



Final Report

National HIV Joint Program Review, Philippines

September to November 2019

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LIST OF ACRONYMS AND ABBREVIATIONS

AEM	Asian Epidemic Model
AIDS	Acquired Immune Deficiency Syndrome
AMTP	AIDS Medium Term Plan
ANC	Antenatal Care
AO	Administrative Order
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CBO	Community Based Organization
CHD	DOH Center for Health Development
CSO	Civil Society Organization
CUP	Condom Use Program
DPCB	Disease Prevention and Control Bureau
DoH	Department of Health
DoH-RO	Department of Health - Regional Office
DILG	Department of Interior & Local Government
DSWD	Department of Social Welfare and Development
EB	Epidemiology Bureau
EPP/Spectrum	Estimation and Projection Package Spectrum (projection software developed by Avenir Health used by the UN Joint Programme on AIDS (UNAIDS) and the World Health Organization)
FSW	Female Sex Worker
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
HACT	HIV and AIDS Core Team
HARP	HIV/AIDS and ART Registry of the Philippines
HIV	Human Immunodeficiency Virus
HSP	Health Sector Plan
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
ICT	Information and Communications Technology
IEC	Information, Education, and Communication
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
IRR	Implementation Rules and Regulations
KP	Key Population
LAC	Local AIDS Council

LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LGU	Local Government Unit
LMIS	Logistics Management Information Systems
LTFU	Loss to follow-up
MCH	Maternal and Child Health
MSM	Males who have sex with males
MSW	Male Sex Workers
MTCT	Mother-to-child transmission
NASPCP	National AIDS & STI Prevention and Control Programme
NCR	National Capital Region
NGO	Non-governmental Organization
NOH	National Objectives for Health
NSP	National Strategic Plan
OHAT	Outpatient HIV AIDS Treatment Package of Phil Health
OST	Opioid Substitution Therapy
PCCM	Philippines Country Coordinating Mechanism
Phil Health	Philippine Health Insurance Corporation
PICT	Provider-initiated Counseling and Testing
PIR	Program Implementation Review
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
PNAC	Philippine National AIDS Council
PrEP	Pre-exposure Prophylaxis
PSM	Procurement and Supply Management
PWID	People Who Inject Drugs
RA 11166	Philippine HIV and AIDS Policy ACT
RAV	Rapid Assessment of HIV Vulnerability
rHIVda	Rapid HIV Diagnostic Algorithm
RHWC	Reproductive Health and Wellness Center
SCP	Save the Children Philippines
SSESS	Sentinel STI Etiologic Surveillance Systems
SHC	Social Hygiene Clinic
STI	Sexually Transmissible Infections
SW	Sex Worker(s)
TB	Tuberculosis
TG	Transgender
TGW	Transgender women
TWG	Technical Working Group
UIC	Unique Identifier Code
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Sessions for HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

The Joint Program Review of the Health Sector Plan for HIV and STI 2015-2020 was conducted from September to November 2019. The main objective of the review was to review and determine the effectiveness and efficiency of the current HIV Program Strategy and Implementation among key affected population across the continuum of services. Key findings and recommendations of the review are as follows:

Key Findings:

On HIV Epidemiology: Current epidemiological trends among Key Population and Status of HIV Cascade of Care

Primary driver of current HIV epidemic. The current HIV epidemic in the Philippines has been driven primarily by sexual contact among males having sex with males. The MSM are the most affected population, making up the majority of new infections. Evidence further reveals that infections are increasing among 15-24 years old MSM. They are also lowest in terms of comprehensive knowledge of HIV prevention and transmission and condom use. The rise in new infections among MSM, particularly young MSM need to be acknowledged and considered in prioritizing sub-groups of key populations in the development of Health Sector Plan 2020-2022.

PWID, a “puzzle to solve”. The proportion of infections through sharing of needles is only 5% of newly diagnosed HIV cases in the country from 2010 to 2015, and concentrated in Cebu and Mandaue. Certain information is circulating on the presence of PWID in Metro Manila but no studies to quantify or categorize these risk behaviors have been conducted yet, particularly that there was no IHBSS for this KP sub group in 2018.

Considering the current political situation that has driven the PWID to go deeply underground, it is even harder to reach them. The key question to answer is what is the level of HIV infection now in 2019 among PWID.¹ The fact that there were very few and localized prevention activities targeting PWID may lead to the assumption that incidence could be at least the same levels and even with increased mortality due to less care and prevention access. However, without epidemiological evidence it is difficult to conclude that the high levels of HIV prevalence observed in 2015 have decreased or increased. Hence, the development of HSP 2020-2022 should be able to identify the most appropriate strategy and innovative interventions to sufficiently address PWID-related issues.

Geographic area prioritization and regional target setting. Cities and urban areas are particularly affected by the HIV epidemic. The 70 high-burden areas, including the 17 cities in Metro Manila, account for 80% of reported HIV cases in the country. The top five regions with the most number of reported cases such as NCR, Region 4A, Region 3, Region 7, and Region 11 must be prioritized.

Factors contributing to the rise in new infections among KP. The JPR findings pointed out the correlation between the increase in new infections among KPs and the following factors:

¹ Cited in Calleja, Jesus Maria Garcia. Epidemiology Review of HIV and STI Philippines, 2019.

- Early onset of risky behaviors but delayed protective behaviors
- Stigma and discrimination
- Lack of access to condom
- Poor knowledge of HIV prevention and transmission
- Access to online platforms for sexual partners
- Demographic changes

As new HIV infections continue to rise each year among MSM, PWID, TGW and young MSM, a more rigorous local study of contributory factors will help the HIV Program to better understand the key populations in their diversity and dynamics. For example, the next HSP may look into the benefits of conducting a local study on “Effects of changes pertaining to population mobility, migration, urbanization, and the age and gender structures of subpopulations on pattern of HIV infections among KP.”

Status of the HIV care cascade. Much has been accomplished in the HIV care cascade, particularly with the diagnosis coverage closely approaching the First 90 target at 72%. However, the gaps in diagnosis (28%, 25,458), treatment (19,065 or 29% for enrollment and adherence – lost to follow up 19,065 or 29%) and viral load testing and monitoring (32,117 or 83%) require fast-track interventions and more innovative approaches from prevention, testing, treatment and viral suppression. Based on the 2019 AEM projections, “With the current program strategies, there will be around 20,000 new infections annually. With business as usual, the number of PLHIV will double by 2025 and triple by 2030”.

Progress in the National Program Strategy Implementation:

On Prevention. Progress so far has been slow despite the various interventions implemented:

- Condom use among MSM (38%), TGW (39%), PWID (Male 15%/Female 16%) and YKP-MSM (36%) is low or below the 80% program target while it is high for RFSW at 85%².
- Comprehensive knowledge on HIV transmission and prevention among all KP is low or below the 50% target³.

This slow progress in achieving prevention program targets is primarily attributed to weak national prevention strategy. Key prevention gaps that were identified include:

- Lack of national condom promotion and distribution plan resulting to:
 - o Limited access to an availability of free condoms and lubricants in clinics, workplaces and establishments frequented by KP;
 - o Weak condom use education and promotion;
 - o Stock-outs of condoms.
- Lack of comprehensive KP-specific Behavior Change Communication Plan (BCC), hence:
 - o IEC materials were not customized per subgroups of key population and geographically contextualized;
 - o Late adoption and weak implementation of Undetectable Viral Load – Untransmittable HIV (U=U) messaging.

² Based on 2018 IHBSS, DOH-EB.

³ Ibid.

- Poor implementation of the developed essential packages for specific KP (MSM, TG, PWID, SWs and Young People).
- Limited access of TGW and MSM to other prevention services aside from provision of condoms and lubricants:
 - Pre-exposure prophylaxis or PrEP is offered, however it is too expensive and not in the national policy or covered by Phil Health-OHAT;
 - Transgender services for Hormones are only available through specialty endocrinologist or obstetrician, which means TGW go underground for HRT as observed by service providers.
- Lack of comprehensive program in addressing human rights and legal barriers affecting the delivery of prevention services to PWID and YKP.
- Lack of safe spaces for KP that could be used as venue for MSM, TWG and YP to conduct social activities, meetings or receive PrEP/condoms and lubricants.

On Testing. The country is getting better at case detection at 72% or 62,942 out of the estimated 90,000 PLHIV in the country. However, there are still remaining 28% or 25,458 PLHIV undiagnosed as of June 2019, and 50% of them are 15-24 years old young PLHIV. The diagnosis gap is linked to the following key issues:

- Accomplishments in reach strategy (awareness raising events and condom distribution) have not yet been fully translated to increased HIV testing and condom use coverage, particularly among MSM.
- Limited options and implementation of targeted testing among KP and their partners (including female partners).
- Limited implementation of CBS and lack of guidelines to expedite nationwide implementation.
- HIV testing is stigmatized and this stigmatization is not sufficiently addressed.
- Poor quality of pre and post-test counseling.
- Slow turnaround time for release of confirmatory test results.

On Treatment. There is a notable improvement in ART coverage among diagnosed PLHIV from 44% in 2015 to 60% in 2019, and the “Treat All Policy” has been instrumental in the increased ART coverage. However, there are still 29% (19,065) of diagnosed PLHIV who have not started treatment. Among the enrolled PLHIV as of June 2019, 13% were lost to follow up. The gaps in enrollment to adherence are attributed to a number of key issues, namely

- On Service Delivery
 - Issues with ARV low supply;
 - Human resource constraints or imbalanced patient to health care provider ratio (too many patients, inadequate staff);
 - Weak capacity of some health facilities to provide comprehensive and quality services;
 - Limitations in the testing and treatment processes/approaches such as the long turnaround of confirmatory test results, additional requirements for treatment of YKP and lack of differentiated approach to care;
 - Low quality of and inadequate infrastructure facilities.

- Policy and guidelines related issues include: ARV regimen in the country does not include Dolutegravir (DTG) – the WHO recommended 1st line drug in July 2019⁴, which is a big issue given the reported cases of dropouts due to side effects of current ARV regimen; “Treat All Policy” is not yet implemented by some facilities; insufficient TB-HIV collaboration; and limited access to PhilHealth OHAT.
- Psychosocial and biomedical issues pertain to ARV side effects
- Lack of family and community support, and depression.

On Viral Suppression.

