including the roll out of data quality assessments, which is seen as important for validating facility-level reports. Efforts to support consistent entry of unique identifier codes (UICs) by facilities have been effective.
- Community-led monitoring (CLM) has not yet been established, but has been adopted as a monitoring and evaluation component of the Seventh AMTP. Pilot testing will be conducted during February-November 2023, focusing on financing, policy, service delivery, and stigma and discrimination. Concerns raised during the assessment include the technical soundness of tools and processes, capacity of community organizations to analyze and communicate data, low awareness of CLM among local government stakeholders, and the longer-term sustainability of CLM.

Objective 3: Promote programmatic sustainability

- Differentiated service delivery, including HIV testing, PrEP and virtual interventions, are supported by recent policy issuances from the Department of Health.
- Community-based screening is the main alternative to facility-based testing in the Philippines. HIV self-testing was introduced in 2020 through a demonstration study and, currently, is only available at some Global Fund- and USAID-supported sites. The Global Fund has financed procurement of kits and there is no domestic funding for this for 2023. Self-test kits are not available through private pharmacies.
- PrEP is still relatively new to the Philippines, an official estimate of need has not been conducted, and awareness among local government stakeholders, physicians and key populations is low. Following a demonstration study in 2016, the Department of

Health released interim guidelines in 2021 and included PrEP in the national drug formulary in 2022. Procurement has been supported by the Global Fund and USAID. The Department of Health will start procurement in 2023 to cover most of those already on PrEP.

- 50% of respondents to the online sustainability pulse check survey saw PrEP as not being readily available to key populations currently, while 44% felt the same way about HIV self-testing.
- Social media platforms and dating apps are used for virtual outreach by community organizations and local government clinics. Online booking platforms for clinic appointments, testing services, ART and PrEP refill delivery are used by some project sites.
- Key populations face challenges accessing the national health insurance system, PhilHealth. Some cannot afford health insurance while others report that out-of-pocket expenses are prohibitive, even for those who have PhilHealth, and there are gaps and discrepancies in what is covered.

Objective 4: Remove human rights- and gender-related barriers to services

- The Philippines has well developed legal and policy pillars for the HIV response and has taken substantive steps to address human rights barriers and to protect basic human rights.
- The LGBTQI community is not criminalized in the Philippines, but criminalization remains in force for people who use or inject drugs and sex workers, adversely impacting their access to HIV-related services. The War on Drugs limits the availability of harm reduction services. Evidence-based HIV prevention services are not provided in most prison settings in the Philippines. The reproductive health law provides only for education and counselling for people under the age of 18, and limits their access to condoms.
- There is a widespread lack of awareness of human rights entitlements among key populations. Low coverage of programs designed to improve their knowledge of and access to legal protections mean that the impact of existing legal protections is suboptimal.
- Stigma and discrimination, especially in healthcare settings, remains a serious issue for key populations and people living with HIV in the Philippines. Confidentiality is also a concern and fear of their status being disclosed is a major reason for people living with HIV delaying treatment. Outside of healthcare settings, key populations face stigma and discrimination in finding employment and in the workplace. Harassment by law enforcement officials and gender-based violence is also reported, notably by female and transgender sex workers. Coverage of programs to address stigma and discrimination is low, but 62.5% of respondents to the sustainability pulse check survey believe that there is a functioning referral mechanism to legal services for cases of patient's rights violations.
- Civil society organizations are engaged in national policy consultations, but are less often involved at local government level. In the survey, 56% of respondents (80% among key population respondents) believe key populations are not adequately represented in planning and decision-making forums.

Key issues and recommendations

The need to strengthen planning for sustainable financing of essential HIV services for key population – Although some planning is in place, most HIV funding is focused on ARV drugs and commodities, with significant gaps in funding for HIV prevention. Sustainability of prevention interventions will be a key challenge as funding from international sources is reduced.

- Ensure that adequate funding is available, including for HIV prevention, through expanding the HIV component of the national health budget and seeking increased funding from a range of domestic and international sources.
- Take steps to include outreach services and new prevention interventions such as HIV self-testing and PrEP in the national health insurance system.

The need to adopt and implement social contracting of HIV services – Given the increasing incidence of HIV among key populations and the comparative advantage of key population-led organizations in delivering essential HIV services to these populations, social contracting is an important strategy.

- Intensify advocacy for social contracting with national government agencies, local government units and other stakeholders.
- Analyze which elements of the HIV response could be optimally delivered through social contracting and the cost of this.
- Develop the mechanisms, processes and skills required for social contracting.
- SKPA-2 specifically should consider supporting a pilot project at subnational level to demonstrate the feasibility and potential of social contracting.

The need to further strengthen the national HIV surveillance system and the OHASIS – While the Philippines has a strong HIV surveillance system, some gaps and weaknesses, including in the OHASIS, need to addressed.

- Consider separate sampling and analysis of men who have sex with men and transgender women in future surveillance surveys.
- Implement plans to enhance the OHASIS to ensure the system captures comprehensive service delivery and client data.

The need to support scale up and sustainability of community-led monitoring – CLM planning is at an advanced stage in the Philippines and its roll-out is being centrally coordinated. Proposed data collection covers an ambitious range of topics. Ensuring the quality, sustainability and effective use of CLM will be critical.

- Develop governance structures, a costed demand generation plan, and tools and procedures for CLM.
- Build the capacity of community organizations for CLM data collection, analysis and communication.

The need to support equitable scale up of PrEP – The Philippines has recently committed to funding PrEP using domestic resources. Scale up requires investment in communication and advocacy.

- Update national policies and service delivery modalities and develop accurate estimation of PrEP needs.

- Build support for PrEP provision among healthcare providers and awareness of and demand for PrEP among key populations.

The need to expand access to HIV self-testing – As Department of Health guidelines have only recently been released, HIV self-testing is not yet available through local government facilities, and HIV self-test kits are not available through private pharmacies. Understanding and awareness are limited.

- Implement awareness and demand creation activities targeting key populations, civil society organizations and health facilities.
- Assess potential private sector involvement in HIV self-testing kit manufacture and distribution through the private sector including pharmacies.

The need to address human rights- and gender-related barriers to accessing HIV services – The Philippines has made considerable advances but barriers related to gaps in legal and policy protections, gender-based violence, and stigma and discrimination in healthcare and other settings remain.

- Build community capacity to advocate for decriminalization of sex workers and people who inject drugs.
- Strengthen community awareness of rights and legal literacy, and expand access to redress mechanisms.
- Deliver training for healthcare providers to reduce stigma and discrimination towards key populations and people living with HIV and gender-specific stigma and discrimination, and strengthen SOPs for maintaining confidentiality.
- Deliver training for law enforcement personnel to increase awareness of barriers faced by vulnerable populations and to eliminate gender-based and police violence.

1. Introduction and country context

BASELINE ASSESSMENT OBJECTIVES AND METHODOLOGY

At the start of the program cycle in Quarter 1 and 2 of Year 1 (July to December 2022), SKPA-2 commissioned a team of independent regional and national consultants to conduct a rapid baseline assessment in each of the four countries, to understand the extent to which these countries are able and ready to provide domestic financial support for HIV service delivery for key populations. The assessment was designed to help host country governments and partners, SKPA-2 implementers and the SKPA-2 Regional Steering Committee better understand the financial landscape, strategic information needs, operational policy and regulatory barriers, and the human rights and gender situation. The assessment also examined the extent to which each country is prepared for the financial sustainability of services for key populations.

The specific objectives of the baseline assessment were to:

1. Establish regional and country-specific baselines against which progress can be measured (during an end-of-program evaluation in Year 3) with respect to increased domestic financing of programs and services for key populations.
2. Assist countries in planning for and implementing comprehensive, sustainable, rights-based policies, programs and services for key populations.
3. Fine tune the SKPA-2 Theory of Change and develop more nuanced, country-specific pathways to sustainability.
4. Examine the extent to which key populations and people living with HIV are meaningfully engaged in their country's national HIV responses.
5. Identity opportunities and approaches where political, bureaucratic and community interests most closely align and can be mobilized through the SKPA-2 program.
6. Determine ongoing technical assistance needs for the principal recipient and subrecipients, particularly regarding financial sustainability, human rights and gender[1].

The consultant team developed the assessment methodology and data collection tools, which were circulated to all stakeholders for comment and revised accordingly[2].

The baseline assessment consisted of four phases of work: 1) inception planning; 2) data collection; 3) data analysis; and 4) production and dissemination of the reports.

Phase 1: Inception planning

- **Assessment team recruited:** A team of 13 external independent consultants were recruited. This included a Regional Team Leader and a Human Rights and Gender Specialist, together with national consultants with expertise in the areas of the four program objectives.
- **Working group established:** An internal SKPA-2 working group was established to oversee the process and ensure coordination with country activities.
- **Desk review:** Subrecipients, consultants and the working group sourced and reviewed a range of relevant documents to help formulate the assessment questions and data collection needs.
- **Data collection tools developed:** Data collection tools, including structured key informant interview guides, were developed for each of the SKPA-2 objectives, and reviewed by the consultants and regional technical assistance providers.

[1] Health Equity Matters has earmarked funding to be programmed at the end of the baseline to support technical assistance and additional activities under Objectives 1 and 4.
[2] More detailed information about the baseline assessment questions and data collection tools can be found in the annexes to the overarching report for the baseline assessment.

- **Stakeholder identification:** SKPA-2 subrecipients and national consultants identified local stakeholders to be interviewed.

Phase 2: Data collection

- **Key informant interviews and focus group discussions:** The national consultant team in the Philippines met with a range of government stakeholders, non-governmental organisations, and key population-led organisations, and conducted interviews with 46 key informants during field visits 24-28 October 2022 and 7-11 November 2022. Information generated by these interviews provided a primary source of data to inform the baseline situation in the country for each SKPA-2 objective.
- **Sustainability Pulse Check Survey:** Using Google Forms, a sustainability pulse check survey was conducted online, engaging a cross-section of key stakeholders from the four countries and responses have been received from 60 stakeholders. The survey was designed to support both baseline and end of project needs, and indicators can be disaggregated by country, objective and stakeholder group (governments, civil society organizations, key populations, and multilateral organisations).

Phase 3: Data analysis

- **Data analysis:** Data collected was analyzed iteratively throughout the process, with fact-checking and verification occurring where required. Survey results were analyzed using R and Power BI for dashboard development. Dashboard results can be accessed online. https://www. healthequitymatters.org.au/our-work/international-program/dashboard/
- **Revision of SKPA-2 Theory of Change:** As part of the data analysis, the baseline assessment team tested the assumptions in the SKPA-2 Theory of Change and constructed more detailed causal pathways and milestones for each country.

Phase 4: Report production and dissemination

- **Country presentation of preliminary findings:** During each country assessment visit, preliminary findings were presented to local stakeholders to verify the data and to discuss the key findings. This meeting took place in the Philippines on 6 December 2022. Further feedback meetings to review the draft reports were organized in February 2023.
- **Dissemination:** The four country reports and overarching baseline report were presented to the Regional Steering Committee at its meeting on 31 January 2023. Following this, the reports were circulated widely to stakeholders for comment and review. This process allowed for verification of key findings and recommendations. The reports were finalised by the end of February 2023.

The limitations of the baseline assessment fall into two categories: limitations related to the data collection process and limitations related to the data itself. The short timeframe for field visits and data collection and analysis was a key challenge and, while many of the program's partners are working at subnational level, the scope of work was limited to collecting baseline data at national level due to practical considerations. Much of the quantitative data gathered by the baseline assessment is from the year 2021, although some of the data used is from previous years. Some of the baseline data collected were sourced from the published literature, compiled by governments

and development partners, and thus reflect their indicators and timelines. The situation in each country also changes quickly, and some of the findings and recommendations in the baseline assessment may be out of date or already in the process of being addressed.

This report is based on information gathered during two field visits to the Philippines in October and November 2022 and during follow-up meetings and discussions. The audience for the baseline assessment includes national policymakers, healthcare workers, key populations, people living with HIV and communities most affected by HIV, regional and country technical partners, the Country Coordinating Committee, other local and international organizations implementing HIV programs, multilateral and bilateral donors, and the Global Fund. The baseline assessment team hopes that the findings will contribute to existing knowledge and enhance understanding of the opportunities and challenges facing the Philippines. Readers are encouraged to read this report in conjunction with the overarching report for the baseline assessment, and may also be interested in the challenges faced and recommendations made in the other SKPA-2 program countries, which are reflected in the corresponding reports for those countries.

HIV EPIDEMIOLOGY

The Philippines is a lower-middle-income country with an estimated population of 111 million people[3]. Despite gaining traction in achieving the 95-95-95 targets, the Philippines continues to have one of the fastest growing HIV epidemics globally, with a more than 200% increase in new HIV infections between 2010 and 2022 (UNAIDS Datahub). In September 2022, there were 1,347 confirmed HIV-positive individuals reported to the HIV/AIDS & ART Registry of the Philippines (HARP). This was a 37% increase compared to the same reporting period in the previous year[4].

The first HIV infection in the Philippines was reported in 1984. From then to September 2022, 105,794 confirmed HIV cases have been reported to the HARP. Of the 105,794 confirmed HIV cases, 99,715 (94%) were male and 6,068 (6%) were female. At the time of diagnosis, 53,588 (51%) were 25-34 years old while 30,685 (29%) were 15-24 years old. Almost one third – 32,133 (30%) – of the reported cases had advanced clinical symptoms at the time of testing[5].

Although the estimated national prevalence is around 0.22%[6], key populations have the highest burden of HIV infections, with 93% of total new HIV infections occurred among key populations[7]. HIV prevalence is estimated at 11.89% among men who have sex with men; 39.38% among males who inject drugs and 23.91% among females who inject drugs; 4% among transgender women; and 0.17% among sex workers[8,9].

According to the Philippines Epidemiology Bureau's HIV modes of transmission modelling, the predominant mode of transmission among the total reported cases has been sexual contact among males who have sex with males (n=86,614; 82%), followed by male-female sex (n=15,106; 14%), and sharing of infected needles (n=2,468; 2%).

Of diagnosed HIV cases, 86% are from 11 high burden areas: regions – National Capital Region, Calabarzon, Central Luzon, Davao Region, and Western Visayas; provinces – South Cotabato and Cebu Province;

[3] https://data.worldbank.org/?locations=PH-XN
[4] https://doh.gov.ph/sites/default/files/statistics/EB_HARP_September_AIDSreg2022.pdf
[5] https://doh.gov.ph/sites/default/files/statistics/EB_HARP_September_AIDSreg2022.pdf
[6] 7th Medium Term Plan (AMTP) 2023-2028: Fast tracking Towards 2030
[7] https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
[8] 7th Medium Term Plan (AMTP) 2023-2028: Fast tracking Towards 2030
[9] https://www.unaids.org/sites/default/files/country/documents/PHL_2019_countryreport.pdf

and cities – Cagayan de Oro, Zamboanga, Baguio, and Puerto Princesa. Modes of transmission vary across regions. For example, 32,371 (38%) of diagnosed males who have sex with males were from the National Capital Region, which includes Metro Manila and almost all (2,461; >99%) reported cases among people who inject drugs were from the regional encompassing Cebu City and its surrounding areas[10].