Although viral suppression is high at 96%, the coverage of viral load testing at the national level is below 20%. There are 32,117 (83%) PLHIV on ART for VL testing and monitoring. Lack of viral load machine and cartridges was the reason cited for the low coverage in VL testing. There are challenges to procurement of VL machine due to operational issues and difficulty in utilization of OHAT funds at the facility level. The utilization of prevention and suppression message of U=U is another issue because it was not widely promoted or utilized in the facilities visited.

Facilitating Factors to Delivery of Services: Crosscutting Areas and Good Practices

Critical aspects in the crosscutting areas of leadership/governance, strategic information system, financing, human resource, legal/policy/social environment and good practices in program implementation facilitated the implementation of intervention strategies in prevention, testing, treatment and viral suppression. These are the following:

- **On leadership/governance**
 - Availability of health sector plan for HIV as guidance document in program strategy implementation;
 - Availability of DOH guidelines;
 - Strong LGU leadership/governance of HIV program.
- **Strategic Information System.** The Philippines has a strong routine reporting system for communicable diseases and has developed in the last few years a very comprehensive surveillance system. The involvement of regional and local government staff in the implementation and use of data to guide local decision-making is a key strength of the HIV surveillance system. eHARP or the electronic system is operational in some of the health facilities visited during the review. More than 50% of health facilities that provide ART to patients have been introduced to eHARP.
- **Financing.** The government’s steady fulfillment of its commitment to increase funding allocation for HIV Program (73% of total resources in 2015 compared to 26% from external sources), the PhilHealth OHAT Package of Benefits and funding support from Global Fund facilitated the implementation of HIV program strategies.
- **Human Resource.** The presence of KP-competent and committed staff was essential to the implementation of program interventions and activities.
- **Legal/Policy/Social Environment.** National Laws such as the 1998 Philippine AIDS Prevention and Control Act, Universal Health Care Act, the National Health Insurance Act of 1995, and R.A 11166 passed on December 20, 2018. One of the most important provisions of this law is that of allowing teenagers from 15 to 18 years old, even younger

⁴ Based on the updated WHO Guidelines on first- and second- antiretroviral regimens, July 2019.

if they are pregnant or engaged in high-risk to undergo HIV testing without parental consent. Local ordinances on HIV and AIDs have also contributed to the national HIV response.

Among the good practices identified in the review are:

- Utilization of Peer Education Approach
- Community Health Outreach Workers (CHOWS)
- PrEP Pilot project implementation
- Community Based Screening (CBS)
- Initiation of rapid HIV Diagnostic Algorithm (rHIVDA)
- ART Delivery through Electronic Consultation
- Differentiated Care Approach for MSM
- DOH Condom Safe Places
- Sundown Clinics;
- One-Stop-Shop Service Delivery
- Same-Day Initiation of Treatment
- Antenatal Care testing of pregnant women and their partners

Barriers to Access of HIV Services

- **Health system factors**
 - Procurement and Supply Management (PSM) issues in terms of poor data quality resulting in poor quantification and forecasting thus commodity shortages (ARV critical low level of supplies experienced in 2018 and early 2019). Procurement of ARV and diagnostics is the cause of most bottlenecks observed in the review. Lack of storage and lack of coordination between all the parties doing procurement, lack of standard operating procedures and lack of trained human resources were also noted. Further, the lack of an integrated nationwide Logistics Management Information System (LMIS) makes PSM a titanic task and causing the bottlenecks in HIV ARV supply, as well as with the other commodities.
 - Human resource barriers
 - Lack of permanent staff for sustainability of program operations;
 - Limited human resources but high demand for services; and
 - Poor quality of some health care workers – poor counseling and unfriendly attitude of some medical personnel.
 - Health facility related barriers pertaining to weaknesses in structure, process and logistics/supply chain.
- **Financial constraints.** Factors that inhibit enrollment in HIV care, particularly for newly diagnosed PLHIV include Indirect costs such as transportation expense, travel time to the treatment facility and inability to miss work to attend to clinical appointments or the fear of losing a job/employment. In all the sites visited in NCR, Luzon, Visayas, and Mindanao, “Out-of-Pocket” expenses (OOP) are often cited as reason for delaying treatment.
- **Psychological and social barriers**
 - Stigma and discrimination
 - Depression, myths about treatment options and family support

- Depression - a recurring reason to interrupt or stop ART;
 - Side effects - fears about side effects of ARV medicines led some to try to stay off ARVs for as long as possible;
 - Myths about treatment options - A few PLHIV thought they could treat themselves with good nutrition or with certain traditional medicine, such as black oil seed, and mentioned this as a reason to stop ART; and
 - Family support - Some review participants mentioned their family as a factor in discontinuing or delaying the onset of their ARV treatment, related to the requirement to have a “treatment buddy”. Treatment-related fears of disclosure to the family and a desire not to be a “burden” on their family.
- **Legal and Policy Barriers**
 - o Lack of legal protection for program implementers of PWID and young KP who face harassment and lawsuits for providing HIV services as obstacle to expansion of prevention, testing and treatment interventions.
 - o Harm reduction and HIV health promotion interventions have been seriously affected by the “War on Drugs”. In particular, “advocacy for investment and services for PWID is significantly silenced in the current political climate, impacting the ability for the response to address the needs of key populations”⁵.

Key Recommendations:

On Prevention

Implement a comprehensive national “Combination Prevention Strategy” with KP specific interventions. In line with this key recommendation, the following measures/actions need to be done:

- a. **Develop and implement a National Condom Promotion and Distribution Plan.** The Philippine National AIDS Council (PNAC) needs to develop and issue a resolution to its member agencies to implement a National Condom Promotion and Distribution Plan to improve access to and use of condom.
- b. **Develop a KP-specific and geographically appropriate national Behavior Change Communication (BCC) Plan.** Key messages in the plan should focus on adoption of preventative behaviors and awareness of HIV prevention and transmission. The plan should ensure the use of all possible communication channels, particularly social media and online applications in delivering key messages for HIV testing, treatment and viral suppression.
- c. **Monitor, assess and improve the implementation of essential package of services per KP (YKP, TGW, MSM, PWID, sex workers).** A full evaluation of the implementation of the essential KP-specific package of services in the HSP 2015-2020 is necessary as basis for improvement in the next HSP. A cost-effectiveness component should be included in the redesigning of the essential package of services.

⁵ National Situational Assessment of HIV Financing in Philippines, SHIFT. 2017.

- d. **Develop and implement a comprehensive package of services for PWID and YKP with a special focus on addressing barriers to access to reach these subgroups.** This should address issues concerning human rights, gender and stigma and discrimination.
- e. **Establish more safe spaces for KP to access HIV services.** Review findings showed the effectiveness of safe spaces in the provision of prevention, testing and treatment services, especially among young MSM.
- f. **Introduce PrEP as a key targeted prevention strategy.** As testing becomes more targeted and case finding is improved, multiple models for PrEP should be expanded and supported as a key targeted prevention strategy. The DOH should develop implementation guidelines on access and pricing.
- g. **Endorse U=U messaging as part of the national health promotion in the HIV implementation.** U=U messaging should be widely utilized and promoted because Viral load results are powerful messages for clients, especially when understood.

First 90, Diagnosis

*Bridge the diagnosis gap by **diversifying and expanding testing strategies** in order to reach the remaining undiagnosed PLHIV. To do this, the HIV program needs to build on the current good practices in HIV testing, improve the low yielding strategies and adopt new innovations. Specifically, the following measures are proposed:*

- a. **Diversify targeted testing options.** Targeted testing should be rapidly expanded using both facility and community based testing and linkage to treatment. In line with this, there is a need to
 - Scale up CBS implementation. Community and School based HIV awareness events should be conducted to promote CBS.
 - Introduce new testing strategies such as Index testing and self-testing. Rapidly expand and regularize index partner testing for MSM and TG for both facility and community based testing, as well as for enrolled PLHIV. Determine the usefulness of self-testing screening for partners of PLHIV as case finding for those who would otherwise not be tested.
 - Develop YKP specific testing strategies to close the gap in testing among 15-24 years old YKP.
 - Expand MSM and TGW targeted testing at all hotspots.
 - Scale-up the utilization of social media to reach high risk KPs for testing.
- b. **Rapidly rollout rHIVda implementation.** The implementation of rHIVda should be decentralized using all potential facilities (SHCs, public and private treatment hubs, and CBO Centers). This should also include rapid expansion of rHIVda testing protocol for pregnant women.
- c. **Conduct client satisfaction survey** to evaluate the quality of pre and post-test counseling. Review findings cited poor counseling as one of the reasons for dropouts in enrollment and treatment adherence. A sound analysis of the root causes of poor pre and post test counseling should be done for improvement. Counseling and should be widely scaled for prevention and client management.

Second 90, Treatment

Approaches for immediate linkage to treatment and care should be rapidly expanded and regularized to ensure follow up for all newly diagnosed PLHIV, whether identified in facilities or through community-based programs and to prevent having lost to follow-up cases. In line with this key recommendation, the following should be undertaken:

- a. Address PSM-related barriers at the central, regional and local levels to ensure uninterrupted supply of ARV supply. The three-month distribution of ARV for eligible and enrolled PLHIV should be continued.
- b. Address the service delivery constraints (human resources and infrastructure) affecting the quality, efficiency, and effectiveness of treatment services. The government should invest in the provision of permanent health human resource at the central (NASPCP and EB), regional, and local levels (CHOWS/PEs/Case Managers) for sustainability and continuity. The infrastructures should be improved to increase uptake of counseling, testing and treatment services.
- c. Fast track the transition to Dolutegravir (DTG) to address ARV side effects issues resulting to delayed enrolment and non-adherence. The planning and measures to ensure preparedness for TLD transition should be continued within an actionable timeline.
- d. Promote and expand the establishment of more one-stop shops. Service delivery network should be strengthened to facilitate ART enrolment and adherence. This should include monitoring the implementation of treat all policy in all treatment facilities.
- e. Implement a differentiated approach to providing HIV treatment, care, and support services. Full service CBO programs that are effectively implementing this approach should be expanded to those areas in need and not reached by government treatment hubs (the LoveYourself Model can be adopted for this purpose).
- f. Improve quality of case management in terms of team composition, roles and responsibilities, and processes of implementation to address psychosocial and biomedical issues.
- g. Develop information system with client tracking capability to track enrolment and lost to follow up.
- h. Improve TB-HIV collaboration through joint program implementation review.
- i. Improve access to PhilHealth OHAT Package of benefits. Facilities should be supported in their accreditation processes. Monitoring of the utilization of OHAT funds for PLHIV treatment needs should be conducted on a regular basis. HIV/AIDS Core Team should have a designated PhilHealth Officer.

Third 90, Viral Suppression

Viral load testing should be rapidly scaled-up to increase coverage at the national level to reach the Third 90 target. The following measures need to be undertaken:

- a. Ensure all treatment facilities have access to point-of-care viral load machine and cartridge. A lab optimization review should be conducted to improve distribution and availability of viral load testing machines and reagents.
- b. Ensure viral load literacy.
- c. Regularize minimal turn around times for viral load monitoring.
- d. Regularize the use of u=u at each opportunity in both facility and community programs for both prevention and suppression.
- e. To improve the capacity (human and lab equipment) of regions for VL testing in the 7 regions that represents 75% of number of people on ART.

Cross-cutting Areas

Procurement and Supply Chain Management⁶

To address PSM-related barriers in service delivery, the following should be undertaken:

- a. Equip facilities with adequate data sources, implement and optimize e-Harp.
- b. Quarterly review of the forecast to correct the trajectory /CHIA Tool Evaluation.
- c. Adopt the international best practice standard which Consist of selecting 3 bidders per formulation.
- d. The DOH together with FDA and the disease programs should make a list of formulations and diagnostics that need a registration fee waiver and CPR.
- e. Develop terms and conditions for fast tracking / exemptions
 - Expedite CPR for WHO PQ products within 3 months
 - Waiver for UN organizations /Develop performance indicators
- f. Need to construct new warehouses (regional hubs).
- g. Optimize the distribution chain/ implementation of LIMS.

On Strategic Information Systems

- **On Routine Data**
 - **HIV mortality data could be improved through:**
 - Coordination with the Central Statistics Office program to request breakdowns of HIV death data (age, sex, geography, etc.);
 - Annually triangulate mortality data from available sources and track trends including the vital statistics, inpatient deaths, modeling output, and program data from eHARP.
 - **HIV co-infection with TB program**
 - Increase the testing rates for HIV among TB patients
 - Improve understanding of the relationship between TB and HIV; compare the geographic, age, and gender distributions of burden of disease (mapping Routine and survey data).

⁶ From the Technical Assistance Report of Clearing House Manager AIDS Medicines and Diagnostic Services HQ/CDS/HIV/SIP World Health Organization, Geneva. JPR Consultant for the review and analysis of the Philippines sourcing, procurement and supply chain management for the HIV commodities and diagnostics, 14-21 October 2019.

- Strengthen interaction/discussion/regular meeting between TB and HIV program focal points to improve collaboration.
- o **HIV case reporting**
 - To include Male to female ratio trends in the analysis
 - To continue monitoring trends of CD4 at the first HIV diagnosis by age, gender and location
 - To monitor HIV diagnosis / ART initiation by month
- o **STI surveillance**
 - Monitoring of syphilis among KPs should be continued.
 - To continue monitoring through facility surveys and/or IHBSS (syphilis, and gonorrhea) in KPs
- o **PMTCT**
 - To strengthen tracking system to monitor HIV+ pregnant women and exposed babies until confirmation of HIV status or up to 18 months.
 - To reinforce the information system to monitor criteria needed to monitor elimination of MTCT. (ANC Coverage, HIV testing among ANC >95%, ART coverage > 95%, MTCT, < 5%)
- o **Care and treatment**
 - To continue to expand eHARP to all sites providing ART.
 - To improve quality assurance and monitoring & evaluation components of eHARP
 - To develop a plan for toxicity monitoring as a part of ART (e.g., through sentinel sites)
- o **Prevention:**
 - Requires clear policy guidance re: confidentiality and security of information (i.e., identity management for implement Unique ID across continuum of services: outreach/prevention, testing, care and treatment.
 - To continue with online IHBSS surveys for young KP
- **Routine Surveillance and Surveys**
 - o **Continuation of Facility Surveillance and IHBSS**
 - Incorporate analysis by age groups and geographical locations
 - Consider expanding coverage of facility surveys to additional sites to detect HIV among KPs outside of current focus regions/states
 - Continue triangulation of program data and IHBSS, at lower levels
 - To continue Pilot test online surveys using social media (dating apps, FB, esp. among MSM)
 - Advocate to include more HIV-related risk behavior questions in the DHS
 - Consider incorporating network scale up for size estimation in the DHS
 - o **Key population size estimations:**
 - To update PSE and focus in the 7 regions that contribute 80% of HIV case reporting

- To Incorporate uncertainty range into PSEs.
- o **Surveillance of drug resistance:**
 - To set up a clear strategy HIV drug resistance on a regular basis
 - Incorporate toxicity monitoring in two main tertiary hospitals (WHO toxicity guidelines).
- o **Use of IHBSS for estimation and projections:**
 - Enter data into AEM on overlapping risk behaviors (MSM-M/TSM-PWID) as it becomes available, in order to understand the impact on projections.
 - Disaggregate new HIV infections among “low-risk” females from AEM output worksheet to understand route of transmission to them (partner of PWID, partner of MSM, partner of client, other).
 - Add breakdown to AEM report to improve understanding of the source of these infections.
 - Disaggregate Spectrum projections for Remaining Areas
 - To continue to develop regional and cities estimates adding uncertainty ranges
- o **Plans, Reports, Evaluations:**
 - To continue monthly progress reports
 - To continue undertaken the program evaluations as the Prevention, cascade for KP
 - Plan to evaluate the effect of interventions on KPs
 - To continue capacity building for data analysis/data management with regions and LGU

On Legal Barriers

Rollout legal literacy training for duty bearers (providers) and rights holders (KPs and clients) to address stigma and discrimination.

1 INTRODUCTION

1.1 Background of the Health Sector Plan for HIV and STI, 2015-2020

The Philippines has implemented a concerted multisectoral response to the HIV epidemic since the first case was detected in 1984. The health sector is mandated to lead the development of a health sector strategy as its contribution to the AIDS Medium Term Plan (AMTP). Hence, the Health Sector Plan for HIV and STI 2015-2020 was developed by the Department of Health with various stakeholders, particularly the Key Populations of FSW, MSW, MSM, TG and PWID. This health sector strategy is designed to guide the comprehensive and efficient country response to HIV and other sexually transmitted infections. The Department of Health through its Disease Prevention and Control Bureau (DPCB) is responsible for coordinating the overall health sector response.

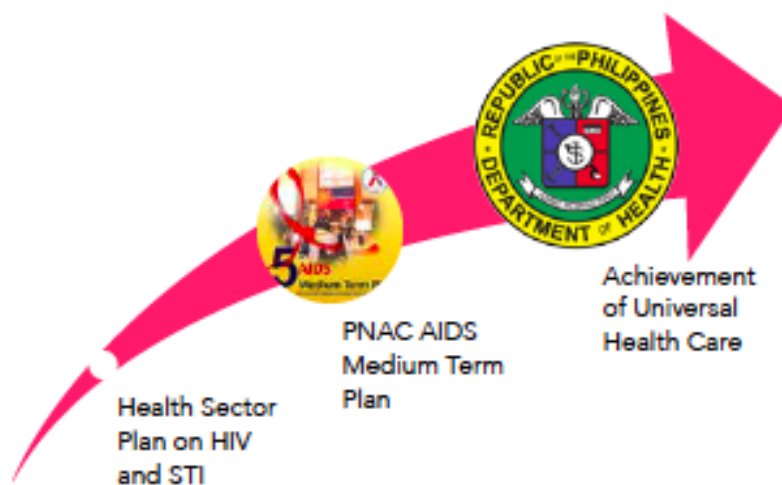
The UN General Assembly Special Sessions for HIV/AIDS and interphase ASEAN's "vision of zero new infections, zero discrimination and zero AIDS-related deaths"⁷ is articulated in the Health Sector Plan. It adopted the themes of "promoting long-term sustainable HIV response by strengthening health and community systems; tackling the social determinants of health that both drive the epidemic and hinder the response; and promoting human rights and gender equity."⁸ The Health Sector Plan is also linked to the country's Universal Health Care or Kalusugang Pangkalahatan. The Framework of Country Response to HIV⁹ is shown below.

Figure 1. Framework of HIV Response

⁷ WHO Global Health Sector Strategy on HIV and AIDS 2011-2015, cited in HSP for HIV and STI 2015-2020.

⁸ *Ibid.*

⁹ Health Sector Plan on HIV and STI, 2015-2020, p.12



As stated in the Health Sector Plan, “the goal is for the country to maintain a prevalence of less than 1% in 2020 by preventing the further spread of HIV infection and reducing the impact of disease on individuals, families, sectors and communities”. Four strategies with priority interventions and activities in each strategy were identified as pathways to goal attainment.

The four strategies in the Health Sector Plan are as follows:

Strategy 1. Continuum of HIV/STI Prevention, Diagnosis, Treatment and Care Services to Key Populations

Objective: To improve coverage and linkage of services from prevention and diagnosis among KP to treatment and care for PLHIV through an intensified delivery of quality and evidence based services.

Key Populations identified in the AMTP are the following:

- a. Female Sex Workers (FSW)
 - High risk group – Freelance FSW or street based
 - Low risk group – FSW in Registered Entertainment Establishments
- b. Men having sex with Men (MSM)
- c. Transgender Women (TGW)
- d. Injecting Drug Users or People Who Inject Drugs (PWID)
- e. Young People (high risk)

Key interventions are focused on the delivery of services for prevention, treatment and care, HIV counseling and treatment (HCT), and essential packages for specific KP.

Figure 2. Implementation of Cascade for the Continuum of Care



Strategy 2. Health Promotion and Communication on HIV and STI Prevention and Care Services

Objectives:

- To raise the awareness of key populations and the public on HIV and STI prevention and care services; and
- To increase demand and access to available HIV and STI services.

Major Activities:

- Implementation of National Communication Plan that strategizes demand generation for STI and HIV services, and executes in part the “One BCC Framework for KP”.
- Assist the LGUs and their respective partners in localizing National Communication Plan that strategizes demand generation for STI and HIV services.
- Develop standards for peer education, peer counseling, and other community-led support services.
- Develop and operate ICT-based BCC tools as supplementing channels for primary approaches of, and for facility-based information services supporting the “One BCC Framework for KP”.
- Develop and produce BCC materials for primary approaches of, and for facility-based information services supporting the “One BCC Framework for KP”.
- Launch publicity-generating national advocacy campaigns on ART, HIV testing and condom use, consistent with “HIV Stigma Management Strategy”.
- Assist private sector and non-health sector partners for strategic participation in demand generation for STI and HIV services (including promotion of Treatment hubs & CBO services, and PMTCT of HIV programs to medical societies and private testing facility).
- Number of advocacy events conducted that help generate demand for HIV and STI services.