The Philippines has committed to the UNAIDS 2030 95-95-95 targets. The Seventh AIDS Medium Term Plan (AMTP) 2023-2028 estimates that the Philippines has attained a 65% case detection rate of the estimated number of people living with HIV[11]. Among individuals who have been diagnosed, 62% are on antiretroviral treatment. Viral suppression among those tested is high at 95%, but viral load testing among those on ART remains low at 34%[12,13,14,15]. Linkage to and retention on treatment remains a challenge to reversing the country's HIV epidemic. The Sixth AMTP 2017-2022 cites that, as of December 2022, 54,725 people living with HIV (PLHIV) were on ART[16].

Several factors are cause for concern in relation to the transmission of HIV among key populations in the Philippines. The low case detection rate, low CD4 counts among persons newly diagnosed with HIV and advanced clinical manifestation at the time of testing all indicate that many infections go undiagnosed for prolonged periods. The potential for transmission among untreated persons remains high. Furthermore, the country's most recent IHBSS (2018) indicates that comprehensive knowledge on HIV prevention and transmission, HIV testing, condom use and condom access among key populations are low[17]. This suggests there is a high risk for continued or increased sexual transmission of HIV among these populations.

The Philippines has committed to preventing new infections among key populations by expanding access to combination prevention options for key populations in both its Sixth AMTP and its Global Fund HIV Country Grant 2019-2022. The Seventh AMTP reinforces this commitment. The Philippines intends to apply for the next Global Fund HIV Country Grant in March 2023, for funding to cover the period 2024-2026.

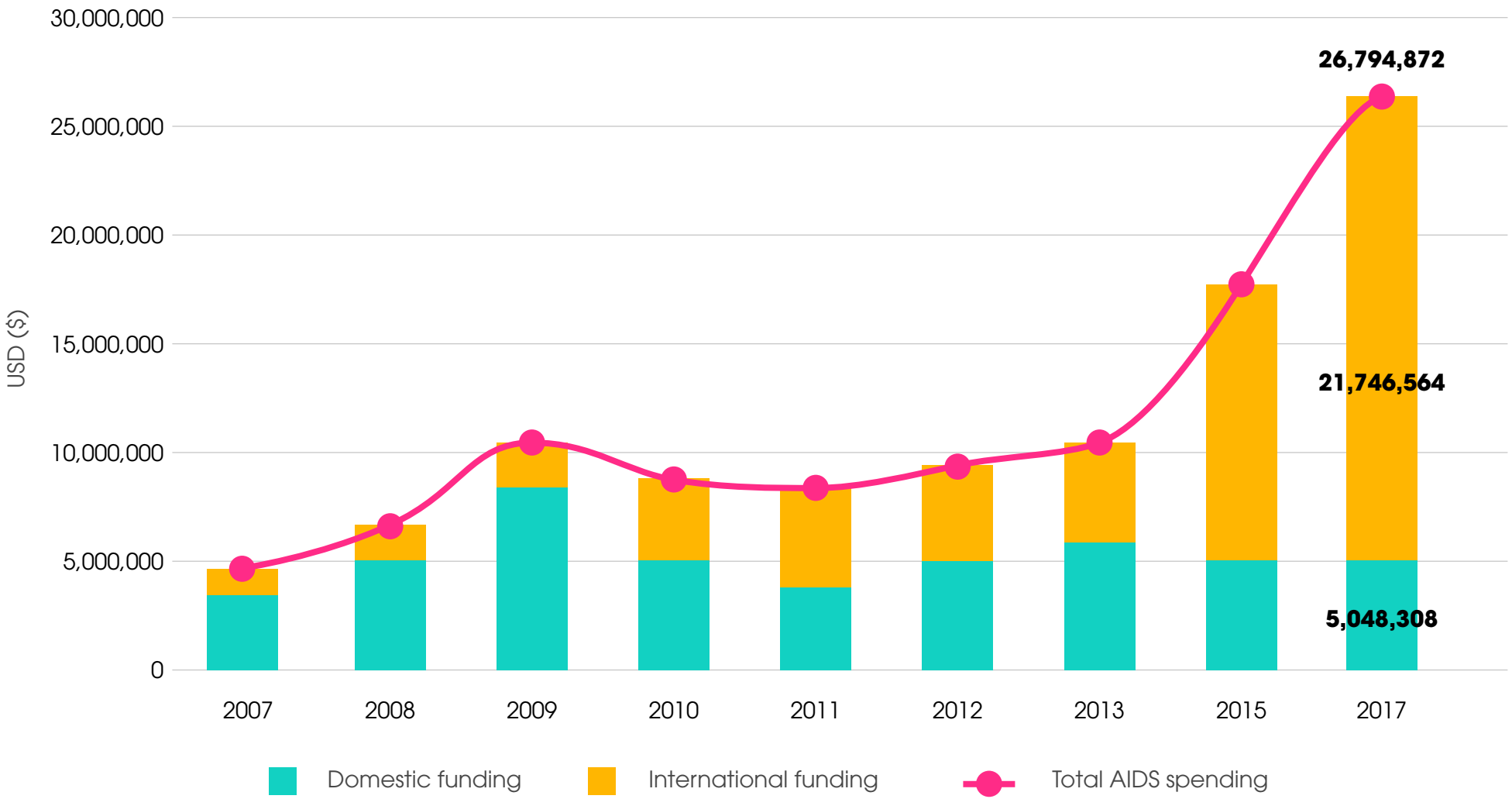
FINANCIAL LANDSCAPE

The Current Health Expenditure (CHE) of the Philippines has increased by 18.5% from Philippines pesos (Php) 917.15 billion (USD 16.82 billion[18]) in 2020 to Php 1.09 trillion (USD 19.98 billion) in 2021 (PSA, 2021). Government schemes and compulsory contributory health care financing schemes comprised 50.3% of the CHE, equivalent to Php 546.64 billion (USD 10.02 billion), followed by household-out-of-pocket payments at Php 451.00 billion (USD 8.27 billion) (41.5%) and voluntary health care payment schemes at Php 89.35 billion (USD 1.64 billion) (8.2%). During the same period, the Total Health Expenditure (THE) share of Gross Domestic Product (GDP) also increased significantly, from 5.6% in 2020 to 6.0% in 2021.

A key component of THE is HIV/AIDS financing, encompassing prevention, treatment, care and support. From 2007 to 2017, AIDS spending has progressively increased, with domestic funding comprising a larger share of total HIV financing (UNAIDS, 2021). International funding for HIV has declined in the same period (see Figure 1. HIV Financing in the Philippines, 2007-2017).

[10] https://doh.gov.ph/sites/default/files/statistics/EB_HARP_September_AIDSreg2022.pdf
[11] 7th Medium Term Plan (AMTP) 2023-2028: Fast tracking Towards 2030
[12] 7th Medium Term Plan (AMTP) 2023-2028: Fast tracking Towards 2030
[13] https://www.aidsdatahub.org/country-profiles/philippines
[14] https://doh.gov.ph/sites/default/files/statistics/EB_HARP_September_AIDSreg2022.pdf
[15] Note that where there are discrepancies between figures presented in the 7th AMTP (December 2022), the HIV/AIDS & ART Registry of the Philippines (HARP) (Latest report September 2022), and the AIDS datahub (updated regularly), the AMTP figures have been used as they are the most recent official figures.
[16] 7th Medium term Plan (AMTP) 2023-2028: Fast tracking Towards 2030
[17] https://doh.gov.ph/sites/default/files/publications/2018%20IHBSS%20Technical%20Report_FINAL_01062021.pdf
[18] US dollar exchange rates rounded and approximate, using xe.com at 16 January 2023.

Figure 1: HIV Financing by Sources, Philippines, 2007-2017, in USD

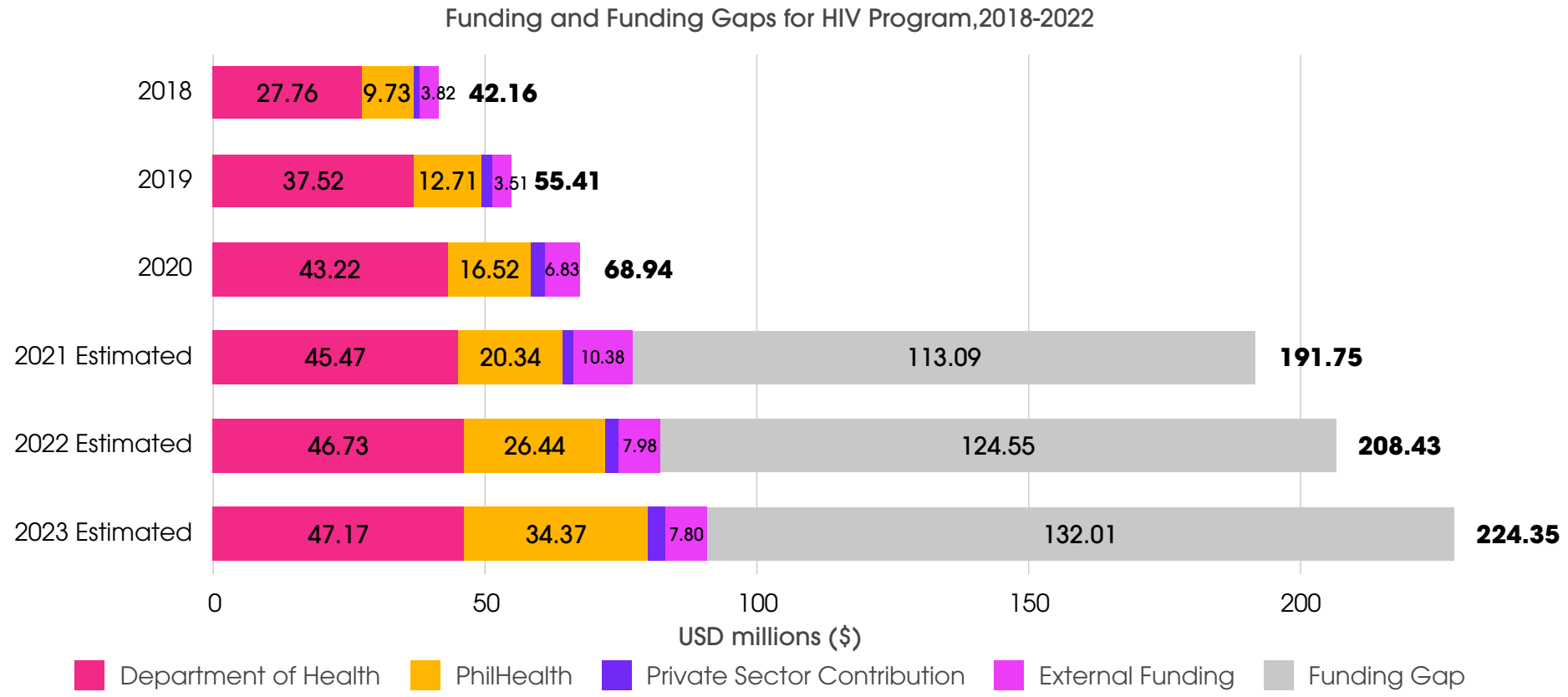


Source: HIV and AIDS Data Hub for the Asia Pacific, 2021

Despite these achievements in domestic health and HIV spending, the Philippines is still struggling to meet the WHO recommendation of spending at least 5% of GDP on health. Overall funding for HIV remains insufficient to meet the country's HIV intervention targets in the next few years (Global Fund, 2020). Analysis shows that even to reach the 90-90-90 targets, the country urgently needs to address significant funding gaps for the required HIV investments **(see Figure 2. HIV Sources and Funding Gaps, Philippines, 2018-2020)**.

Figure 2. HIV Sources and Funding Gaps, Philippines, 2018-2020, in USD (Global Fund, 2020)

Large funding gaps remain vs needed investments to reach 90-90-90 targets



Source: GF Funding Requests 2020-2022

The increase in cases due to COVID-19 pandemic disruptions to services requires additional resources for the catch up strategy. The pandemic has severely affected the delivery of HIV services particularly testing, treatment and access to ARV drugs and other commodities (UNDP, 2020) and, in 2021, 12,341 confirmed HIV cases were reported to the HARP, representing a 54% increase from 8,058 cases in 2020.

HIV funding sources

HIV services in the Philippines are supported through domestic and international funding. Domestic funding comprises support from the national government – Philippines National AIDS Council (PNAC), Department of Health, PhilHealth (the national health insurer), and other national government agencies, local government units (Local AIDS Councils and City and Municipal Health Offices) and the private sector (public-private partnerships and private sector financing). International funding involves official development assistance in the forms of loans and grants, including support from the Global Fund, United Nations agencies and other development partners.

The national budget is financed through revenues from both tax and non-tax sources, borrowing from both domestic and foreign sources, and withdrawals from available cash balances. Major classes of tax revenue include taxes on income and profits, taxes on property, taxes on domestic goods and services, taxes on international trade and transactions and other taxes such as motor vehicle tax, immigration tax and forest charges. Non-tax revenues are impositions or collections of the government in exchange for services rendered, assets conveyed and penalties imposed (DBM, 2012).

The local government funding comes from local and external sources, as well as receipts from capital investments, loans and borrowings. An important source of revenue is the Internal Revenue Allotment (IRA) that each Local Government Unit (LGU) receives from the national internal revenue taxes (NIRT) equivalent to 40% of the total revenue collection of the 3rd year preceding the current fiscal year. National internal revenue taxes include income tax, estate tax and donor's tax, value-added tax, other percentage taxes, and taxes imposed by special laws, such as travel tax.

Through an ordinance, LGU-managed hospitals may charge user fees for HIV and other health-related services. PhilHealth-accredited LGU health facilities also receive reimbursements and capitation funds from PhilHealth. The Outpatient HIV/AIDS Treatment (OHAT) Package Benefit seeks to increase the proportion of the population having access to effective HIV/AIDS treatment and education services, aligned with PhilHealth's All Case Rate Policy.

The LGUs secure support from the Department of Health (DOH) through provision of public health commodities and capital investments under the Health Facilities Enhancement Program (HFEP). Further, LGUs are also authorized to borrow from Government Financial Institutions (GFIs) such as the Land Bank of the Philippines and Development Bank of the Philippines, and Municipal Development Fund Office.

Grants and technical assistance from bilateral and multilateral agencies, including the Global Fund, UN agencies and World Health Organization (WHO) are also crucial in the provision of HIV and other health services at the local level. In addition, LGUs partner with local non-government organizations and the private sector on HIV advocacy and education initiatives.

KEY POPULATION-LED CIVIL SOCIETY OVERVIEW

The Philippines has a rich resource of community-based organizations working with all key populations. Policy leadership is provided by the Philippine National AIDS Council (PNAC) which coordinated the Seventh AMTP. PNAC's Civil Society Organization Caucus comprises the AID Society of the Philippines, Action for Health Initiatives, Inc (ACHIEVE), Alliance against AIDS in Mindanao, TLF Share Collective Inc, Positive Action Foundation Philippines, Inc (PAFPI), Pinoy Plus Advocacy Pilipinas (PPAPI) and Pilipinas Shell Foundation, Inc.

Many key population-led and community-based organizations are active in HIV in the Philippines. Among them are: ACHIEVE, which is highly active in financial sustainability and other HIV/AIDS issues in the Philippines and across Asia; the AIDS Society of the Philippines, which has managed over 60 projects with international support, including advising the PNAC on national policies; the Red Whistle, which raises funds to provide free testing and counseling and financial support to people living with HIV; B-Change, which aims to integrate technology and social change through web applications and social media, connecting the HIV-affected youth to allies and other peers; PAFPI, which assists patients and affected family members through counseling and psychological support services, provides education and care, and provides temporary shelter to people living with HIV; PPAPI, which represents people living with HIV in the Philippines, offers counseling, referral, care and support programs, and is a PNAC member; and Take the Test project (TTT) which promotes voluntary counseling and testing and knowing one's status as a form of sexual empowerment.

Community-based services are an important strategy for reaching and increasing rates of testing and treatment among key populations. The Love Yourself (LYS), a volunteer-driven community-based organization, manages community centers in Manila, providing HIV education, testing and counseling for men who have sex with men, transgender women, and young people. The community centers have evolved to include a primary treatment hub for HIV and TB and a transgender health clinic and are proponents of community-led pilot implementation of PrEP and self-testing. LYS has supported other community-based organizations to establish and operate their own champion community centers nationwide[19].

Civil society organizations and key population services work with many actors including the DOH and its Epidemiology Bureau (soon to be transitioned into the Philippines Center for Disease Prevention and Control) and National HIV/AIDS and STI Surveillance and Strategic Information Unit, City offices representing LGUs, HIV and AIDS treatment hubs and testing facilities, and development partners including the Global Fund, the UNAIDS Secretariat, the Joint UN Theme Group (WHO, UNICEF, UNFPA, UNDP, UNODC and ILO), USAID, PEPFAR and the US Centers for Disease Control, and Australia's Department of Foreign Affairs and Trade (DFAT), along with implementing organizations.

With this wealth of stakeholders – both donors and service delivery organisations - there is a sense that the HIV space is quite crowded. SKPA-2 is finding that with modest funding, it is struggling to find a clearly focused, suitably catalytic response. For example, although in other countries SKPA-2 is an important partner on Community Led Monitoring (CLM), but in the Philippines, where other partners have designed a comprehensive program of work in support of CLM,

[19] Love Yourself Community Centers in Metro Manila: Anglo, in Mandaluyong City; Uni, in Buendia, Pasay City; Victoria, in Libertad, Pasay City; Lily, in Parañaque City; Welcome, in Manila. CBO-led Champion Community Centers outside Metro Manila: Pampanga (managed by Juan Positive Movement); Cavite (Cavite Positive Action Group) Palawan (Project H4-Palawan); Iloilo (2 centres), managed by the Family Planning Organization of the Philippines-Iloilo Chapter; Cebu (3 centers),operated by LYS; Cebu, Bisdak Pride and the Cebu United Rainbow LGBT Sector; Zamboanga operated by the Mujer LGBT Organization; Cagayan de Oro, operated by Kagay-an PLUS, and Davao operated by the Olympus Society of Davao.

SKPA-2 is not well placed to make a strong contribution to CLM (this is discussed under Objective 2 - strategic information, below). Similarly, SKPA-2's planned contribution represents a small minority of Love Yourself's budget, for activities that are outside its traditional service delivery role. Accounting for these funds and implementing these activities could therefore place a disproportion burden on the organisation. This report considers, inter alia, the issue of relevance and impact, and makes recommendations for changes to SKPA-2's focus. These recommendations relate to providing technical support to the Philippine National AIDS Council, which has a huge task ahead to lead the delivery of the Seventh AMTP, and suggestions around capitalising on the considerable leadership, thought and positive preconditions already in place for social contracting, by launching and supporting a pilot project at subnational level.

2.

Key findings by objective

SK PA·2

OBJECTIVE 1: ACCELERATE FINANCIAL SUSTAINABILITY

The Philippines has highly developed national legal and policy pillars for the HIV response. This section of the baseline report describes those pillars and introduces key aspects of the budget and planning process for HIV at both the national and sub-national or local levels, including the participation of civil society organizations.

The substantial benefits to national and local government of harnessing civil society organizations' knowledge, access and expertise in the HIV response through social contracting has been articulated clearly in two recent technical papers: "Development of (a) social contracting mechanism for HIV programs in the Philippines (UNAIDS, 2022) and "Feasibility assessment of social contracting for HIV services in selected Philippine LGUs across Regions 3, 4A and the National Capital Region (Alliance for improving health outcomes, 2022). ACHIEVE has been an important partner in evaluating options for establishing social contracting in the Philippines.

This approach offers opportunities for civil society organizations in the Philippines to contribute to the provision of essential HIV services for key populations and in doing so to enable their own financial sustainability.

The Philippines is well positioned to put in place a social contracting mechanism under which HIV services are procured through civil society organizations. More progress has been made at the national level and in some cities than at the local government level, but the country has yet to successfully deliver a social contracted service. It will be important for local governments to learn lessons from the experiences of "early adopter" cities and local governments. It is also important that local government and civil society actors understand the legal and policy frameworks and mechanisms for social contracting at national and local level and the mechanics of the budgeting and planning process and, for this reason, the baseline report includes considerable detail about these issues.

National legal and policy frameworks and plans for the HIV response

This section provides an overview of national policy frameworks for the HIV response, including the *AmBisyon Natin* 2040 or Long-Term Vision (LTV) for the Philippines, Philippine Development Plan (PDP) 2017-2022, Universal Health Care (UHC) in the Philippines, Philippine HIV/AIDS Policy Act of 2018, Philippine Health Agenda 2016-2022, Health Sector Plan for HIV and STI 2015-2020, Philippine Health Sector HIV Strategic Plan 2020-2022, HIV Adaptive Plan 2021 and other policy and administrative issuances.

AmBisyon Natin 2040 or Long-Term Vision (LTV) for the Philippines, and Philippine Development Plan (PDP) 2017-2022

The 25-year AmBisyon Natin 2040, adopted through Executive Order No. 5 dated 11 October 2016, envisions that by 2040, "Filipinos shall enjoy a strongly rooted (matatag), comfortable (maginhawa) and secure (panatag) life". The government is committed to enforce fiscal, monetary and regulatory policies towards achieving AmBisyon, contributing to all dimensions of development, including economic, human and physical capital, institutional and cultural.

The AmBisyon Natin 2040 prioritizes economic and social sectors, including housing and urban development, manufacturing, connectivity, education, tourism and allied services, agriculture,

health and wellness, and financial services. HIV services form part of health and wellness services.

To operationalize AmBisyon Natin 2040, the Philippine Development Plan (PDP) 2017-2022 was developed, with the goal of reducing poverty prevalence from 21.6% in 2015 to 14% by 2022. The PDP 2017-2022 is anchored on three main pillars: Enhancing the social fabric (Malasakit), which aims to regain people's trust in public institutions and cultivate trust among fellow Filipinos; Reducing inequality (Pagbabago), which focuses on increasing opportunities for growth of output and income; and Increasing growth potential (Patuloy na Pag-unlad), which focuses on realizing and sustaining economic growth.

The social development component of the PDP seeks to improve the access of Filipinos to quality social services, including education, training and culture, health and nutrition, population and development, housing, social protection, and asset reform. Recognizing the need to improve maternal health and combat HIV/AIDS, social development strategies include achieving universal coverage in health, strengthening civil society-basic sector participation and public-private partnerships, and developing and strengthening institutional capacity.

Universal Health Care (UHC) in the Philippines

The Universal Health Care (UHC) Act (Republic Act No. 11223), enacted in February 2019, aims to provide all Filipinos with equitable access to quality and affordable health care goods and services, and protect them against financial risks. The UHC Act seeks to promote a systematic approach and clear delineation of roles of key agencies and stakeholders towards improved health system performance.

The UHC Act enables automatic inclusion of every Filipino into the National Health Insurance Program (NHIP), development of a health care delivery system that allows every Filipino to afford either a public or private primary care provider, provision of population-based health services free of charge at point of service for all Filipinos, DOH accreditation of health care facilities within the network, and ensuring patient privacy and confidentiality in the maintenance of health information systems.

Philippine HIV and AIDS Policy Act of 2018

In December 2018, the Philippine HIV and AIDS Policy Act of 2018 (Republic Act No. 11166) was passed into law, affirming the State's duty to respect, protect and uphold human rights as the foundations of an effective HIV/AIDS response and promote meaningful inclusion and participation of persons directly and indirectly affected by the HIV and AIDS situation, in eliminating the virus.

The law repeals the Republic Act No. 8504, otherwise known as the Philippines AIDS Prevention and Control Act of 1998, and reconstitutes the PNAC to ensure the implementation of the country's response to the HIV and AIDS situation. Further, the law provides for HIV and AIDS education and information dissemination and prohibits bullying and other forms of discrimination based on actual, perceived or suspected HIV status.

The Implementing Rules and Regulations (IRR) prescribe guidelines, procedures and standards for the implementation of the mandates and objectives of the Republic Act No. 11166.

Philippine Health Agenda 2016-2022

The Philippine Health Agenda 2016-2022 commits to address all life stages and triple burden of diseases, including communicable diseases such as HIV/AIDS, TB and malaria; improve the service delivery network; and strengthen universal health insurance. The strengthened Philippine health system aspires to contribute to improved financial risk protection and better health outcomes and responsiveness for all Filipinos.

To attain these goals, the Health Agenda adopts the A.C.H.I.E.V.E. Strategy: A- Advance quality health promotion and primary care; C-Cover all Filipinos against health-related financial risk; H-Harness the power of strategic Human Resources for Health (HRH) development; I-Invest in eHealth and data for decision-making, E- Enforce standards, accountability and transparency; V- Value all clients and patients, especially the poor, marginalized, and vulnerable; and E- Elicit multi-sectoral and multi-stakeholder support for health.

AIDS Medium Term Plan 2017-2022

The PNAC is mandated to develop a comprehensive national HIV plan, known as the AIDS Medium Term Plan (AMTP). The Seventh AMTP 2023-2028, launched on World AIDS Day 2022, builds on previous Medium Term Plans to set targets within the timeframe and provide strategic direction for a national, regional and local multi-sectoral HIV response.

The AMTP's interventions are geared towards reducing new infections; improving health outcomes and wellness of people living with HIV; strengthening systems (health, non-health, and community systems), including strategic information; improving leadership accountabilities for the delivery of the AMTP; and increasing domestic financing for a sustainable HIV response.

The AMTP aims to increase knowledge on STI and HIV transmission, prevention and service coverage among those aged 15 to 24 years to 90%; prevent new infections among 15 to 24 year olds focusing on key populations; test 90% of estimated people living with HIV and treat 90% of those who need treatment; and eliminate mother-to-child HIV transmission.

Learning from the disruptions caused by the COVID-19 pandemic, the Seventh AMTP is designed to be crisis-resilient and fully resourced. It seeks to acknowledge the contributions of national, sub-national and international stakeholders, and reflect the joint effort of the health sector, relevant non-health sectors and community-level organizations.

Health Sector Plan for HIV and STI 2015-2020

Anchored on the AMTP and consistent with the UHC goals, the Health Sector Plan for HIV and STI 2015-2020 sought to reduce new HIV infections and improve the quality of life of people living with HIV. The Health Sector Plan envisioned zero new infections, zero discrimination and zero AIDS-related deaths. Specifically, it aimed to reduce HIV incidence among men who have sex with men to <50%; maintain HIV prevalence of <1% among young (<20 years) childbearing women in NCR cities and Cebu City from baseline; reduce the percentage of key populations with syphilis to <1.5%; reduce HIV-related deaths by 80%; and reduce TB-related deaths to <1%.

The Health Sector Plan comprised various strategies including: (1) continuum of HIV/STI prevention, diagnosis, treatment and care services to key populations; (2) health promotion and communication of HIV and STI prevention and care services; (3) enhanced strategic information systems; and (4) strengthened health system platform for broader health outcomes.

To determine the effectiveness and efficiency of the HIV Program Strategy, a National HIV Joint Program Review was undertaken from September to November 2019. Specifically, the review sought to analyze and present epidemiological data; assess the effectiveness and appropriateness of the strategy; determine opportunities for efficiency and improvement in the areas of financing, regulation, service delivery, governance and performance accountability; and present recommendations and provide guidance on the development of the National Strategic Plan (NSP) for HIV. Key findings of the review were:

- Men who have sex with men were the most affected population
- Cities and urban areas were particularly affected by the HIV epidemic
- There was a correlation between the increase in new infections among key populations and (a) early onset of risky behaviors but delayed protective behaviors; (b) stigma and discrimination; (c) lack of access to condoms; (d) poor knowledge of HIV prevention and transmission; (e) access to online platforms for sexual partners; and (f) demographic changes
- Much has been accomplished in the HIV care cascade, particularly with the diagnosis coverage
- Progress on prevention was generally slow
- The country was getting better at case detection
- On treatment, there was a notable improvement in ART coverage among diagnosed people living with HIV
- While viral suppression was high at 96%, the coverage of viral load testing at the national level was below 20%
- Critical aspects in the areas of governance, strategic information system and financing, and human resource management facilitated the implementation of intervention strategies in prevention, testing, treatment and viral suppression.

The key recommendations were:

- Implement a comprehensive national "Combination Prevention Strategy" with key population-specific interventions
- Diversify and expand testing strategies to reach the remaining undiagnosed people living with HIV
- Expand approaches for immediate linkage to treatment and care
- Scale up viral load testing to increase coverage at the national level
- Improve procurement and supply chain management
- Enhance strategic information systems.