Strategy 3. Enhanced Strategic Information Systems

Objective: To provide timely –evidence-based information for planning, monitoring, evaluation and quality assurance of HIV and STI program.

Major Activities:

- a. Implement surveillance activities
 - Integrated HIV Behavioral and Serologic Surveillance (IHBSS) – AIDS Registry (Form A, B, D)
 - Sentinel STI Etiologic Surveillance Systems (SSESS)
- b. Implement activities related to estimates and projections
 - Rapid Assessment of HIV Vulnerability (RAV) – micro-mapping
 - AEM, EPP Spectrum
- c. Implement HIV program monitoring
 - Unique Identifier Code (UIC)
 - Development of tracking system to monitor patient follow-up in treatment hubs
 - Opportunistic Infections and TB-HIV Reporting
- d. Implement special studies
 - Bed Assay, STI and HIV Drug Resistance Study (Transmitted Resistance), TG &/or partners of PLHIV, Opioid substitution therapy for Nalbuphine, HIV Risk and Vulnerabilities in Closed-settings and among emerging sub groups KP (e.g. Deaf Mute), HIV related stigma, PLHIV mental health, etc.
- e. Implement data utilization activities in sites
 - Local Dissemination Fora
 - Develop LGU Data Utilization scorecards – local strategic and operational planning
- f. Implement strategic and operational planning in sites
- g. Conduct monitoring, evaluation, and quality assurance of EB data systems
- h. Conduct quality assurance and evaluation of HIV programs
 - Program Implementation Review (PIR) – Prevention programs and STI services
 - HCT services
 - Treatment and care services
- i. Ensure timely release and utilization of data

Strategy 4. Strengthened Health System Platform for Broader Health Outcomes

Objective: To intensify delivery of quality STI and HIV services through a strengthened support system by addressing barriers, improving linkages and ensuring availability of critical enablers.

“The DOH National Objectives for Health (2011-2016) states that the Philippine health sector should aim to: a) improve the health status of the population, b) develop a health system that is more responsive to the health needs of the people, and c) ensure equity in financing health care. To achieve these goals, the health sector must first strengthen its health system in terms of efficiency and effectiveness”¹⁰.

Major Activities:

¹⁰ Cited in Health Sector Plan for HIV and STI 2015-2020, p.66.

Leadership/Governance

- a. Strengthen regulation/guidelines for HIV and AIDS Core Teams in hospitals.
- b. Establishment of psychosocial support through partnership with professional organizations like the Psychological Association of the Philippines.
- c. Establish and maintain public-private partnership in the delivery of STI and HIV services for key population.
- d. Strengthen coordination and linkages with TB, MCH program at national and regional level ensuring guidelines are disseminated and implemented by local implementers.
- e. Strengthening of Procurement Supply Management Chain from National to Treatment Hub.

Leadership/Governance LGU-related

- a. Develop policy to establish sub-national laboratories for HIV diagnosis.
- b. Organization and conduct of HIV and STI advocacy and stigma reduction activities.
- c. Expand sites implementing 100% Condom Use Program (CUP).
- d. Organization and Strengthening of Local AIDS Council (LAC), which includes a local community organization as an active member through an ordinance.
- e. Establish performance-based financial grant mechanism to LGU and/or NGO financing HIV and STI services.

Human Resources/Manpower – Capability building among key stakeholders in the LGU on

- a. 100% CUP (Condom Use Program)
- b. SOGIE (Sexuality, Orientation, Gender Identity and Expression)
- c. PWID interventions
- d. Capacity building of LAC members to respond to HIV

1.2 Objectives and Focus Areas of the Review

To review and determine the effectiveness and efficiency of the current HIV Program Strategy and Implementation among key affected population across the continuum of services (Annex 1, JPR-TOR). Specifically, the review seeks to:

- a. Review, analyze and present epidemiological data: (i) Geographic Area Prioritization and Sub populations; (ii) Regional Target Setting; and (iii) HIV Cascade and Care Continuum.
- b. Assess the effectivity and appropriateness of current strategy, including barriers to access.
- c. Determine opportunities for efficiency and improvement in the different component such as Financing, Regulation, Service Delivery, Governance and Performance Accountability.
- d. Present recommendations and provide guidance on the development of the National Strategic Plan (NSP) for HIV.
 - Provide perspective on specific geographical area per sub population, which warrants attention including greater investment of financial resources and/or reallocation of resources to focus on more effective higher impact interventions; and
 - Determine integration of HIV in the health system and future opportunities in the context of

Universal Health Care (UHC).

Focus areas assessed in the review for the program strategy and crosscutting areas are presented below:

PROGRAM STRATEGY						
Prevention		Testing		Treatment	Viral Suppression	
What have we achieved vs. the targets? What key activities/strategies contributed to the achievement of targets? What are the facilitating factors? What are the barriers to service delivery? What needs to be done to improve the HIV Cascade of Care and achieve the 90-90-90 targets?						
Cross-cutting Areas						
Governance	Financing	Information Systems	Regulation	Human Resource	Legal/Policy / Social Environment	CSO-KP Engagement

2 METHODOLOGY

2.1 Review Process

The HIV Technical Working Group (TWG) that is chaired by the DOH-NASPCP led the conduct of the Joint Program Review from September-November 2019. The TWG members include representatives from government agencies, civil society, and development partners (Annex 2, HIV-TWG Members).

A team of consultants and representatives of UNAIDS, WHO, Save the Children, DOH-NASPCP, DOH-Epidemiology Bureau, KP and PLHIV community, and DOH Regional Offices (DoH-RO/CHD) undertook the Joint Program Review activities. A total of 47 members comprised the review team (Annex 3, JPR Team Members).

The conceptual framework for this review explained how the various inputs and processes implemented from the National Health Sector Plan (NSP) for HIV and STI, 2015-2020 are linked to expected outputs, outcomes and impacts (Annex 4a). The review framework outlined the assessment criteria (appropriateness, effectiveness and efficiency), questions, tools and sources of data (Annex 4b). These frameworks guided the review.

The review team followed these methodological steps in conducting the review:

- Developed individual evaluation questions for each of the review criteria;
- Conducted desk review;
- Developed tools for key informant interviews (KII), focus group discussion (FGD), facility observation and client exit interview;
- Conducted site visits in NCR, Luzon, Visayas, and Mindanao;
- Conducted KIIs, FGDs, Facility Observation and Client Exit Interviews;
- Analyzed and synthesized collected secondary and primary data;
- Prepared draft JPR report to the TWG for comments and inputs
- Presented key findings and recommendations during the High-Level Meeting with key officials from DOH, other government agencies, development partners and CSOs;
- Disseminated JPR key findings and recommendations during meetings with CHD regional coordinators and staff and GF Country Coordinating Mechanism-Key Affected Population Committee; and
- Finalized JPR Report for use in the development of Health Sector Plan for HIV and STI 2021-2025.

2.2 Data Collection and Analysis

The methods for data collection and analysis are summarized below:

2.2.1 Desk Review on relevant published and unpublished HIV and AIDS-related documents to understand the current state of the HIV Program and provide further evidence to the review questions (Annex 5, Tool for Desk Review).

2.2.2 Key Informant Interview (KII) was conducted with program stakeholders from government, service providers, and development partners to seek explanations on identified issues and perspectives and deepen understanding of processes and outcomes of program interventions, barriers to effective service delivery and areas for improvement (Annex 6, KII Guide). A total of 46 individuals were interviewed (Annex 7, List of Persons Interviewed).

2.2.3 Focus Group Discussions (FGDs) with KP-CSO were conducted to discuss specific questions or issues, particularly on the appropriateness of interventions and quality of services (Annex 8, FGD Guide). A total of eight (8) FGDs with 52 participants were conducted (Annex 9, List of FGD groups).

2.2.4 Site Visits were undertaken in 30 sites for NCR, Luzon, Visayas, and Mindanao during the period of September 30 to October 11, 2019 (Annex 10, List of Geographic Sites/Facilities). Using the Field Visit Guide, four teams conducted site visits to assess the existing capacity to deliver program interventions and validate information gathered from desk review and KIIs (Annex 11, Field Visit Guide for Review Teams). A total of 67 clients from 22 facilities participated in the Client Exit Interviews. (Annex 12, Client Exit Interviews). Health facility observation was conducted in 26 facilities using a Checklist for Observation.

2.2.5 Data analysis was done through the use of the following methods: a) content analysis, b) narrative analysis, c) cost analysis, d) results analysis for outcomes and impacts, and e) gap analysis. Multiple-method triangulation was used in data analysis to ensure validity and reliability. Materials for triangulation came from secondary data and insights/opinions gathered during key informant interviews, focus group discussions and site visits.

3 LIMITATIONS OF THE REVIEW

There were some limitations encountered in conducting the Joint Program Review in terms of methodology, data sources and time constraints. These limitations are:

- First, there was no Mid-Term Review conducted for the Health Sector Plan 2015-2020 to assess progress of HIV strategy implementation and to provide information on how the recommendations in the 2013 External Review of the Health Sector Response to HIV and STI were addressed. Therefore, there was lack of assessment-based data after 2013 for use in validation or further analysis during the 2019 JPR.
- Second, there was lack of data, time and resources to do the cost effectiveness analysis of the essential packages for KP-specific interventions, which was a part of the original TOR. Hence, during the September 27 TWG meeting, it was decided that this will no longer be pursued, instead it will be included as part of recommendations for HSP 2022-2022. Also, the Efficiency criteria will be looked into results of inputs and processes vis a vis outputs targeted and sufficiency of human resources and logistical support for the implementation of program activities and strategies.

- Third, there was lack of data or documentation on LGU funding and level of investment for HIV program and activities. It is important to account and document LGU expenditures for HIV, particularly those LGUs who are proactive and providing substantial investments as basis for sustainability planning and buy-in for Local Chief Executives (LCEs).
- Finally, the literature focusing on epidemiology and program interventions for KPs in the Philippines within the ages of 15-17 is scarce. Hence, the limited analysis on the factors that contributed to the increasing infections within this age bracket of young people. This is important because data shows that their numbers are increasing and the link between adolescent programs and HIV among young KPs is still inadequate.

4 REVIEW FINDINGS

This section presents the Joint Program Review findings on: (i) HIV and STI Epidemiology in the Philippines, particularly the current epidemiological trends of key populations, the factors contributing to the rise in HIV infections among key populations, and the status of HIV Cascade for the Continuum of Care; (ii) Progress in the HIV national program strategy implementation; (iii) Facilitating factors to the delivery of HIV services: cross-cutting areas and good practices; and (iv) Barriers to access of services.

4.1 HIV Epidemiology in the Philippines

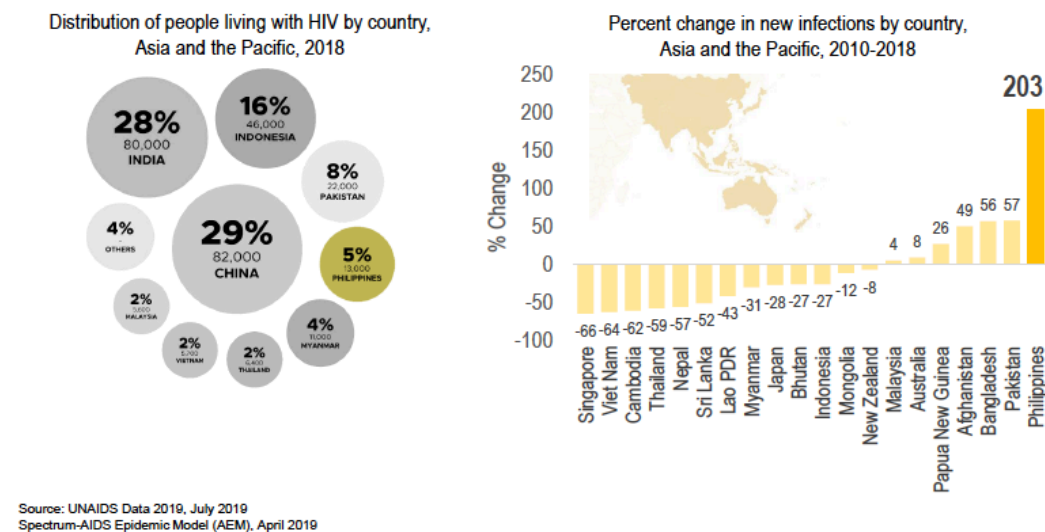
4.1.1 Overview of the Epidemic

Thirty-eight million people are estimated to have HIV worldwide. Of those infections 16% or six million are in Asia and the Pacific Region. While the Philippines contributes only a small portion

of infections to Asia-Pacific Region, the annual new infections in the country has increased rapidly, especially in the last decade, since the first reported HIV case in January 1984.

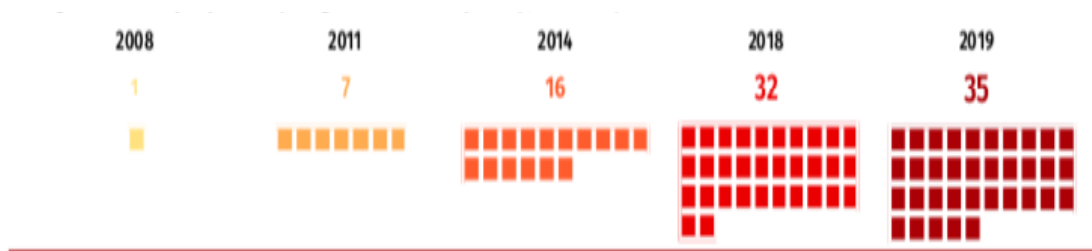
Although the country has one of the lowest rates of infection at less than 1%, it has the fastest growing HIV epidemic in the world. In contrast to its neighbors who were able to reverse their local epidemic, the Philippines has 203% increase in new HIV infections from 2010 to 2018, making the Philippines one of the eight countries that account for more than 85% of new infections in the region.¹¹

Figure 3. Data on HIV Epidemic in Asia and the Pacific



The figures below illustrate the steady increase in HIV infection per day in the Philippines from one in 2008 to 35 in 2019. As reported in HIV/AIDS & ART Registry of the Philippines (HARP), there were 1,006 newly confirmed HIV-positive individuals in June 2019 and a cumulative total of 68,401 diagnosed cases from January 1984 to June 2019.

Figure 4. Average number of people newly diagnosed with HIV per day, selected years

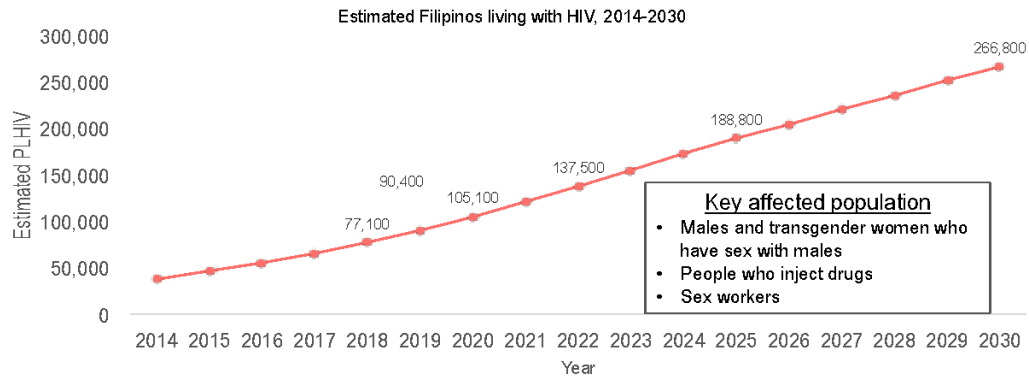


The rapid increase in annual new infections results to estimate that around 90,000 Filipinos living with HIV by the end of the year 2019 as could be seen in Figure 5. If the current course in the response is maintained or the business-as-usual strategy continues, the estimated number of people living with HIV will double by 2025, and triple by 2030.

¹¹ UNAIDS Data 2019, UNAIDS, April 2019

Figure 5. Estimated number of PLHIV by 2030

**By the end of 2019,
around 90,000 Filipinos will be living with HIV**



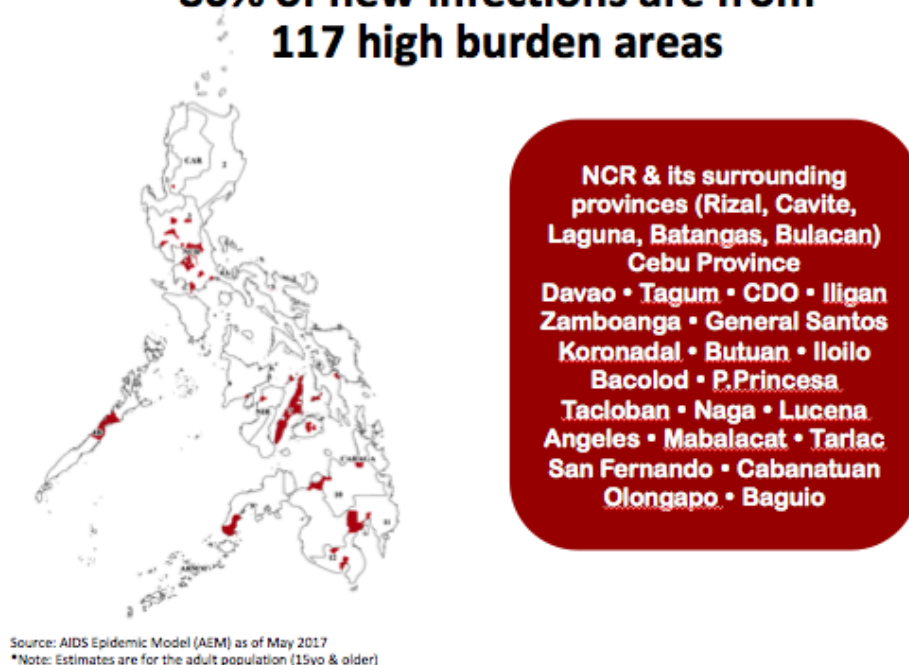
Source: Spectrum-AIDS Epidemic Model (AEM), April 2019

4.1.1.1 *Geographic Distribution of HIV Cases*

Cities and urban areas are particularly affected by the HIV epidemic. The 70 high-burden areas, including the 17 cities in Metro Manila, account for 80% of reported HIV cases in the country¹².

¹² UNAIDS. Cities in Philippines plead to lower HIV infections and improve their track record. Retrived from: <https://www.unaids.org/en/resources/presscentre/featurestories/2018/august/philippines>

80% of new infections are from 117 high burden areas

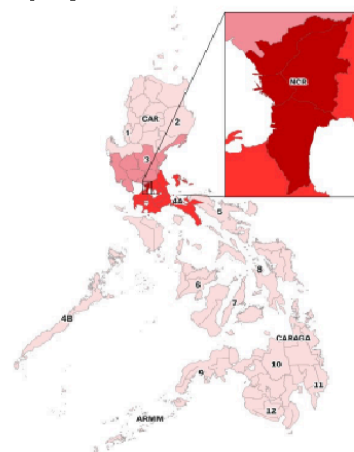


Based on the HARP report from January 1984 to June 2019, the top five regions with the most number of cumulative reported cases were NCR (39%), Region 4A (15%), Region 3 (9%), Region 7 (9%), and Region 11 (5%). The rest of the country accounts for 21% of the total cases while 1,138 (2%) did not report region of residence. At least 26% or 1,119 of the 4,276 females infected with HIV came from NCR. The most number of Overseas Filipino Workers (OFWs) reported to HARP also came from NCR with 2,176 or 32% cases, followed by Regions 4A (1,170/17%), and Region 3 (802/12%). The distribution of total HIV diagnosed cases by regions in June 2019 showed that Metro Manila still has the highest number of cases¹³.