Philippine Health Sector Plan HIV Strategic Plan 2020-2022

Building on the gains of the previous strategic plans, the Philippine Health Sector HIV Strategic Plan 2020-2022 aimed to target high-risk key populations among men who have sex with men, transgender women, young key populations, and people who inject drugs in high-burden areas through high-impact prevention, testing, treatment and adherence (HIPTTreA) strategies. The plan addressed the priorities identified during the consultation process with key stakeholders and incorporates lessons learned from previous health sector plans.

The specific objectives of the Health Sector HIV Strategic Plan 2020-2022 were to:

- Increase condom use among men who have sex with men and transgender women from 38% (2018) to 80% (2022); sustain condom use among registered female sex workers to 85%; and increase condom use among freelance female sex workers from 35% to 85%
- Increase men who have sex with men receiving PrEP from 250 (2017) to 10,000 (2022)
- Increase HIV diagnosis from 77% (2018) to 95% by 2022; increase quality of targeted HIV testing with a sero-positivity rate of 3% to 14%; and increase monthly diagnosis of 1,200 cases per month to 2,700 per month
- Increase ART coverage from 57% in 2018 to 95% by 2022; and increase the retention rate from 82% in 2018 to 95% by 2022
- Sustain viral suppression among people living with HIV on ART at 95%; and increase coverage of viral load testing from 17% to 95% by 2022
- Increase safe injecting practices among people who inject drugs to 80% by 2022
- Reduce barriers to accessing HIV prevention, testing and treatment services in the healthcare delivery system.

The plan was also designed to achieve the 95-95-95 targets set by UNAIDS through the following strategies:

- Men who have sex with men, transgender women, people who inject drugs and female sex workers remain as the main focus of prevention interventions, with special attention to young key populations, women at risk and pregnant women
- Prevention strategies include implementation of a combination prevention strategy and national condom strategy, establishment of knowledge and condom access points, public introduction of PrEP, development of a Trans-Health Package of Services, strengthening community and online outreach, and establishment of key population-led community centers
- Use of a combination of HIV testing strategies to target the hardest-to-reach key populations, including community-based screening, facility-based screening, self-screening, social and sexual network testing, intimate partner testing and provider-initiated counseling and testing; and advocacy campaigns to adopt online testing approaches and integration of HIV testing in the UHC framework
- Introduction of innovative and differentiated approaches to treatment and adherence; and establishment of one-stop shops for prevention, testing, treatment and care

- Addressing barriers to accessing prevention, testing, treatment and care; and enhancing governance of the health sector response.

HIV Adaptive Plan 2021

The HIV Adaptive Plan provides specific measures and adjustments to the implementation of the Health Sector Plan, and a range of HIV prevention, testing, care and treatment guidelines. Covering the period from 2021 to 2023, it ensures the sustainability of services across the HIV continuum of care and complements the COVID-19 response of designated health facilities and providers.

The HIV Adaptive Plan serves as a reference in updating relevant documents and guidelines such as the PrEP Allocation Plan, the HIV testing service guidelines, the HIV scale-up plan, the Tenofovir, Lamivudine, and Dolutegravir (TLD) transition plan and the viral load scale-up plan. It also serves a basis for identifying the investment requirements for the annual budget and procurement planning of the DOH National AIDS and STI Prevention and Control Programme (NASPCP), LGUs and HIV care providers.

The general guidelines serve as guiding principles underpinning the adaptive changes and specific adaptive measures to mitigate the effects of the COVID-19 pandemic on the provision of HIV services.

COVID-19 Mitigation

- Observe minimum public health standards for COVID-19 mitigation in settings across public and private sectors
- Orient and train all healthcare workers on standard infection prevention control (IPC) measures
- Institutionalize IPC
- Disinfect equipment and surfaces after every patient
- Triage for COVID-19 at entry to health facilities
- Conduct COVID-19 case investigation and contact tracing.

HIV Service Provision

- Ensure uninterrupted access to HIV services across the HIV prevention, treatment and care continuum
- Pursue a multi-sectoral, whole of government approach in the country's HIV response
- Integrate HIV in the existing Health Care Provider Network in the LGU
- Observe a client-centered approach in DOH-designated treatment hubs and primary HIV care facilities
- Promote and institutionalize the use of digital technologies for information dissemination, HIV service delivery and monitoring and evaluation
- Provide services at treatment hubs and primary HIV care clinics to people living with HIV irrespective of their place of residence and/or registration
- Facilitate the movement of individuals, including people living with HIV, community-based HIV screening providers and HIV case managers during COVID-19 related travel restrictions.

COVID-19 Vaccination for Providers and People living with HIV

- Frontline and other health workers including community-based health workers are in Priority Group A1 for COVID-19 vaccination
- People living with HIV are identified in Priority Group 3 for COVID-19 vaccination, upon submission of proof of co-morbidity and medical clearance from their attending physician
- LGUs shall ensure COVID-19 vaccination is conducted in HIV treatment hubs or LGU vaccination sites, at times separate from other population groups to maintain privacy and confidentiality of people living with HIV
- Ensure that COVID-19 vaccination for healthcare providers and for people living with HIV is documented and monitored.

Local government Memorandum Circulars

The Department of the Interior and Local Government (DILG) issued several memorandum circulars, directing the local chief executives to ensure the implementation of HIV programs at the local level. These include:

- DILG Memorandum Circular No. 99-233: Directs all local chief executives to undertake programs and projects as mandated in RA No. 8504 to support the overall national HIV prevention and control efforts
- DILG Memorandum Circular No. 2013-29: Mandates the organization of a functional Local AIDS Council (LAC) to localize the provisions of RA No. 8504 and promote synergy among LGUs and various stakeholders on HIV prevention and treatment efforts. The LAC is a multi-sectoral local body chaired by the local chief executive, co-chaired by the chairperson of the Sanggunian Committee on Health/Social Concerns, and members composed of local functionaries and sectoral representatives
- DILG-DOH-DSWD Joint Circular on the Formation and Operation of Regional AIDS Assistance Teams (RAATs): Provides guidance in establishing Regional AIDS Assistance Teams (RAATs) to help strengthen local government capacity to implement a sustained, coordinated and multi-sectoral AIDS response.

The HIV planning and budgeting processes at the national level

National HIV planning and budgeting generally follows the national planning and budgeting processes as provided for by the Philippine Constitution, Executive Order No. 292 (Administrative Code of 1987) and other relevant circulars issued by the oversight agencies, including the Department of Budget and Management (DBM), Commission on Audit (COA), Department of Finance (DOF) and Bureau of the Treasury (BTr).

Planning and budgeting

The annual planning and budgeting exercise officially starts with Budget Call, which sets the parameters and procedures to guide the agencies in preparing their respective budget proposals. The

DOH Central Office issues guidelines to implementing units, including attached agencies and Centers for Health Development (CHD). The budget proposals submitted by the implementing units such as PNAC, NASCP and Epidemiology Bureau are then reviewed and consolidated by the central office for submission to the DBM through the Online Submission of Budget Proposals System (OSBPS).

The DBM reviews the agency proposals through Technical Budget Hearings and Executive Review Board sessions, with participation of other government agencies, including the National Economic Development Authority Investment Coordination Committee (NEDA-ICC) for capital projects, NEDA Infrastructure Committee for infrastructure projects, Governance Commission for GOCCs (GCG) and Department of Finance (DOF) for the proposals of Government-Owned or-Controlled Corporations (GOCCs) and Department of Information and Communication Technology (DICT) for ICT projects.

The Development Budget Coordination Committee (DBCC), composed of DOF, DBM and NEDA present the proposed budget to the President and the Cabinet. The President then submits the National Expenditure Program (NEP) within 30 days from the opening of the regular session of Congress. Budget legislation is completed once the President signs the General Appropriations Act (GAA) into law.

With the GAA as an Allotment Order (GAAAO), the enacted Budget itself serves as the allotment release for all budget items except those contained in a negative list that are issued the Special Allotment Release Order (SAROs). Following DBM issuance of allotments, agencies are then authorized to incur obligations as they implement programs, activities and projects.

The Government Procurement Reform Act prescribes the rules and regulations for the modernization, standardization and regulation of the procurement activities of the government.

The DBM releases disbursement authorities such as Notice of Cash Allocation (NCA), a cash authority issued to central, regional and operating units through the authorized government servicing banks of the Modified Disbursement Scheme (MDS) to cover the cash requirements of agencies.

HIV programming, planning and budgeting processes at the local level

HIV planning and budgeting at the local level is governed by the local budget cycle and processes as provided for by the Local Government Code and other policy issuances. The Local Health Offices and Local AIDS Councils participate in the investment programming and planning processes to ensure that HIV/AIDS interventions and other health programs and projects are considered in the preparation of the LGU budget.

Comprehensive Development Plan (CDP) – a six-year action plan that contains priority sectoral and cross-sectoral programs and projects and integrates national plans with local plans. The CDP covers social, economic, physical, environmental and institutional sectors. HIV/AIDS response and other health services are included in the social development sector. The Local Health Department can be a member of the Planning Support Group, tasked to provide health-related data and information for ecological profiling, a critical point in mainstreaming HIV/AIDS response in the CDP.

Local Investment Plan for Health (LIPH) – a medium-term local public investment for health that governs health operations and activities towards achieving better health outcomes. The LIPH serves as a strategic plan for the implementation of UHC at the local level, and a basis for the provision of financial and non-financial grants from the national government. The LIPH contains, among others, population-health services including health promotion programs and campaigns, HIV surveillance, disease prevention and elimination services, and other public health programs and services aligned with UHC Act and DOH and PhilHealth guidelines.

Local Investment Plan for HIV – a plan which ensures that AMTP priorities are programmed and implemented at the local level based on situational analysis. Anchored on the LIPH, the local investment plan for HIV is a critical tool in mobilizing resources within the LGU or from the national government, private sector, and other development partners. The HIV programs and projects set in the local investment plan may feed into the Executive and Legislative Agenda, aligned with the administration term.

Executive and Legislative Agenda (ELA) – a three-year planning document corresponding to the term of local elective officials, mutually developed and agreed by both executive and legislative. To ensure that HIV priorities set in the CDP and HIV investment plan are implemented and monitored within the term of a particular administration, the City/Municipality Health Office should take part in the preparation of the ELA.

Local Development Investment Program (LDIP) – a basic document that links the local development plan to the budget for cities and municipalities. It translates the CDP into programs, projects and activities (PPAs) and identifies initiatives to be supported through the annual general fund. HIV programs and projects form part of Health, Nutrition and Population Control under Social Services.

Annual Investment Program (AIP) – the annual slice of the Local Development Investment Program (LDIP), which constitutes the total resource requirements for all PPAs. HIV programs, projects and activities form part of Health Services, under the Social Services component. Once approved by the Local Development Council, the AIP is endorsed by the local budget officer for budget preparation and to determine the annual budgetary allocations for PPAs vis-à-vis allocations for other purposes.

The Local Health Office takes the lead in the formulation and implementation of policies, plans, programs and projects to effectively respond to HIV and AIDS, in close coordination with the Planning and Development Coordinator's Office and other LGU offices. In providing inputs to the development plans and investment programs, the Local Health Office and other stakeholders may revisit LGU's commitments on HIV/AIDS, including the Philippine Health Agenda 2016-2022 and the AMTP. The Local Health Office can consult with Local AIDS Council and PNAC on programs and projects to be included in local development plans. The Local Health Office also participates in the local budgeting process, including budget preparation, budget authorization, budget review, budget execution and budget accountability.

Budget Preparation – involves cost estimation of PPAs, preparation and executive review of budget proposals, preparation of the Local Expenditure Program (LEP) and preparation of the budget message. The Local Health Office participates in the budget preparation exercise, from the issuance of the budget call to the submission of the Local Expenditure Program to the Sanggunian.

Budget Authorization – starts from the time the Sanggunian receives the LEP submitted by the Local Chief Executive (LCE) and ends with the enactment of the Appropriation Ordinance and approval thereof by the LCE. An Appropriation Ordinance is enacted by the Local Sanggunian in compliance with the Local Government Code provision that "No money shall be paid out of the local treasury except in pursuance of an Appropriation Ordinance or law."

Budget Review – determines whether the Appropriation Ordinance has complied with the budgetary requirements and general limitations set forth in the Local Government Code of 1991, and other applicable laws. It starts from the time the reviewing authority receives the Appropriation Ordinance for review and ends with the issuance of the review action.

Budget Execution – involves the release of allotments, the certification of available appropriations and cash, the recording of actual obligations and disbursements of funds for approved PPAs and the delivery of goods and services to target beneficiaries.

Budget Accountability – entails use of management control techniques to assist in tracking receipts of income/revenues and controlling expenditures. This mechanism provides an opportunity for the LCE, Local Sanggunian and stakeholders to be continuously informed of the status of implementation of PPAs.

The Local Government Units perform internal control and audit functions in compliance with the National Guidelines on Internal Control Systems and the Philippine Government Internal Audit Manual. The COA, as the external auditor, examines the legality and propriety obligations and expenditures in the process of executing the budget.

Throughout the budget cycle, the Local Health Department and other offices monitor the utilization of funds, from appropriations to allotments, obligations and disbursements – as they implement programs, projects and activities. After completion of the annual budget process, the HIV Program Managers and Health Department, together with the Local AIDS Council, review the HIV Investment Plan and identify which initiatives have been funded and supported.

CSO participation in HIV programming, planning and budgeting at the national and local levels

The 1987 Philippine Constitution clearly recognizes the important role of civil society organizations at all levels of social, political and economic decision making. This includes participation in national government planning, budgeting and performance monitoring.

At the national level, civil society organizations may participate in the planning and budgeting process through Budget Partnership Agreements (BPAs) and Citizen Participatory Audit (CPA). BPAs are legal instruments formalizing their engagement in budget preparation and execution at the agency level. The CPA is a mechanism by which civil society organizations work with the COA in conducting performance audits in government projects.

The Local Government Code (LGC) of 1991 further provides for civil society participation in local government policy development and implementation and planning, and in the delivery of public services. Civil society organizations

may participate in local planning and budgeting through Local Development Councils and Local Health Boards.

The Philippine Council for NGO Certification (PCNC) certifies non-stock and non-profit organizations based on minimum criteria for NGO governance and accountability. PCNC certification is used by the Bureau of Internal Revenue (BIR) as a basis in granting "donee Institution status" to qualified non-stock, non-profit organizations.

Social contracting

Many of the preconditions needed for social contracting are in place

In September 2021, the "HIV Community Agenda: United towards meaningful community and government partnership to end AIDS" was developed to advocate for enhanced HIV policies, programs and services through the PNAC. The HIV Community Agenda was a product of collaboration among civil society organizations, communities of people living with HIV, and key and vulnerable populations. It advocates for enhanced HIV financing and sustainability, including social contracting to allow civil society organizations to utilize government funding to deliver HIV programs and services.