Figure 6. Distribution of total HIV cases diagnosed by region, June 2019

¹³ HIV/AIDS and ART Registry of the Philippines, June 2019

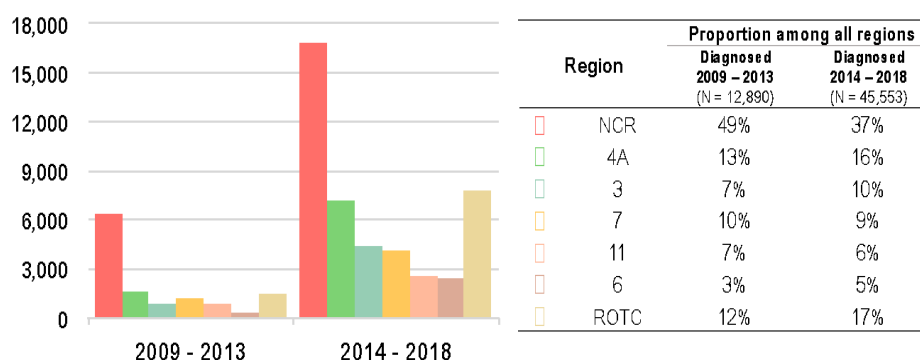
Region	Diagnosed Cases	% (N = 68,401)
NCR	26,452	39%
4A	10,251	15%
3	6,409	9%
7	6,060	9%
11	3,857	6%
6	3,444	5%
12	1,658	2%
1	1,534	2%
10	1,490	2%
5	1,182	2%
9	910	1%
8	900	1%
2	866	1%
4B	805	1%
CARAGA	705	1%
CAR	548	1%
ARMM	192	0%



No reported region of residence for 1,138 (2%) of cases
Source: HIV/AIDS and ART Registry of the Philippines, June 2019

However, the proportion of reported cases for the last five years outside Metro Manila are also rising. Though Metro Manila still holds the record for the highest number of reported cases among its residents from 2014 to 2018 compared to other regions as shown in the left bar graph of Figure 7, its overall proportion to the national figure has decreased in the past 5 years compared to the period of 2009 to 2013 while those of other regions increased. This shows an increase in case detection outside of Metro Manila implying that responses should not be focused on Metro Manila alone, but should also include the other regions.

Figure 7. Comparative distribution of HIV cases by region, 2009-2013 and 2014-2018



Source: HIV/AIDS and ART Registry of the Philippines, June 2019

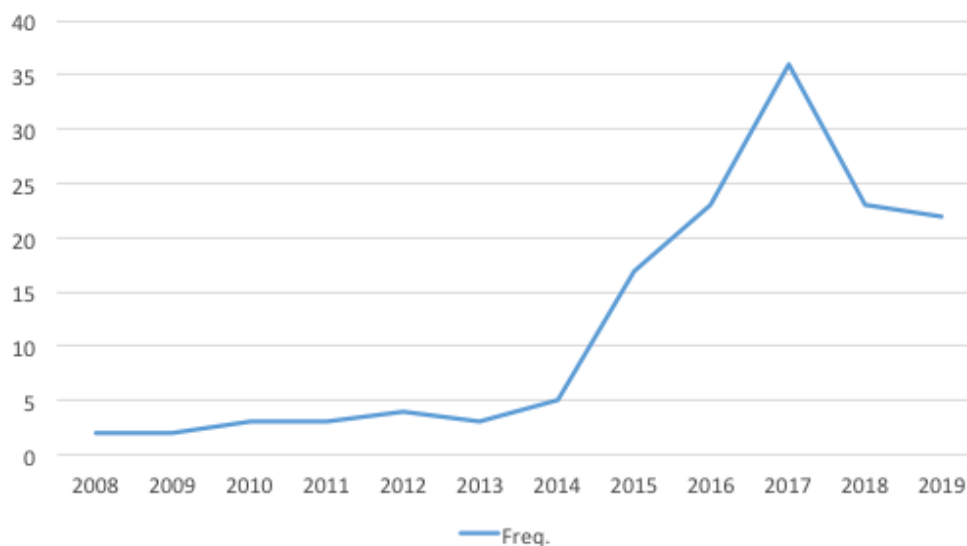
4.1.1.2 *Mother-To-Child Transmission of HIV (MTCT)*

Since 2011, HARP had included reporting of pregnancy status at the time of testing. From that year, a total of 323 diagnosed pregnant women were reported¹⁴. At the time of diagnosis, more than half or 55% (177) were 15-24 years old, and 38% (122) were 25- 34 years old. The highest number of diagnosed pregnant cases were from NCR (47%), followed by Region 7 (23%), Region 4A (10%), and Region 3 (6%).

In June 2019, five pregnant women were newly diagnosed with HIV, two of the cases were from NCR and Region 7 respectively, and one was from Region 6. The age of diagnosis ranged from 26 to 40 with median age of 30.

The number of HIV cases through MTCT had a sharp increase in 2015 and since then around 20 cases are being detected annually. A higher number of MTCT cases were reported in 2017. In 2018, the cases reverted back to 23 cases diagnosed and as of June 2019, 22 MTCT cases have been reported (Figure 8)

Figure 8: Number of diagnosed HIV cases through MTCT, 2008-May 2018



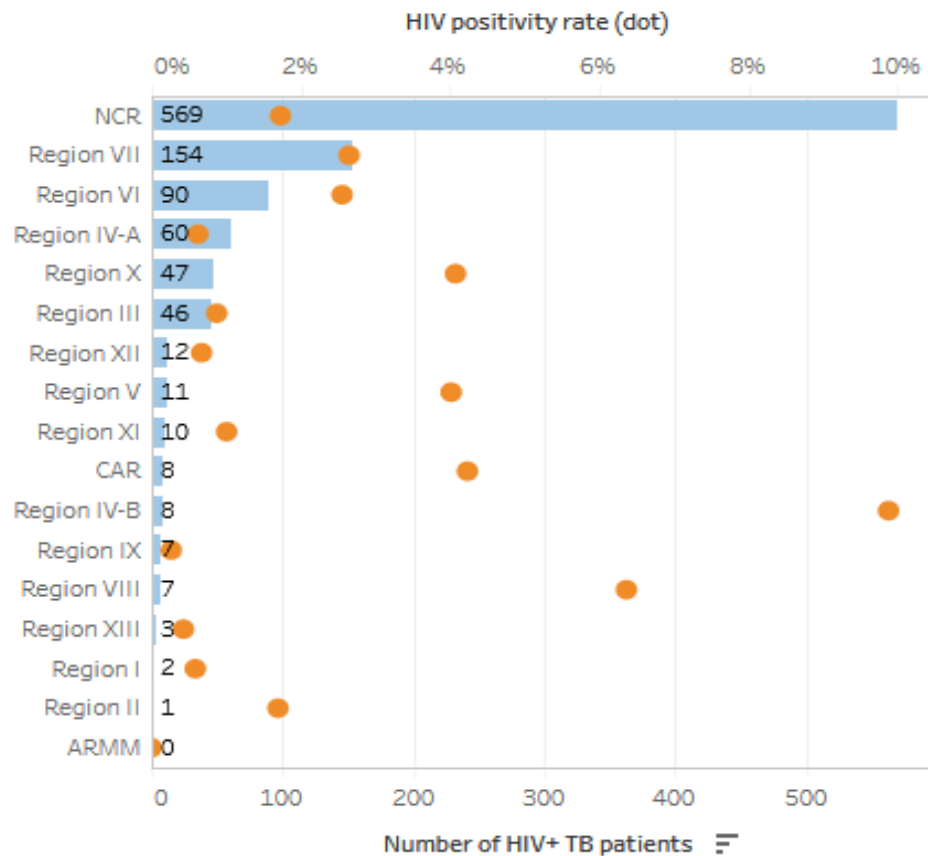
¹⁴ HIV/AIDS and ART Registry of the Philippines, June 2019

4.1.1.3 TB-HIV

TB is the 5th cause of death in the Philippines. There is information in the number of people tested for TB among HIV infection (Figure 9). Closer collaboration between TB and HIV programs need to be established, particularly in data sharing.

The monitoring of reactivity of TB patients for HIV is essential information for strategic information and could increase the number of people starting ART. Depending on the region, it is likely that 1% to 10% of TB patients are HIV-positive. Screening accomplishments among TB patients vary widely by region. Some health facilities screen all HIV patients, some screen only drug resistant TB patients and others do not screen.

Fig 9. Number and proportion of TB cases tested for HIV



4.1.2 Current Epidemiological Trends of Key Populations

The HIV epidemic in the country remains concentrated among key populations namely males and transgender women who have sex with males, people who inject drugs and sex workers. MSM and Transgender women comprise majority of reported cases in the country.¹⁵

Unprotected sexual contact has consistently been the most common mode of transmission¹⁶. From January 1984 to June 2019, HARP statistics showed that sexual contact among males who sex with males (MSM) at 85% (54,433) was the predominant mode of transmission.

4.1.2.1 Classification of problematic HIV areas for prioritization¹⁷

According to the Health Sector Plan 2015-2020, in 2012, the DOH with partners identified 70 priority areas for HIV intervention for MSM, PWID, and FSW. The following criteria were then considered for prioritizing and selection of intervention, sites where the greatest impact can be seen:

- Number of reported cases from 2009 to 2011 reflected in HIV/ AIDS registry
- HIV prevalence in selected sites (IHBSS sites)
- KP population size specifically MSM

The areas were then divided into 3 categories based on the immediacy and need for intervention. In 2012, there were 22 cities/municipalities identified as Category A requiring the highest priority for HIV intervention, followed by 18 in Category B then the 30 in Category C. In 2017, PAHI was updated and all 70 high burden areas are now classified as Category and the rest of the municipalities in country are in Category B (middle burden) and Category C (low burden).

According to the geographical trends for HIV cases reported, there is a change in the pattern of geographical transmission since more cities and municipalities in the country are now in Category A, from 22 in 2012 to 70 in 2017.

4.1.2.2 HIV and STI prevalence and incidence

Males who have sex with males (MSM)

Based on the 2018 IHBSS results, HIV prevalence increased among MSM, in particular for Angeles, Iloilo, and Mindanao sites. While a drop in prevalence was observed in Cebu province, it was concluded not to be a true drop in HIV prevalence but rather a factor of the sampling. The 2018 IHBSS sample represent only a segment of the MSM population – those who are

¹⁵ HIV/AIDS and ART Registry of the Philippines, June 2019

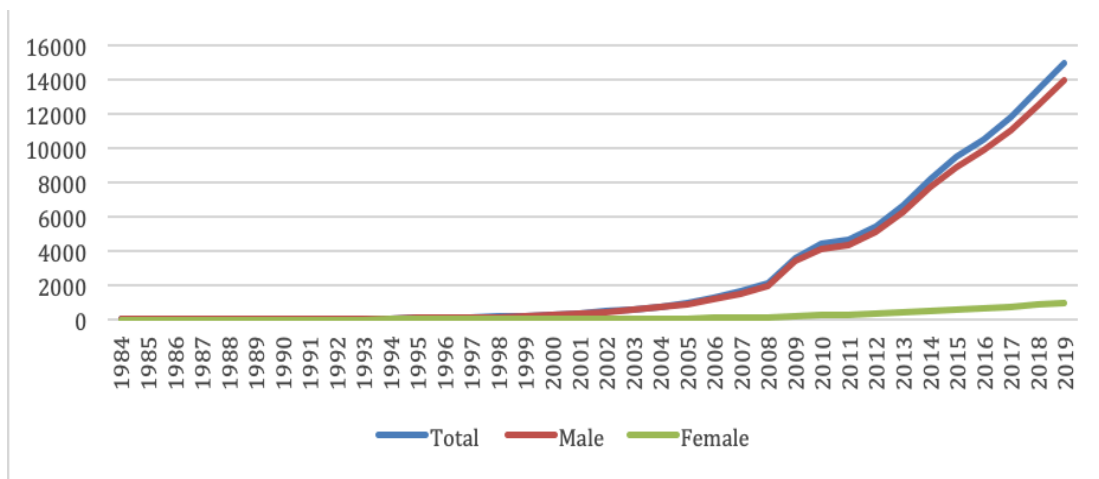
¹⁶ Health Sector Plan on HIV and STI, 2015-2020.