Government is still exploring the possibility of purchasing HIV services through social contracting. As noted earlier in this report, there are already legal and regulatory frameworks promoting civil society organization participation in HIV service delivery, including the Philippine Constitution, Local Government Code and Procurement Law. Many of the preconditions needed for social contracting are in place. These include:

Some HIV services are covered under the health insurance scheme: The Outpatient HIV/AIDS Treatment (OHAT) Package introduced in 2010 aims to increase the proportion of the population having access to effective HIV/AIDS treatment and education services, aligned with PhilHealth's All Case Rate Policy. Use of the OHAT Package is based on the policies and guidelines on the use of ART among people living with HIV and HIV-exposed infants prescribed by the Department of Health as per PhilHealth Circular No. 011-2015. The OHAT package is paid through a case-based payment scheme, with an annual reimbursement at a maximum of Php 30,000.

Department of Health rules are broadly favourable for social contracting: The DOH has issued various administrative orders promoting the participation of civil society organizations in policy, planning and programming processes, as follows:

- DOH Administrative Order 2020-0002 issued on 16 Jan 2020: Guidelines for the Accreditation of Civil Society Organizations as Implementing Entities of Programs and Projects of the Department of Health
- DOH Administrative Order No. 2017-0019 issued on 15 Sept 2017: Policies and Guidelines in the Conduct of Human Immunodeficiency Virus Testing Services in Health Facilities, which encourages civil society organizations to assist in policy dissemination through training, education and advocacy, and coordinate and collaborate on community-based HIV screening implementation
- DOH Administrative Order No. 2009-0006: Guidelines on Antiretroviral Therapy among adults and adolescents with

HIV infection, which allows civil society organizations to work with the members of the HACT in treatment hubs in providing care and support for people living with HIV especially those on ART.

There are examples of national and local government purchasing specific HIV services from civil society organizations: This is not yet routine. Rather, specific governments have recognized and used a combination of – existing policies which permit purchasing of services from civil society organizations; health insurance covering some services; and the existence of a process for accrediting civil society organizations to be permitted to provide services – to contract some civil society organizations to provide specific services on a one-off basis. As of January 2023, PhilHealth has not refunded these services, although it is expected to.

Remaining challenges

The main limitations relate to the need for government to be convinced of the opportunities offered by the social contracting approach, realistic costing of services, and the inclusion of essential services in social health insurance.

In practise, government is not well positioned to provide prevention and outreach HIV services, whereas civil society organizations are trusted by key populations, have access and the commitment required to provide services to their communities. National and local governments need to be convinced of the value of this and of social contracting. The work of PNAC, UNAIDS and other partners on the HIV Community Agenda is very important to achieving this.

A major limiting factor is paying a full and fair cost for services provided by civil society organizations. In the view of some government officers, these organizations should fund their own operational budgets, with government paying them the same amount as they would pay government staff or facilities to provide the services. However, government facilities are fully funded by government and do not need to consider the real cost of service delivery, whereas civil society organizations need to recover the true cost of service delivery to be viable. This concept has been elaborated in some countries (including neighbouring Thailand) and needs discussion. Another key limitation is that social health insurance in the Philippines is directed towards clinic-based HIV treatment, not prevention and outreach. Again, further discussion is needed.

It would be particularly useful to show through a demonstration project how the approach can be efficient, financially, and effective, programmatically. A demonstration project would need to work through the many issues around establishing a social contracting program: finding a suitable location where the HIV epidemic is not in check, where there are capable CSOs which could be contracted to deliver priority services, where government (local government is broadly amenable to trialling social contracting. In addition, the following need to be carefully considered and established: scoping the magnitude and cost of the task; contracting modalities, mechanisms for accreditation of CSOs, that ensure CSOs can manage a contract, including financial management, service delivery at the required quality and volume, management of strategic information, and risk management. Equally, participating LGUs need to ensure that they have the requisite plans, systems, and skilled staff. It will be important to have suitable technical assistance to introduce a pilot project – this is something SKPA-2 could consider providing.

Similarly, PNAC has a large task ahead, and SKPA-2 could consider providing technical assistance in support of sustainable financing and removing human rights and gender barriers (see objective 4 section, below).

In the online sustainability pulse check survey of Philippines' stakeholders conducted as part of the baseline assessment, only one respondent saw government being in a position to expand HIV services for key populations without reliance on external donors within the next three years.

OBJECTIVE 2: IMPROVE STRATEGIC INFORMATION AVAILABILITY AND USE

As with other objectives, HIV strategic information system developments are closely linked to ongoing health systems integration as part of UHC reforms. This will likely impact the current HIV surveillance system as well as the future of routine HIV service data collection. Disease-specific units in the DOH Epidemiology Bureau, including the HIV Unit, will be transformed into process-based teams within the Philippines Center for Disease Prevention and Control, and data platforms will be integrated through the National Health Data Repository and the OneUHC app. At the time of this report, the transition has not been fully implemented. Although the DOH Epidemiology Bureau has stated that HIV information needed by stakeholders will continue to be produced, it is not yet clear how this will be done. Operational planning for the transition is expected to be completed by the end of 2023. HIV services are also envisioned to be integrated into the primary health care system, but there is no guidance or timeline from DOH yet on how this will be carried out; a different service delivery context will affect CLM implementation as well. These developments will affect implementation of community-led monitoring and may also affect recommendations on what needs to be done to improve the surveillance and routine data collection system as UHC reforms gather pace.

HIV surveillance system for key populations

The Philippines has a mature second generation HIV surveillance system, with the eighth round of HIV prevalence and risk behavior surveys taking place this year, complemented by modeling the epidemic through the Asian Epidemic Model (AEM), and size estimations of different key population groups. The HIV surveillance system has helped the Philippines to target services to key populations. In 2022, modeling from the AEM shows the majority (92%) of new infections are among key populations, with most of these infections occurring among men who have sex with men and transgender women. Age-disaggregated analysis shows that almost half (47%) of new infections in 2022 were among young key populations aged under 24 years[20]. Table 1 below shows current estimates of HIV prevalence, population size and 95-95-95 progress for different key population groups.

[20] Seventh AMTP 2023 to 2028

Table 1. HIV prevalence, population size estimates and 95-95-95 targets by key population

	Indicators and groups	HIV prevalence (2021)[21]	Number of new infections (2021)[22]	95: % of people living with HIV who know their HIV status (2021)[23]	95: % of people who know their HIV status who are on treatment (2021) [24]	95: % of people on treatment who achieve viral load suppression (2021)	Population size estimate (2021)†
1	All adults	0.22%	21,200	65% (88,780 /135,800)	62% (54,725 / 88,780)	95% among VL tested (17,685 / 18,554) VL testing coverage: 34% (18,554 / 54,725)	113,564,616
2	Men who have sex with men and transgender women[24]	11.89%	19,300	68% (72,591 / 106,000)	66% (48,017 / 72,591)	96% among VL tested (14,922 / 15,541) VL testing coverage: 32% (15,541 / 48,017)	691,900
3	Sex workers[25]	0.17%	10	n/a	n/a	n/a	88,000 (female)
4	People who use drugs/ inject drugs[26]	Male: 39.38% Female: 23.91%	3,000	76% (2,270 / 3,000)	18% (400 / 2,270)	85% among VL tested (93 / 110) VL testing coverage: 28% 110/400)	8,000
5	Transgender women	4% (2018)	n/a	n/a	n/a	n/a	159,100

Sources, table 1: Modelled HIV prevalence among adults 15-49 years old based on Philippines AEM-Spectrum, May 2022. PLHIV estimates were updated with data from the 2018 IHBSS for MSM & TGW and FSW, 2015 IHBSS for PWID, HARP 2021, 2020 Population Census, and other program data.

[21] Annual new HIV infections among ;5 years old and above. Estimates were rounded off to the nearest hundreds.
[22] Annual new HIV infections among 15 years old and above. Estimates were rounded off to the nearest hundreds.
[23] Among adults 15 years old and above who were diagnosed as of December 2021 (diagnosed PLHIV/estimated PLHIV)
[24] Assigned male at birth, had sex with a male in the past 12 months, ages 15 years old and above.
[25] Includes both registered and freelance female sex workers ages 15 years and above
[26] Among PWID in Cebu Province (including Cebu City) ages 15 years old and above

In terms of gaps in the surveillance system, Table 1 highlights limitations in disaggregated data on men who have sex with men and transgender women, with both populations grouped together and not sampled separately in the IHBSS. However, there is the ability to separate transgender women in the analysis, and this is what is shown in the last row of the table. Given these are both sizeable key populations, there is a strong case for sampling these populations separately in the future. Also missing from HIV prevalence surveys since 2015 are people who inject drugs, likely due to the country's recent "war on drugs". The Philippines does have some key population-specific cascade data – although there are gaps in data for female sex workers and transgender women – which indicate the need for improvement in performance across the cascade.

Key population risk profiles indicate the potential for further HIV transmission. For example, condom use is low (39% for transgender women and 38% for men who have sex with men at last sex, and 64.1% consistent condom use for sex workers), and the number of sexual partners is high (over 50% of sex workers reported seven or more partners in the last month, and around half of men who have sex with men had three or more partners in the last year). A new IHBSS round was taking place around the same time as this baseline assessment, and efforts should be made to update the table with the new findings when they are released.

Coverage of priority key population HIV services

The Philippines national HIV data collection system is the One HIV and STI Information System (OHASIS). Managed by the DOH's Epidemiology Bureau, OHASIS is an electronic case-based surveillance system that can track people across the HIV cascade. All HIV service providers, including private facilities and community organizations, must report to OHASIS. The Global Fund, PEPFAR and local governments are aligning with using OHASIS and Epidemiology Bureau forms for data collection instead of a separate set of tools. The system, which contains three primary modules (testing, prevention and treatment) and secondary modules including laboratory and other STIs, will be the main means by which coverage and other indicators of key population performance on the HIV cascade will be measured. There is currently no provision to enter data on self-testing in the OHASIS data collection tools.

Given the ongoing efforts to strengthen OHASIS, it is difficult to get an accurate sense of coverage of prevention services from the routine data system, and coverage indicators presented in Table 2 below are mostly sourced from the 2018 IHBSS. Table 2 shows the available coverage data of key populations with HIV prevention, testing and PrEP interventions.

Table 2: Coverage of key populations with HIV prevention, testing and PrEP interventions

	Indicators and groups	HIV prevention coverage[27,28]	Number of people on PrEP[29] (received any time in last year)	% of key populations reached with prevention interventions provided by key population led organizations	Number of people who received HIV testing in last year[30]	Number of people who received HIV self-testing in last year	Avoidance of health care due to stigma and discrimination
1	All Adults	n/a	6,706[31]	n/a	152,779	n/a	No data
2	Men who have sex with men	In the past 12 months[32] • Received HIV information: 36% • Received free condoms: 40% • Tested for HIV: 32% • Received all three: 22%	6,368	No data	93,085	No data	No data
	% of overall results from civil society organization service delivery	No data	80% (5,096 /6,368)	n/a	49% (45,556 /93,085)	-	n/a
3	Sex workers	In the past 12 months[33] • Received HIV information: 87% • Received free condoms: 88% • Tested for HIV: 57% • Received all three: 52%	5	No data	2,513	No data	No data

[27] UNAIDS definition: Prevention coverage is measured as the percentage of people in a key population who report having received a combined set of HIV prevention interventions in the past three months (at least two out of three services): (1) given condoms and lubricant; (2) received counseling on condom use and safe sex; (3) tested for STIs (for transgender people, sex workers and gay men and other men who have sex with men) or received sterile needles or syringes (for people who inject drugs).
[28] Available data from DOH-EB is as follows: Received HIV prevention services in the past 12 months (not mutually exclusive). Receiving HIV information may be from a peer educator, social hygiene clinic or health staff, health provider, CBO or NGO worker. Since there is no information on STI testing, proxy data on HIV testing is provided.
[29] Cumulative number of people currently on PrEP as of October 2022. Tagging of key population groups is not mutually exclusive; a person may be included in more than one KP group.
[30] Tested for HIV from November 2021 to October 2022. Tagging of % results from CSO service delivery was based on the facility or organization that provided the testing services, regardless of modality of testing (e.g. community-based screening, facility-based screening, etc.)
[31] Among clients 15 years and older upon PrEP enrollment
[32] IHBSS 2018
[33] IHBSS 2018

Indicators and groups		HIV prevention coverage[27,28]	Number of people on PrEP[29] (received any time in last year)	% of key populations reached with prevention interventions provided by key population led organizations	Number of people who received HIV testing in last year[30]	Number of people who received HIV self-testing in last year	Avoidance of health care due to stigma and discrimination
	% of overall results from civil society organization service delivery	No data	80% (4/5)	n/a	8% (191/2,513)	-	n/a
4	People who use drugs/inject drugs	In the past 12 months: Males in Cebu City: • Received free needle/syringe and any information on HIV prevention, transmission or testing from social hygiene clinic, or DIC or peer educator: 51% • Received free condoms: 55% • Tested for HIV: 9% Female in Cebu City: • Received free needle/syringe and any information on HIV prevention, transmission or testing from social hygiene clinic or DIC or peer educator: 46% • Received free condoms: 67% • Tested for HIV: 23%	66	No data	Male: 780 Female: 101	No data	No data

Sources Table 2: UNAIDS Asia Pacific Data and Philippines Department of Health.

The data show that coverage of key populations with priority services is patchy. Two-thirds of men who have sex with men and transgender women were aware of facilities offering HIV testing, but only around one-third actually received a test in the last 12 months. Civil society organizations are well integrated into the service delivery landscape, responsible for about half of HIV testing results among men who have sex with men and transgender women and about 80% of PrEP coverage. PrEP utilization is increasing among these two key populations with over 6,000 clients accessing PrEP in the last 12 months. However, the number of PrEP users among other key population groups is negligible. Men who have sex with men (40%) were less likely than female sex workers (88%) to have received free condoms in the past 12 months. Around half of male people who inject drugs in Cebu city received free condoms (55%) and free needles/syringes (51%), but they were much less likely to have been tested for HIV (9%). Female sex workers were the most likely of any key population group to have received information on HIV (87%). The data collection form for ART does disaggregate by key population, but this data is not currently used in regular analysis. A disaggregated analysis of this data in 2018 found that only 36% of transgender women knew free HIV treatment is available.

Some of the service coverage variables are not well aligned with global standard indicators. For example, coverage of prevention services appears quite high, but there is no data on the UNAIDS prevention coverage indicator (receipt of a combined set of prevention interventions in the last three months). Data on avoidance of health care due to stigma and discrimination is also not available. The AMTP 7 plan cites declining coverage of prevention services for men who have sex with men and transgender women, from 26% in 2018 to 17% in 2020. This was based on data from Global Fund project sites representing individuals receiving information on HIV and a HIV test.

Gaps in collecting and reporting key population HIV service data

There are several provisions to ensure good quality data in the Philippines HIV strategic information system. These include standard data collection tools for PrEP, testing, and treatment; standard operating procedures for filling in most paper forms; and many sites have participated in annual data quality improvement assessments led by the DOH. The roll-out of data quality assessments, including a new protocol, has been seen as extremely important for validating facility-level reports. Key informants expressed the need for these to continue "more regularly until the system is OK". There is also a proposal to decentralize this responsibility to regional units, and recognition that these units "need a lot of capacity building" before they can fulfill this role adequately. Service providers are given an orientation to OHASIS prior to use in their facility or organization, but there is no user manual available for later reference and no refresher courses for facilities already implementing OHASIS. Quality assurance mechanisms are in place, including automated and manual protocols for data cleaning and de-duplication, and a data quality assessment activity is done annually by the Epidemiology Bureau.

There are some gaps in key population HIV service data. For PrEP, which is a newer service and hence new to the surveillance system, follow-up is not consistently reported. The reasons given include a large overall client volume, the lengthy reporting form, and lack of understanding on the part of some providers about the need to report follow-up visits. HASH, a community-based organization offering HIV services, reported having to develop

its own Excel template for tracking PrEP clients, as this function is not currently supported in OHASIS. For testing, service providers for community-based screening, many of which are community-based organizations, are not as well-mapped as treatment providers and not all are reporting to OHASIS. According to the Epidemiology Bureau, the gap is mostly in testing and outreach, and there are plans to expand, initially to Global Fund sites that have their own system for outreach that is not recorded in the national system. Another gap in testing data is that clients with negative HIV test results are not reported by most facilities, unless they are on PrEP.

While OHASIS captures data on key population groups, there have been issues in disaggregation of data relating to transgender women. In the field from which data on gender identity is derived, some clients choose the "Other" option and indicate sexual orientation. Possible reasons include service providers not being able to adequately guide clients in answering the question, clients not being aware of the difference between gender identity and sexual orientation, or the question itself needs improvement to elicit more accurate answers. Earlier forms also did not allow tagging for transgender women, and this information was not updated in the system for affected clients later on. As a result, there has been limited data for transgender women in DOH Epidemiology Bureau reports. Information on people belonging to multiple key population groups is available in the database but also not included in these reports.

There has been a lot of work to support consistent entry of unique identifier codes (UICs), and LGUs visited commented that now facilities understand why it is important and fill in the UIC field.

OHASIS data is collected in a central server at the Epidemiology Bureau. Some facilities enter data into OHASIS in real time as the service is given, but many use the paper versions of the forms before encoding them at a later time. Offline encoding is not yet available, although there is an expressed need for it for sites without strong internet connectivity. A key informant from the Global Fund national grant estimated that 30-40% of GF PROTECTS data is not encoded into OHASIS because there are not enough staff to do this. Without dedicated encoders, when there is high client volume, service providers prioritize service delivery and consequently, data quality can suffer. Removing additional data entry by entering data directly into OHASIS is one potential solution to reducing the data collection burden, but there are then threats to data quality if the system goes down. Integration of OHASIS into the service workflow is seen to potentially help improve uptake and timeliness of reporting to OHASIS, especially among civil society organization providers, and some PEPFAR projects will support this in their sites.

Strengthen use of data by expanding access to dashboards to inform policy/programs

At the national level, DOH's Epidemiology Bureau provides data that is used for strategic direction, site prioritization, procurement and program planning. National and regional epidemiological and cascade reports are released to the public monthly. The major gap for OHASIS is that data are not readily available in a dashboard template for operational improvement at facility and local level. This was confirmed during the latest

data quality assessment, which emphasized the need for data to be more available to stakeholders. As a result, the DOH and the Epidemiology Bureau plan to prioritize the development of OHASIS dashboards for facilities and sub-national partners next year as well as capacity building on data interpretation. Currently facility-level and sub-national service data are available only during annual strategic information reviews or sub-national strategic planning, or when requested by other parties from DOH. This leads many facility-level staff to view OHASIS primarily as a reporting tool, rather than a platform to support better service delivery. There is also limited awareness among stakeholders on what information can be obtained from OHASIS, thus limiting their capacity to request data to be used for service improvement.

Aside from data for planning, service providers expressed the need for information systems to be able to automatically track clients, for example, for ART or PrEP follow-up or linkage to care from testing. OHASIS does not currently have this ability and so the Bureau allows facilities to export their data in tables for analysis or data tracking with any external tool. Some service providers, including Global Fund for their sites, use the exported data with Excel to enable the monitoring functionality they need, but many facilities do not have the capacity to do this. The release of the new person-centered HIV strategic information guidelines (WHO, 2022) could be seen as an opportunity to strengthen and standardize systems for individual-level data collection, as well as to establish inter-operability protocols or tools for exporting core and additional indicators to OHASIS.

Community-led monitoring

Community-led monitoring (CLM) has not yet been established in the Philippines, but has been recently adopted as an official monitoring and evaluation component of the Seventh AMTP. Pilot testing of its service quality component will begin in February 2023 through a consortium of stakeholders including funding from PEPFAR and DFAT, with UNAIDS leadership of the process. The activities already planned by the consortium are comprehensive, with CLM's focus areas including financing, policy, service delivery and stigma and discrimination. The civil society organization TLF Share Collective is leading CLM development in the DFAT project, including the road map development, until November 2023.

TLF Share organized a consortium of key population networks and organizations for CLM development, including its road map. However, the consortium has no clear governance structure or official terms of reference for partner organizations. There is also no plan yet for who will take on the leadership of CLM after TLF Share in November 2023.

Several concerns of government, service providers and development partners were raised regarding CLM in the assessment. First, the technical soundness of CLM tools and processes, especially for the pillars of financing, policy, stigma and discrimination. While the tools and indicators for service quality have been developed and consulted on with partners, more robust and evidence-based tools are needed for the other pillars. TLF Share is seeking academic institutions they can partner with to address this.

Secondly, community organizations must have the technical capacity to manage and analyze data, to effectively communicate the process and results to stakeholders for advocacy, and to address questions from stakeholders on the methodology, analysis, and recommendations. To support this, FHI 360 (supported by USAID/PEPFAR) is developing training modules for community organizations on monitoring and evaluation, data analysis, and advocacy using data. Training is expected to commence early next year.

Thirdly, there is a need for sensitization, especially of LGUs. Given the devolved health system, local governments are key stakeholders in any potential implementation of CLM. However, currently there is low awareness of CLM among LGUs, and potential acceptance among LGUs is seen as a challenge. Involvement of smaller community organizations in CLM could potentially help in advocating to LGUs that the larger organizations currently engaged in CLM may not have direct links to.

Fourthly, issues of CLM coverage need to be addressed. There is criticism that the focus is too much on category A (high burden) sites, while category B sites are being left behind.

Finally, plans for the long-term sustainability of CLM must be developed, since international donor funding is only a short-term solution. The inclusion of CLM in the Seventh AMTP Plan, which will span six years, is an important step in getting more support from other stakeholders for CLM. The CLM consortium is also seeking potential funding from the PNAC budget, but this is not guaranteed and there is also the question of the independence of CLM if it is funded by the government, as well as if its data servers and tools are integrated into DOH systems. Regarding the latter, the decision for now is not to pursue such integration but to interface during analysis instead. Given the large number of stakeholders supporting CLM it is difficult to identify a meaningful role for the SKPA-2 project.

OBJECTIVE 3: PROMOTE PROGRAMMATIC SUSTAINABILITY

Differentiated HIV testing service delivery, including virtual outreach, and PrEP are supported by recent policy issuances from the DOH.

Availability of HIV testing services

Community-based screening, which is lay provider testing in a community setting, is the main differentiated testing model and alternative to facility-based testing in the Philippines. Clients with reactive results from community-based screening must be referred to a facility for confirmatory testing. The three-test confirmatory algorithm, called Rapid HIV Diagnostic Algorithm (rHIVda), is available in only 34 sites nationwide. Aside from rHIVda sites, confirmatory testing is also done at the National Reference Laboratory in Manila. HIV testing is offered for free by government facilities and community-based organizations.

HIV self-testing was introduced to the country in 2020 through a demonstration study led by LoveYourself, a community-based organization in Metro Manila. Currently, there is limited implementation of HIV self-testing, which is only available at some Global Fund- and USAID-supported sites. The Global Fund has financed procurement of kits and there is no domestic funding for this for 2023. As the DOH guidelines were just released in 2022, HIV self-testing has not yet been taken up by local government facilities. Self-test kits are not available through private pharmacies.

Most clients access HIV self-testing through an online service called SelfCare run by LoveYourself. It has a dedicated Facebook page through which clients can request the kits and are assisted by chatbots using pre-recorded prompts and messages from celebrity ambassadors. The self-test kits are delivered by commercial courier services nationwide. Some community organizations also have stocks at their facility for clients in their area.

As SelfCare is an online service, internet access can be a limiting factor for some clients. Feedback suggests that the kits are easy to use, but some clients require more help in understanding the English-language instructional video and pamphlet, particularly young key populations. The data collection requirements of DOH and funders, which include personal identifiers, deter some clients from going through with the self-test.

Availability and use of Pre-Exposure Prophylaxis (PrEP)

A PrEP demonstration study was conducted in the country in 2016 and PrEP was adopted as a program by LoveYourself in 2019. DOH released interim PrEP guidelines in 2021 and included PrEP in the national drug formulary in 2022. PrEP is still relatively new to the Philippines, and the 2018 IBHSS found that only 8% of men who have sex with men and transgender women were aware of PrEP at the time[34].

Procurement has been supported by the Global Fund and USAID. DOH will start procurement in 2023 to cover most of those already on PrEP; the national target for people on PrEP in 2022 was 10,000. PhilHealth does not reimburse PrEP and related services, such as laboratory tests for monitoring. An official estimation of PrEP need has not yet been done for the country.

[34] https://www.aidsdatahub.org/resource/factsheets-2018-integrated-hiv-behavioral-serologic-surveillance-ihbss

PrEP requires a physician's prescription, so initiation is mostly done in facilities. Some organizations have started initiating PrEP on-site during outreach activities, with a physician present physically or virtually through telemedicine. Certain facilities have also started to offer PrEP refill with HIV monitoring (through self-testing) through courier delivery, using an online booking system.

Stakeholders consulted for this assessment indicated that there is a need to increase awareness and knowledge of PrEP especially among people who inject drugs, transgender women and young key populations. Concerns were also raised among transgender women about adverse effects when PrEP is taken with hormone therapy. Some local governments are not supportive of providing PrEP services in their facilities as they think this will cause STI cases to increase. Some physicians are also not comfortable with giving PrEP; others who are more supportive need guidance and training.

Some community-based organizations are advocating for the demedicalization of PrEP, but this would require revision of national guidelines. DOH expressed the need for evaluation of PrEP implementation, as well as relatively newer strategies like community-based screening and HIV self-testing, to inform updating of policies as well as to justify government investment.

50% of respondents to the online sustainability pulse check survey of Philippines' stakeholders saw PrEP as not being readily available to key populations currently, while 44% felt the same way about HIV self-testing.

Virtual interventions

Men who have sex with men and transgender women actively use social media to find new sex partners, as reported by around half of respondents (48%) from these target groups in the 2018 IBHSS. Social media platforms and dating apps – especially Facebook, Twitter and Grindr – are widely used for virtual outreach by community organizations and local government clinics. Paid social media ads are also being used by some organizations.

Online booking platforms for clinic appointments and ART or PrEP refill delivery are used by some project sites, e.g. EpiC's QuickRes and Global Fund PROTECTS' AwraSafely. Some sites noted an increase in the number of clients availing testing services after introducing online appointment booking systems. The SAIL clinics of the civil society organization Sustained Health Initiatives of the Philippines (SHIP) use a more extensive system (Connect for Life) with adherence support and electronic medical records.

One challenge is that OHASIS, the national HIV information system, has no functionality yet to receive data directly from these platforms, so sites must encode into OHASIS separately. There has been some discussion between DOH's Epidemiology Bureau and some organizations using such platforms, but there is no timeline as yet for when OHASIS will have this functionality. DOH is also developing a "OneUHC" app that will cover all health areas, but there is no guidance yet on how existing apps can interface or integrate with OneUHC app.

Service delivery and UHC reforms

The COVID-19 pandemic disrupted some HIV program activities – for example, staff transfers from HIV to COVID-19 work resulting in lower testing and treatment enrollment rates. UHC reforms will seek to resolve the fragmented and overlapping responsibilities of different health agencies through restructuring functions and/or offices in the DOH. Currently there is a lack of institutional capacity and readiness to implement UHC and decentralized funding. The implementation of UHC will require increased advocacy and communications at the local level.

Civil society organizations and other service providers have no clear guidance and timeline from DOH yet on how disease programs will be integrated operationally. Key informants from USAID/EpiC reported that they are initiating closer coordination with specific related programs such as TB and maternal and child health, and they are also anticipating a revised Philhealth package for primary care and intend to support their sites to become accredited for it.

OBJECTIVE 4: REMOVE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO SERVICES

In the Philippines, our assessment of human rights- and gender-related barriers to accessing HIV services builds on the substantial body of work already conducted under the Global Fund's Breaking Down Barriers Initiative. In 2017, the Philippines conducted a Baseline Assessment of human rights barriers, and followed that up in 2020 with a Mid-Term Assessment of progress on key barriers and recommendations from the baseline report. The Breaking Down Barriers Initiative in the Philippines focuses on strategies to strengthen access to comprehensive and quality programming in three ways: (1) create a supportive environment to address human rights-related barriers; (2) facilitate programmatic scale-up; and (3) support momentum towards quality programming and sustainability.

Positive developments in building a supportive environment

Building on the findings from the Breaking Down Barriers assessments, our assessment found that the Philippines has taken substantive steps to address human rights barriers, notably by strengthening legislative and policy frameworks to build a supportive environment. Human rights have long been integral to the Philippine's response to HIV. Indeed, the Philippines Health Sector Plan for HIV and STIs 2015-2020 lists among its guiding principles and core values, the protection and promotion of human rights and gender equality, non-stigmatizing attitudes of health providers, and meaningful involvement of key populations.