¹⁷ From the report of Dr. Jesus Maria Garcia Calleja, Consultant, HIV Epidemiological Review Philippines, 2019.

commonly found in cruising sites. Data shows that in recent years, less young MSM hang out in cruising sites to find sex partners. Instead, they use online applications and dating websites.

Although both the 2015 and 2018 IHBSS did not provide incidence results, data from the AIDS Epidemic Model (AEM)/Spectrum projections suggest elevated prevalence in all sub-regions among MSM. The estimates showed a clear increase on the new infections rate that are mostly attributed to MSM subpopulation". Further, the HIV/AIDS and ART Registry of the Philippines report in June 2019 indicated that 95% (951) of the 1,006 newly diagnosed cases were males, and more than half the cases (52%, 522) were 25-34 years old, and 29% (296) were 15-24 years old at the time of testing. While the number of women infected has increased, the general pattern of the HIV epidemic is not changing¹⁸.

Figure 10: Estimated number of new infections by gender, 1984-2019



Transgender Women

Transgender people¹⁹ have an increased risk for HIV infection worldwide and Philippines is not an exception as presented in Figure 11. Data collected in the 2015 IHBSS showed that HIV coexists with other communicable diseases, like syphilis and hepatitis B, with the highest values in Cebu. Around 70% of TGW respondents in both cities were less than 24 years old (Cebu 71.0%; Angeles 72.9%), and had the median age of 20 years old. More than 80% of TGW in both cities had their first sex before the age of 18.

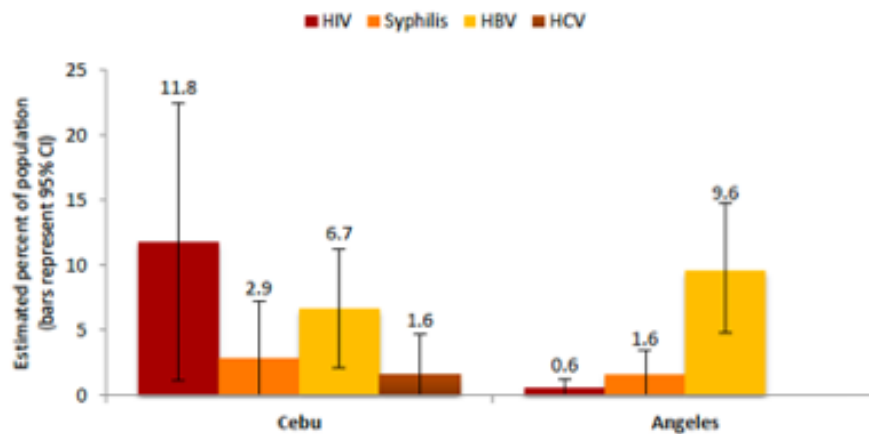
The disease profile differs widely between TGW in Cebu and Angeles. In Cebu, prevalence of HIV is at 12% while in Angeles, it is less than 1%. Similarly, prevalence of syphilis is nearly twice as

¹⁸ *Ibid.*

¹⁹ From the report of Dr. Jesus Maria Garcia Calleja, Consultant for HIV Epidemiological Review Philippines, 2019.

high in Cebu (3%) as in Angeles (<2%). In Cebu, hepatitis B and C prevalence are at 6.7% and 1.6%, respectively. It should be noted, however, that the sample size for these populations and the number of cases for each disease were quite small. As a result, the confidence intervals for the numbers are relatively wide.

Figure 11: Prevalence of HIV, syphilis and hepatitis B infection among TGW, 2015 IHBSS



People Who Inject Drugs (PWID)

Due to the complicated political environment, no survey was conducted among PWID in the 2018 IHBSS. Hence, the 2015 IHBSS data was used in this report.

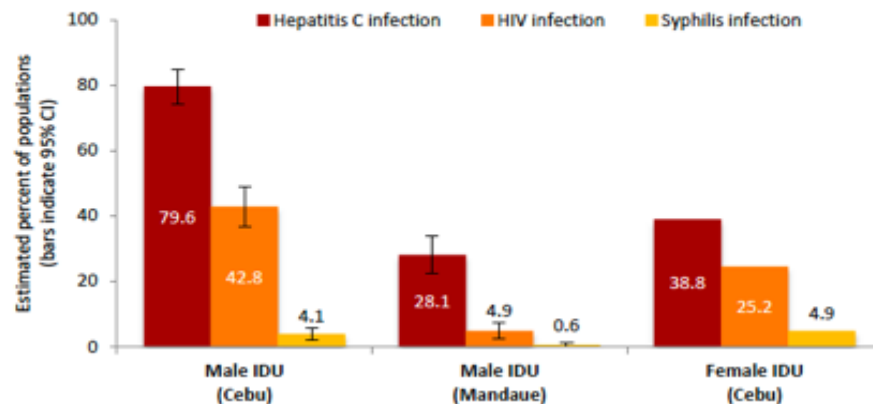
For PWID, data shows that²⁰:

- High HIV prevalence detected among PWID in Cebu at 42.8% among males and 25.2% among females. HIV prevalence among male PWID in Mandaue was substantially lower at 4.9% in the 2015 survey.
- Hepatitis C infection was more prevalent among male PWID respondents in Cebu (79.6%) than male PWID in Mandaue (28.1%), and female PWID in Cebu (38.8%). A slight decline but not really significant (Figure 12).
- Sharing of needles accounted for 5% of newly diagnosed HIV cases in the country from 2010 to 2015²¹.
- Male and female PWID in Cebu were generally older than male IDU in Mandaue. Almost 80% of IDU in Cebu were aged 25 years old and above. In Mandaue, almost half (44.7%) of PWID were 18 to 24 years old.

²⁰ Summarized from the report of Dr. Jesus Maria Garcia Calleja, HIV Epidemiological Review Philippines, 2019.

²¹ HIV/AIDS and ART Registry of the Philippines, 2015

Figure 12. Hepatitis C, HIV and Syphilis prevalence among PWID, 2015 IHBSS



Female Sex Workers (FSW)

The Female Sex Workers (FSW) in the Philippines are categorized into Freelance FSW or street based (high-risk group) and FSW in registered entertainment establishments (low risk group)²². 2015 IHBSS data showed that more than three quarters of the FSW-respondents were over the age of 18 when they were first paid for sex. Both the FFSW and establishment-based FSW practiced sex work at selected times of the year only or when the need arises. This suggests a high degree of turnover in the population of sex workers²³.

The FSW in Philippines that work in establishments have kept very low levels of HIV infection. However, Freelance FSW have much higher of prevalence of HIV, hepatitis, and other STI²⁴, with HIV prevalence at 5.2%, syphilis prevalence at 6.8%, and hepatitis B infection at 5.2%²⁵. Among those with HIV infection, only 30.8% had been previously tested and were aware of their HIV status (Figure 13)²⁶.

Figure 13: Prevalence of HIV syphilis and hepatitis B infection among FSW, 2015 IHBSS

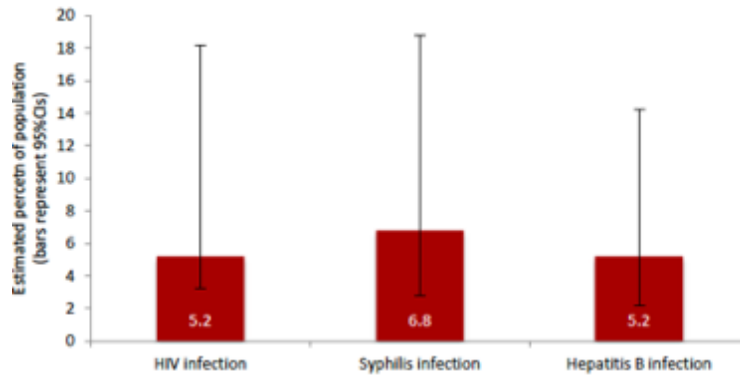
²² Health Sector Plan on HIV and STI, 2015-2020.

²³ Based on the analysis of Dr. Jesus Maria Garcia Calleja, Consultant for HIV Epidemiological Review Philippines, 2019.

²⁴ Cited in the report of Dr. Jesus Maria Garcia Calleja, HIV Epidemiological Review Philippines, 2019.

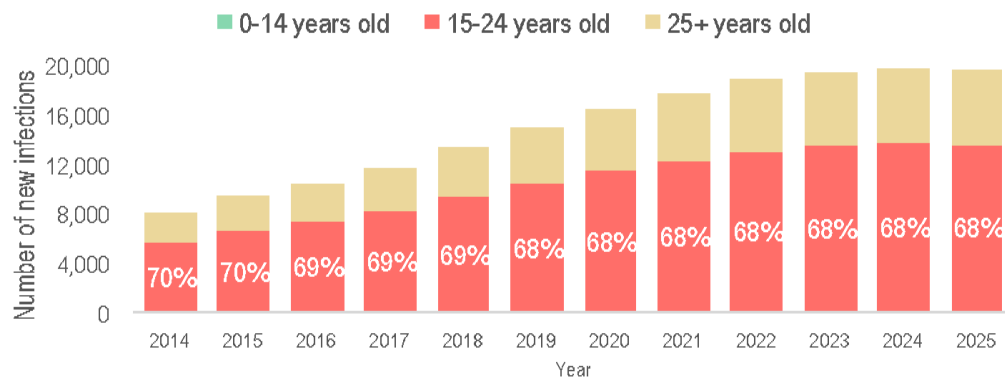
²⁵ *Ibid*.