Human rights in the context of HIV took an important step forward with the passage of the HIV and AIDS Policy Act (Republic Act 11166) on December 20 2018. The Act addressed a critical barrier for young key populations – the age of consent, by lowering it to 15 years of age. The Republic Act 11166 also reconstituted the PNAC – an important governance body that has seven seats allocated to civil society organizations that represent people living with HIV and key and vulnerable communities. A Human Rights Committee, under the PNAC, was established in March 2020, which has developed a National Advocacy Plan, a Human Rights Roadmap and a Joint Circular on Uniform Rules on Redress Mechanisms for Persons Living with HIV. A HIV Community Agenda has been developed and endorsed by PNAC.

The Seventh AMTP 2023-2028 builds on these developments. It "underscores the state's obligation to respect, protect, and promote the people's entitlement to basic human rights; invokes the rights of citizens (communities, civil society organizations, and networks of people living with HIV) to actively participate in the response and to engage the state in addressing their needs and concerns" and "recognizes individual rights regardless of sexual orientation, gender identity and expression, and free from stigma and discrimination". The LGBTQI community is not criminalized in the Philippines. Same-sex marriage is not legal in the Philippines, but, in 2022, two civil union bills were refiled and proposed in the Philippine Congress, seeking to recognize and provide benefits and protection to same-sex couples.[35]

[35] https://en.wikipedia.org/wiki/LGBT_rights_in_the_Philippines#cite_note-:13-12

Gaps in legal and policy protections

Criminalization remains in force for some key populations, and adversely impacts their health and access to HIV-related services. The War on Drugs and criminalization of people who use or inject drugs, drives drug users underground, makes them reluctant to attend health services, and makes it difficult for them to protect themselves from HIV infection. For example, our desk review[36] and interviews found that carrying sterile needles has been used as evidence of illegal activity in some parts of the Philippines. The Philippines' criminal justice approach to people who use or inject drugs means that critical components of harm reduction services (as defined by WHO and UNODC), such as needle and syringe programming and evidence-based drug treatment with methadone or buprenorphine, are not available in the country. Similarly, evidence-based HIV prevention services are not provided in closed settings in the Philippines although, in Cebu, HIV testing, TB screening and ART are available to people in closed settings. Sex work is also illegal in the Philippines. Article 202 of the Revised Penal Code of the Philippines criminalizes people who sell sex, but not those who purchase it.

A **lack of alignment among legal provisions** makes some key populations more vulnerable to HIV infection. Notably, although the 2018 HIV and AIDS Policy Act improved young people's access to HIV testing, reproductive health law – the Responsible Parenthood and Reproductive Health or RA 10354 – provides only for education and counseling support for people under the age of 18, and is silent on contraception for adolescents, thereby legally constraining their access to condoms. Similarly, there is a lack of alignment between the HIV and AIDS Policy Act and the national approach to UHC, especially at the LGU level. The Philippines' highly decentralized health system means that national policies must be translated into local policies and action taken by each LGU. As a result, acceptance of new approaches to HIV services is very uneven. For example, in some LGUs, there has been resistance to offering HIV self-testing, due to lack of capacity and associated fears of adverse outcomes.

Insufficient utilization of existing legal protections, and low coverage of programming designed to improve key population communities' knowledge of and access to legal protections have meant that the impact of existing legal protections is sub-optimal. For example, only one case has been investigated under the National Redress Mechanism which was established in 2021. The Breaking Down Barriers Mid-Term Assessment notes, and our interviews also found, that existing programs to facilitate access to legal services offer promising models, but are "generally small scale, and limited in scope for geographic and key populations coverage"[37]. Promising, if limited, programs include the paralegal services that was offered by Justice Learning and Access Officers and integrated into 12 community centers across the country, the Aid for AIDS Network in Central Manila supported by ACHIEVE, and the Streetlaw program supporting people who use drugs in Cebu City. Building on the Justice Learning and Access Officers program, which ended in 2021, the CARE Program, operational since 2021, aims to provide low threshold legal support in order to address gender and human rights barriers and improve access to HIV services. It includes community-level redress mechanisms through dialogue with judges and prosecutors.

[36] HIV Community Agenda: United towards meaningful community engagement and government partnership to end AIDS. September 2021. Action for Health Initiatives, INC. (ACHIEVE)
[37] The Global Fund, Breaking Down Barriers Mid-Term Report, 2020. P. 23.

Finally, this review found a **widespread lack of awareness among community members about key achievements and milestones related to human rights.** Many of the community members we interviewed were not aware of the existence of the Human Rights Committee, and none had seen, read or heard of the Breaking Down Barriers assessments.

Challenges accessing the benefits of health insurance

Key populations face challenges accessing the Philippines national health insurance system, PhilHealth. The most vulnerable community members reported that they could not afford to purchase health insurance. Others noted that out-of-pocket expenses were prohibitive, even for those who did have PhilHealth, and that there are gaps and discrepancies in what is covered. The PhilHealth package covers critical services for people living with HIV including routine drugs, laboratory tests and professional fees, but it does not cover the cost of treating opportunistic infections. Further, out-of-pocket expenses differ between treatment hubs and regions and, because PhilHealth does not stipulate a set menu of services and benefits, the decision about what can be included in health insurance claims is highly dependent on the individual healthcare provider. Key populations, who often face stigma and discrimination in healthcare settings, find it especially challenging to navigate this system.

Stigma and discrimination and gender-based violence

Our review found that stigma and discrimination, especially in healthcare settings, remains a serious issue for key populations and people living with HIV in the Philippines. Women living with HIV reported that health professionals advised them not to have a child because of their status[38] and HIV-positive mothers reported that healthcare providers label their children "baby of an HIV+ mother"[39]. For transgender people, health services lack care guidelines and limited availability of hormone replacement therapy drives transgender people to seek underground service providers.

Confidentiality remains high on the list of concerns. The 2019 Stigma Index found that fear of their status being disclosed was a major reason why people living with HIV delayed treatment[40]. Some people living with HIV and members of key populations, such as men who have sex with men, reported that they chose not to subscribe to PhilHealth for fear of being "outed". Sex workers also report avoiding HIV-testing for fear of losing their source of income if they find that they are HIV-positive[41].

Harassment by law enforcement officials and gender-based violence were also reported in key population communities, notably by female and transgender sex workers[42].

Outside of healthcare settings, key populations face stigma and discrimination in finding employment and in the workplace.

[38] Laguna, Elma P and Villegas, Justine Kristel. The Philippine People Living with HIV and AIDS (PLHIV) Stigma Index (2019), Demographic Research and Development Foundation (DRDF), Inc. and Pinoy Plus Advocacy Pilipinas, Inc. (Pinoy Plus).
[39] PNAC Roadmap to Address Rights-Based Barriers to Accessing HIV and AIDS Services, March 2021.
[40] Laguna, Elma P and Villegas, Justine Kristel. The Philippine People Living with HIV and AIDS (PLHIV) Stigma Index (2019), Demographic Research and Development Foundation (DRDF), Inc. and Pinoy Plus Advocacy Pilipinas, Inc. (Pinoy Plus).
[41] PNAC Roadmap to Address Rights-Based Barriers to Accessing HIV and AIDS Services, March 2021.
[42] PNAC Roadmap to Address Rights-Based Barriers to Accessing HIV and AIDS Services, March 2021.

Promising programs to address stigma and discrimination do exist, but their coverage is low, they are urban-centric, ad hoc, and their impact has not been well evaluated. One potentially promising example is the National Health Sector Plan, 2015-2020 support for a national campaign, as well as Local Government Units, to implement advocacy on "HIV stigma management"[43].

62.5% of respondents to the sustainability pulse check survey believed that there is a functioning referral mechanism to legal services in case of incidents of patient's rights violations or violence linked to HIV service access.

Engagement in national processes

Civil society was closely engaged in the formulation of the HIV and AIDS Policy Act that passed in 2018. The passage of this Act represented the culmination of nine years of collaborative government -civil society work, led by the Network to Stop AIDS Philippines – a coalition of more than 27 civil society organizations – with support from ACHIEVE and in close collaboration with PNAC. As noted above, there are seven seats allocated to civil society organizations on the PNAC.

Key civil society organizations remain fully engaged in the formulation of critical documents, including through the CCM. Key population groups are represented in national-level and other major consultations such as the PNAC and national HIV Technical Working Group, but are less often involved at the local government level. Reasons include the lack of active mechanisms for key population participation and the lack of strong community organizations in some cities and municipalities with the capacity to engage with LGUs.

In the sustainability pulse check survey, the majority (56%) of respondents believe key populations are not adequately represented in planning and decision-making forums. This goes up to 80% among key population respondents.

It was clear through the study that PNAC has a large task ahead, and it would be useful if SKPA-2 or other partners were to provide technical assistance to support PNAC with the many initiatives needed to remove human rights and gender related barriers for the HIV response for key populations.

[43] Republic of the Philippines, Philippine National AIDS Council. Certification of 23 March 2020 (2020), cited in Breaking Down Barriers Mid-Term Assessment 2020.

3.

Recommendations

SK PA·2

Recommendations in this report are grouped under issues that reflect the key findings above. They are not all activities which the modestly funded SKPA-2 program has the scope to address, but rather are intended to help the national and sub-national programs and stakeholders to consider and address priorities for the Philippines HIV response.

Issue 1. Although some planning for sustainable financing of essential HIV services for key populations is in place, a number of crucial steps still need to be taken.

The baseline assessment found that most HIV funding is focused on ARV drugs and commodities, with significant gaps in prevention outreach. Overall funding needs to be addressed, the services funded need to be better balanced between prevention and treatment, and the mechanisms by which outreach and prevention are delivered need to be optimised to ensure services are delivered by entities which are best placed to do so.

Recommendation 1: In light of reductions in funding from international sources, ensure that adequate funding is available by reviewing HIV funding from all sources, including expanding the HIV component of the national health budget, and seek increased funding opportunities domestically through partnership with the private sector, novel taxation options ("sin taxes") and internationally from bilateral, international and philanthropic and public-private partnerships.

Recommendation 2: Remove barriers to financial support for prevention and testing by revising the inclusions of the social health insurance program (ref PhilHealth Circular No 2021 – 0025) to include outreach services and new prevention technologies such as HIV self-testing and PrEP.

Recommendation 3: Noting the increasing incidence of HIV among key populations, ensure that necessary levels of essential HIV services for key populations are provided by organizations that are best suited to deliver them. The most suitable mechanism is social contracting key population led organisations to deliver appropriate services on behalf of governments. Advocacy for social contracting of HIV services should be intensified, and the high potential work that is already being done to develop social contracting in the Philippines should be put into practice. This has several dimensions, detailed below:

Recommendation 3.1: Existing advocacy efforts should be maintained and intensified with national government agencies, local government units, civil society organizations, development partners, and the private sector.

Recommendation 3.2: Analyse the financial and programmatic implications of adopting social contracting at scale. Identify which elements of the HIV response would be optimally delivered through social contracting of CSOs/KP-led organisations. Quantify the volume of work that could be delivered at regional and national levels, prioritise as appropriate, and identify the cost.

Recommendation 3.3: Develop necessary mechanisms for delivery of social contracting of HIV services, by creating a strategy for tendering services in a regularized and transparent manner so

that competent, accredited civil society organizations can bid to provide services by presenting a technical and financial offer.

Recommendation 3.4: Review the costing of services financed by the PhilHealth outpatient HIV/AID treatment (OHAT) package in light of the social contracting approach. Following international best practise, costing of services currently detailed in PhilHealth circular No 2021 – 0025 should be reviewed to ensure that compensation for service delivery by PhilHealth includes reasonable costs for organizations which are not underwritten by government, i.e., the true cost of service delivery for a civil society organization.

Recommendation 3.5: Review the accreditation process and understand precisely what skills are needed among CSOSs participating in social contracting, and design mechanisms to build those skills where needed. Participating CSOs need to have the capacity to managed finances, deliver services at agreed quality and volume, and to manage contract deliverables including management of strategic information.

Recommendation 3.6: Review the systems and skills which managers in national and local government units will require to manage social contracting, and if necessary, design and launch a process to develop these systems and skills.

Recommendation 3.7: Noting that considerable research has been done into social contracting in the Philippines, move from theory to practise by establishing at least one social contracting pilot project at a local government level in a location/locations where the model has high potential. This will require concerted advocacy with the local governments and ensuring community members are well capacitated. Preconditions might be the presence of an HIV epidemic which is not well controlled, availability of community organizations that already have or can be capacitated to provide essential prevention services for key populations, and a local government which is prepared to trial this approach (requiring accreditation, capacity building and necessary systems addressed in recommendations 3.2 – 3.6).

Issue 2. Need to further strengthen national HIV surveillance system. The Philippines has a strong HIV surveillance system, but some enhancements are needed to serve the country's needs going forward.

Recommendation 4: Consider inclusion of transgender women as separate group in the IHBSS going forwards given high population size estimates and potentially different risk profiles. This will permit future analyses to present men who have sex with men data separately from transgender people.

Recommendation 5: Align coverage data and other indicators with the latest UNAIDS standard definitions, including prevention indicators, and avoidance of health care due to stigma and discrimination.

Issue 3. Need to strengthen OHASIS strategic information system. The OHASIS data platform is in the process of being rolled out and improved by the DOH. Recommendations raised during the baseline assessment are outlined below, keeping in mind many of these are already scheduled to be completed in the next 1-2 years.

Recommendation 6.1: Review the data collection system for self-testing and integrate with other HIV testing data in OHASIS.

Recommendation 6.2: Rollout offline capability for OHASIS data entry.

Recommendation 6.3: Map HIV prevention and testing service providers, and consider the inclusion of standard UNAIDS HIV prevention and testing indicators representing their activities in OHASIS. The Global Fund-supported data collection system for outreach also needs to be reviewed with a view to integration into the national platform.

Recommendation 6.4: Perform a disaggregated analysis of key population ART data, to understand whether one or more key population groups or sub-groups are falling behind on ART retention or viral load access.

Recommendation 6.5: Review and improve standard operating procedures around collecting data on transgender people, to improve accuracy of the key population disaggregated data.

Recommendation 6.6: Review the PrEP data collection system and build capacity of providers to improve adherence to data entry requirements including the follow up form.

Recommendation 6.7: Hold consultation workshops with community stakeholders for the development of OHASIS dashboards and assess the needs for additional OHASIS user manuals.

Recommendation 6.8: Conduct annual data quality improvement assessment linked to the development of SOPs for data management.

Recommendation 6.9: Strengthen and standardize individual-level information systems to align with the new WHO person-centered strategic information guidelines and create interoperability layer with OHASIS.

Issue 4. Support the roll-out of CLM with key populations at the forefront. CLM planning is at an advanced stage in the Philippines, and the roll-out is being centrally coordinated. Proposed data collection covers an ambitious range of topics. The following recommendations should be kept in mind during both piloting and scale up of CLM.

Recommendation 7.1: Develop a national-level CLM governance structure with key populations at the forefront.

Recommendation 7.2: Develop a costed CLM demand generation plan that includes communication and engagement with local governments, service providers, clients, and community organizations.

Recommendation 7.3: Develop and field test tools and procedures for CLM domains including financing, policy, and stigma and discrimination pillars. Use the field test to finalize indicators and share with OHASIS on a regular basis.

Recommendation 7.4: Build the capacity building of community organizations on CLM data management, analysis, and advocacy.

Recommendation 7.5: Further develop and strengthen the CLM feedback mechanism, including following up on whether the recommendations were implemented.

Issue 5. Need to support equitable scale-up of PrEP. The Philippines has recently committed to funding PrEP using domestic resources. Scaling up the service has real potential to help reverse the current trend of increasing infections but requires a significant investment in communication and advocacy. Involvement of key populations will be critical to increased and sustained uptake of PrEP.

Recommendation 8.1: Evaluate community-based PrEP implementation to support updating of national policies and service delivery modalities and increased government investment.

Recommendation 8.2: Build the capacity of DOH-EB in estimation of PrEP needs.

Recommendation 8.3: Advocacy to physicians and other service providers to build support for PrEP provision and to deliver PrEP services.

Recommendation 8.4: Design and implement demand generation activities to promote uptake of PrEP and HIV self-testing, tailored to specific key populations, in particular transgender women, people who inject drugs, and young key populations.

Issue 6. Expand access to HIV self-testing. As the DOH guidelines were released just this year, HIV self-testing has not yet been taken up by local government facilities, and HIV self-test kits are not available through private pharmacies. Other bottlenecks in the current implementation arrangement include a lack of offline access, difficulties with English language for some, and the use of personal identifiers in required data collection.

Recommendation 9.1: Design and implement demand creation campaign for HIVST that involves both health facilities, CSOs and key populations.

Recommendation 9.2: Address HIVST offline availability by assessing potential private sector involvement in HIVST kit manufacture and distribution (pharmacies), and develop strategy to expand access through the private sector.

Recommendation 9.3: Translate HIVST information into local language(s).

Recommendation 9.4: Investigate removing personal identifying information from the HIVST data collection tools.

Issue 7. The Philippines has made important advances in removing human rights- and gender-related barriers to a successful HIV program. Nonetheless significant barriers remain, including gaps in legal and policy protection, challenges accessing the benefits of health insurance, stigma and discrimination, and gender-based violence.

Recommendation 10.1: Mitigate the impact of legal and policy barriers on key populations and people living with HIV, including at subnational level, by building advocacy capacity among CSOs that work with criminalised populations – people who inject drugs and sex workers rights, and supporting them to conduct advocacy for evidence-based services for people who use drugs (notably needle and syringe programs and evidence-based drug treatment with methadone or buprenorphine), and for people in closed settings.

Recommendation 10.2: Documenting legal gaps and intra-legal inconsistencies (such as lack of alignment between the HIV and AIDS Policy Act 2018 and Reproductive Health Law) and developing guidelines or recommendations on bringing inconsistent laws and policies in line in order to best support a human rights approach in HIV services.

Recommendation 10.3: Strengthening legal literacy at all levels through activities that expand access to the national Redress Mechanism, increase coverage and institutionalise the CARE program through government channels, build legal literacy in communities, and fully engage with grassroots community-based organisations.

Recommendation 10.4: Supporting policy localisation at LGU level to translate national legal progress and programming (such as HIVST) into local action.

Recommendation 10.5: Expanding legal literacy programming at the LGU level.

Issue 8: There is still a need to reduce or eliminate the barriers posed by stigma and discrimination, in healthcare settings and law enforcement, by:

Recommendation 11.1: Expanding, creating and delivering training and capacity building programs for relevant providers, specifically designed to reduce stigma and discrimination towards key populations and people living with HIV.

Recommendation 11.2: Developing and providing gender-specific anti-stigma training for healthcare service providers in maternity, neonatal and paediatric care.

Recommendation 11.3: Developing standard operating procedures on maintaining confidentiality, or reviewing and revising existing standard operating procedures to appropriately incorporate confidentiality considerations, disseminate them to healthcare facilities, and ensure adequate training, mentoring and supervision for healthcare staff on how to implement them.

Recommendation 11.4: Develop new, or revise / update / adapt existing training materials for law enforcement on interacting with vulnerable populations, especially sex workers, and eliminating gender-based and police violence[44].

Issue 9: Lack of a clear strategic role for SKPA-2 or significant impact for its investments.

The baseline assessment takes place in at a time when there are many donors and activist groups working on HIV in the Philippines. While this is very positive, SKPA-2, with its modest funding, is struggling to find relevance in a crowded and active donor space. For example, SKPA-2 is not making a particularly strong contribution to CLM, where other partners are already investing and working. Similarly, SKPA-2's support represents a very low percentage of Love YourSelf's budget and the program emphasis is no longer consistent with its core work.

On the other hand, there are important opportunities for SKPA-2's investment to be catalytic. One is in response to the Seventh AMTP which recognizes the need to strengthen PNAC – SKPA-2 could provide welcome targeted technical assistance inputs. Another is to shift the discussion and analysis of social contracting in the Philippines from the theoretical to the practical, by launching a project designed to support one or more local governments to develop and launch a social contracting model designed to make sustainable the provision of essential HIV services for key populations.

Recommendation 12.1: SKPA-2 should withdraw its investment in LoveYourself and in CLM in the Philippines. SKPA-2 should work with its stakeholders to redeploy efforts to areas where catalytic funding can make a difference.

Recommendation 12.2: SKPA-2 should work with the Philippines National AIDS Council to design terms of reference for two advisers, a Financial Sustainability Adviser and a Human Rights and Gender Adviser, and finance those two positions.

Recommendation 12.3: SKPA-2 should consider working on a high potential demonstration project to test and show the potential of social contracting at the subnational level (discussed in Issue 1 and supporting recommendations, especially **Recommendation 3.7**).

[44] An example of gender-specific training materials for law enforcement can be found at: https://whrin.site/ourpublication/training-manual-for-gender-responsive-harm-reduction-policing-and-law-enforcement-2020/

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- Philippine Health Agenda 2016-2022
- Philippines Health Insurance Corporation (PhilHealth) circulars:
  - » Circular 2012 – 54 Accreditation of external clinics
  - » Circular No 2018 – 0004 Accreditation of standalone HIV treatment hubs and satellite treatment hubs as providers of PhilHealth outpatient HIV/AIDS treatment (OHAT) package
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ANNEX 1: PATHWAY TO FINANCIAL SUSTAINABILITY OF KEY POPULATION HIV SERVICES

Philippines' pathway to financial sustainability of key population HIV Services

Sustainable financing mechanism: National and/or local governments in the Philippines procure priority key population HIV services from key population organizations

Assumptions/Rationale: Governments already contracting out services to key population-led CSOs, on a one-off basis. There are existing accreditation and registration systems in place to facilitate KP-led organisations to receive reimbursement by PhilHealth (social health insurance) and ensure it is operational.

What might sustainable financing look like under social contracting?

Strand 1: Social contracting mechanism adopted as Standard Operating Practice (SOP)

GoP/LGUs contract CSOs to provide key population services

Mechanism: Direct contracting or overarching contract

Assumptions/Rationale: Contracting can be done directly by LGUs or national government, or a suitable organisation could be engaged to manage contracting.

AND

Strand 2: Essential HIV services which are delivered by CSOs are reimbursed by PhilHealth

CSOs reimbursed by Health insurance Fund for providing essential HIV services for key populations

Mechanism: PhilHealth issues circular adding PrEP, HIV self-testing to reimbursable services; select accredited CSOs licenced to deliver services and claim from PhilHealth

Assumptions/Rationale: GoP/LGUs considers these services to be important in the HIV response and that CSOs are best suited to deliver them.

Support from SKPA-2 Financial Sustainability Advisor

What are the key processes and activities?

LGUs/national gov't analyse and adopt social contracting approach as SOP.

Processes & activities: Calculate scope of services to be covered by CSOs and estimate costs; model likely epidemiological impact; determine consistent and transparent tendering process; publish accreditation criteria for CSOs to deliver services; consult with PhilHealth to ensure coverage of services.

Advocate with PhilHealth to expand list of reimbursable HIV services

Assumptions/Rationale: The existing package of reimbursed services is welcome, but limited. It should be expanded to include outreach and newer prevention services such as preexposure prophylaxis and HIV self-testing. PNAC and members are probably the best people to advocate with PhilHealth.

What is the baseline situation & bottlenecks that need to be addressed?

GoP and LGUs already contract CSOs to provide key population services

Assumptions/Rationale: Government are already contracting CSOs on one-off basis, but this is not formalised as routine practice. Significant opportunity exists to make impact on rising HIV epidemic.

PhilHealth funds some CSO-delivered HIV services

Assumptions/Rationale: Adding essential HIV prevention and outreach services to the list of services covered by social health insurance will increase their sustainability in context of reductions in international finance.

ANNEX 2. KEY INFORMANTS INTERVIEWED IN THE PHILIPPINES

Philippines: Stakeholder Interviewed			
Name	**Title**	**Organisation**	**Objective**
Dr. Jose Gerard B. Belimac	Program Manager	Department of Health - National Center for Disease Prevention and Control (DOH-NCDPC)	1, 3
Dr. Louie R. Ocampo	Country Director, Philippines	Joint United Nations Program on HIV and AIDS (UNAIDS)	1,2,3,4
Ms. Mara Quesada	Executive Director	Action for Health Initiatives, Inc. (ACHIEVE)	1,2,4
Dr. Emilia May P. Aquino	Project Officer II	Philippines CCM	1
Jofti Villena	Health Cluster	Alternative Budget Initiative (ABI)	1
Dr. Graham Harrison	Officer-in-Charge	World Health Organization	3
Ms. Arlene S. Ruiz	Chief, Economic Development Specialist	National Economic and Development Authority	1
Luisa Orezca	Executive Director	Philippine National AIDS Council (PNAC)	3
Rench Chanliongco	Secretariat	Philippine National AIDS Council (PNAC) (Research Planning, Policy and M&E Division) is currently in the process of developing the 7th AIDS Medium	1

Philippines: Stakeholder Interviewed			
Name	**Title**	**Organisation**	**Objective**
Dr. Delia A. Becina	Chief Health Program Officer	Philippine National AIDS Council (PNAC) Program Information, Partnership Development Division	1
Ms. Rowena C. Lora	Director IV	DOH Financial and Management Service	1
Ms. Maria Cresencia D. Dunga	Director	Department of Budget and Management-Budget and Management Bureau A	1
Dr. Gloria Nenita V. Velasco	Director III	Epidemiology Bureau, Department of Health	2
Dr. Rolly Cruz	Director III	Quezon City Epidemiology and Disease Surveillance Unit (CESU)	2
Ms. Michelle Lang-Alli	Office of Health Director	USAID Philippines, Pacific Islands, and Mongolia	2
Ms. Irene Fonacier-Fellizar	President	AIDS Society of the Philippines	2,3
Hon. Victor Ma. Regis N. Sotto	Mayor	Pasig City	2
Sir. Noel S. Palaypayon	Unit Manager/Supervising Health Program Officer	National HIV/AIDS & STI Surveillance and Strategic Information Unit, Surveys, Monitoring and Evaluation Division (SMED), Epidemiology Bureau, Department of Health	2

Philippines: Stakeholder Interviewed			
Name	**Title**	**Organisation**	**Objective**
Dr. Lloyd Norella	HIV Program Manager	Pilipinas Shell Foundation	2,3
Jose Mari Maynes	Program Manager	LoveYourself Inc. / CHAMPION Community Center Network	3,4
Joshua Young	Senior Program Officer	FHI360	3
Ralph Ivan Samson	President/CEO | Focal Point In-charge	Youth Peer Education Network (Y-PEER) Pilipinas, Inc.	3
AR Arcon	Chairperson	LakanBini Network	3,4
Tanya Laguing	President	Decent Image of South Signal Association (DIOSSA)	3
Rev. Father Dan	CBCP ECHC	Catholic Bishop Conference of the Philippines - ECHC	1
Mx. Toni Gee Ramirez Fernandez	Executive Director	Mujer-LGBT Organization Inc.	3
Noemi D. Bayoneta-Leis	Program Manager	TLF Share Collective, Inc.	4
Boying Velasco	Program Officer	AIDS Society of the Philippines, Inc.	3

Philippines: Stakeholder Interviewed			
Name	**Title**	**Organisation**	**Objective**
Jap Ignacio	Executive Director	Babaylanes Inc.	4
Vince Liban	National Convener	Pantay	4
Dr. Precious Montilla	Task Lead for Social Contracting	Alliance for Improving Health Outcomes	1
Ms. Rhoda Tiongson	Financial Sustainability Advisor	ACHIEVE	1
Mr. Roberto Figuracion	Capacity-Building Officer	DFAT-UNAIDS Project, ACHIEVE	2
Mr. Andrew Desi Ching	Executive Director	HIV & AIDS Support House, Inc.	2
Ms. Bettina Kaye Castaneda	Senior Strategic Information Advisor	FHI360	2,3
Mr. Rocky Rinabor	CLM Officer	TLF-Share	2
Teresita (Bai) Marie Bagasao	EpiC Country DIrector - Philippines	FHI360	3
Maria Michella Rabara	PrEP Focal Point	FHI360	3

Philippines: Stakeholder Interviewed			
Name	**Title**	**Organisation**	**Objective**
Kate Leyritana	Medical Director	Save and Improve Lives (SAIL) Clinics; Sustained Health Initiatives of the Philippines (SHIP) Inc.	2,3
Earl Patric Penabella	Program Manager	Save and Improve Lives (SAIL) Clinics; Sustained Health Initiatives of the Philippines (SHIP) Inc.	3
Charlene Tinaja	Monitoring and Evaluation & Strategic Information Specialist	DOH EPI Bureau	2
Krystal Pamittan	Health Program Officer II	DOH Epi Bureau	2
John Benedict Palo	Database Specialist	DOH Epi Bureau	2
Elisa Nympha Sia	Laboratory Specialist for HIV, Hepatitis, & STIs / UHC	WHO - Philippines Country Office	3
Mark Angelo Amoroso	UHC / HIV, Viral Hepatitis & STI Technical Specialist	WHO – Philippines Country Offfice	3
Kiyohiko Izumi	Technical Officer (HIV, Hepatitis, STI - WPRO)	WHO-WPRO	3

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