²⁶ IHBSS 2015, DOH-EB.



Young People (15-24 years old)

Figure 14. Distribution of new infection by age groups, 2014-2025



Source: Spectrum-AIDS Epidemic Model (AEM), April 2019

From January 1984 to June 2019, 28% (19,472) of the reported cases were 15-24 years old. Ninety-seven percent (18,865) were infected through sexual contact, 2% (475) through sharing of needles, 1% was through mother-to-child transmission, while another 1% (131) had no data on mode of transmission.

Seventy-nine percent (15,288 out of 19,472) of all those 15-24 years old at the time of testing were diagnosed from January 2014 to June 2019, and majority of them were males. However, the number of diagnosed HIV cases among female youth had increased significantly in the past five years. The total diagnosed females aged 15-24 years old (172) in 2018 nearly tripled as compared with the same reporting period (60) in 2013.

In June 2019 alone, 296 (29%) cases were among youth ages 15-24 years old and 95% of them were males. Almost all or 99% of the 295 cases were also infected through sexual contact²⁷.

²⁷ Source: HARP, June 2019.

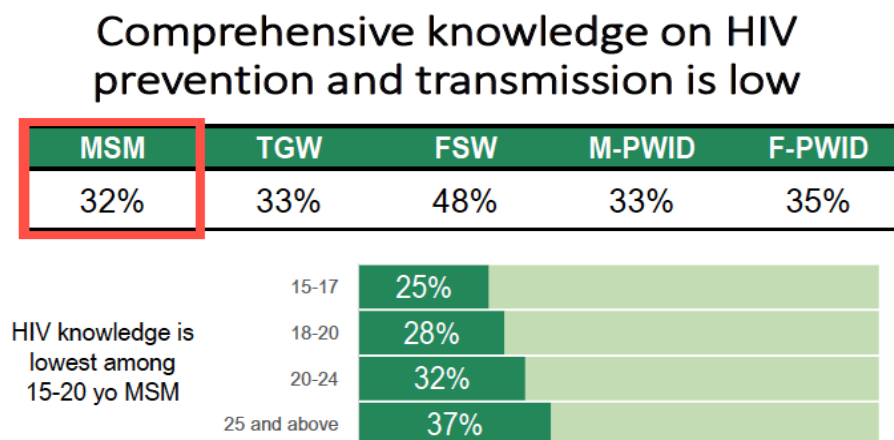
4.1.2.3 Comprehensive Knowledge on HIV prevention and transmission

Comprehensive knowledge on HIV transmission includes correct knowledge on all five basic information²⁸:

- A healthy looking person can have HIV
- Condom use prevents HIV transmission
- Having a faithful uninfected partner reduces HIV transmission
- HIV cannot be transmitted by mosquitoes
- HIV cannot be transmitted by toilet bowls

The level of knowledge on HIV prevention and transmission among all sub-groups of key populations is low, with the lowest among 15-25 years old MSM. The data presented in Figure 15 is from the 2018 IHBSS, except for PWID figures, which are from the 2015 IHBSS in Cebu and Mandaue. There was no IHBSS conducted for PWID in 2018.

Figure 15. Comprehensive knowledge on HIV prevention and transmission



For MSM and TWG, 2018 IHBSS was conducted in 13 sites including: Angeles, Baguio, Cagayan de Oro, Cebu, Davao, General Santos, Iloilo, Zamboanga, Mandaue, Talisay, Quezon City, Pasay and Taguig. Among 30% of the 4,098 respondents was female-identifying and were considered as TGW in the analysis, while 62% were young MSM and TGW between 15-24 years old²⁹.

The FSW figures only represent registered female sex workers as the 2018 IHBSS among them was conducted with those who regularly visit Social Hygiene Clinics (SHCs) in the 10 sentinel sites of IHBSS³⁰.

4.1.2.4 Condom use

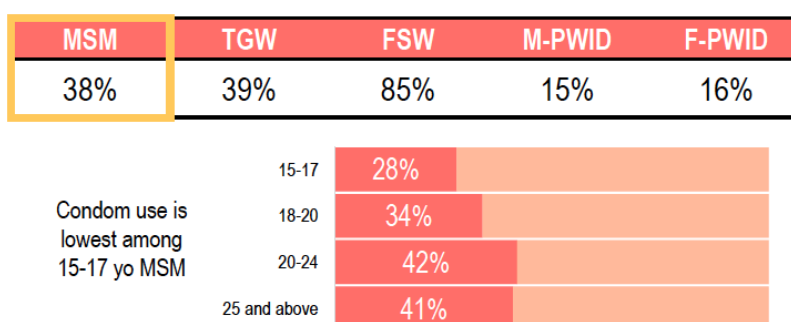
Figure 16. Condom use among 2018 IHBSS Respondents

²⁸ Source: DOH-Epidemiology Bureau, 2019.

²⁹ Source, DOH-Epidemiology Bureau, 2019.

³⁰ *Ibid.*

Condom use among 2018 IHBSS respondents is low



As indicated in the 2018 IHBSS, while condom use among registered FSW is high at 85%, it is low among MSM and TGW,³¹. Among the MSM respondents, 38% said that they used condom the last time they had anal sex with a male partner. Condom use is lowest among 15-17 years old MSM at 28%. Similarly, among TGW respondents, 39% said they used condom the last time they had sex. Among PWID, 15% male and 16% female respondents stated that they used condom the last time they had sex.³²

4.1.3 Factors Contributing to the Rise in HIV infections among Key Populations

To understand why the number of new HIV infections among key populations is increasing, there is a need to look into some relevant factors that are contributing to its rise. These include: (i) early onset of risky behaviors but delayed practice of protective behaviors; (ii) stigma and discrimination; (iii) lack of access to condom; (iii) poor knowledge on HIV prevention and transmission; (v) access to online platforms for sexual partners; and (vi) demographic changes.

4.1.3.1 Early onset of risky behaviors but delayed practice of protective behaviors

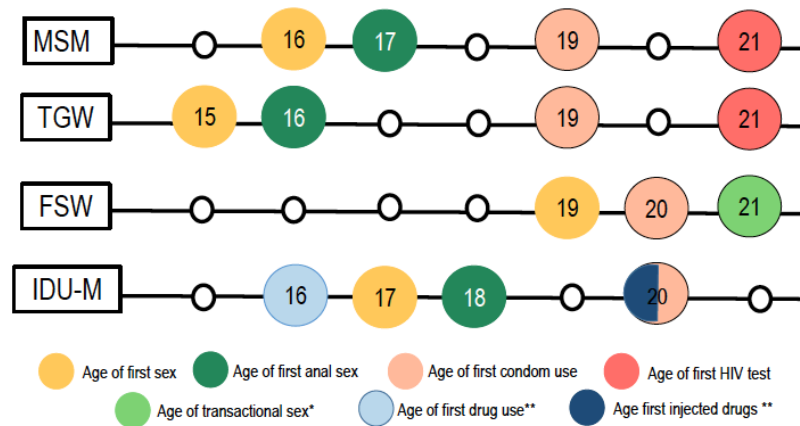
Based on the 2015 and 2018 IHBSS results, the risky behaviors among MSM, TGW, FSW and IDU-Male start early but their protective behaviors start late. For example, among MSM the median age for first condom use is two years later than their first sex, and the median age for first HIV test is 21 years old, which is four years later than their first anal sex.

Figure 17. Risky Behaviors among KP

³¹ *Ibid.*

³² 2015 IHBSS, DOH-Epidemiology Bureau.

Risky behaviors start early, Protective behaviors start late



Source: 2018 IHBS weighted data for MSM, and TGW; 2018 IHBS unweighted data for FSW data; 2015 IHBS for IDU males

4.1.3.2 Stigma and discrimination

According to UNAIDS, “HIV and AIDS-related stigma and discrimination is a process of devaluation of people either living with or associated with HIV and AIDS.”³³ Stigma and discrimination prevent people from accessing HIV services and can lead to risk-behaviors that drive transmission.

In general, the Filipinos are still averse to publicly discussing issues, which are of a sexual in nature, or topics related to homosexuality, HIV, and STI. Students who are lesbian, gay, bisexual, and transgender (LGBT) too often find that “their schooling experience is marred by bullying, discrimination, lack of access to LGBT-related information, and in some cases, physical or sexual assault”³⁴.

Figure 18. Areas with Anti-Discrimination Ordinances

³³ Cited in Quinto, Noel et al. Discrimination Experiences of People Living with HIV and AIDS in the Philippines.

³⁴ Just let us be: Discrimination against LGBT Students in the Philippines. Retrieved from:

<https://www.hrw.org/report/2017/06/21/just-let-us-be/discrimination-against-lgbt-students-philippines>



Source: Human Rights Watch

Reluctance to seek HIV testing is one of the major effects of stigma among key population. The IHBSS results in 2018, for example, reported that 70% of HIV+MSM do not know they have HIV. “Studies have shown that MSM who experience discrimination and harassment are more likely to engage in risky sexual behavior” such as unprotected anal sex.³⁵

4.1.3.3 Lack of access to condoms

Condoms are a key component of comprehensive HIV prevention, yet access to steady supply remains a big issue in the Philippines, particularly among key populations. As shown in the 2018 IHBSS results, more than a third of MSM and TGW have no access to condoms. Condom access is lowest among 15-20 years old MSM.

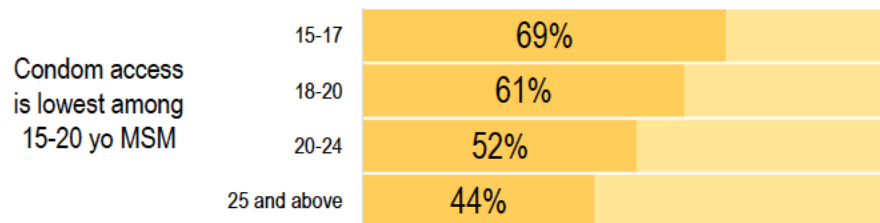
³⁵ Stigma and MSM: A Barrier to Prevention. Retrived from:
<https://www.thebodypro.com/article/stigma-and-msm-a-barrier-to-prevention>

Figure 19. Condom Access Among MSM and TGW

More than a third of MSM and TGW have no access to condoms

Percentage per key population groups that have no access to condoms

MSM	TGW
52%	42%



4.1.3.4 Poor knowledge of HIV prevention and transmission

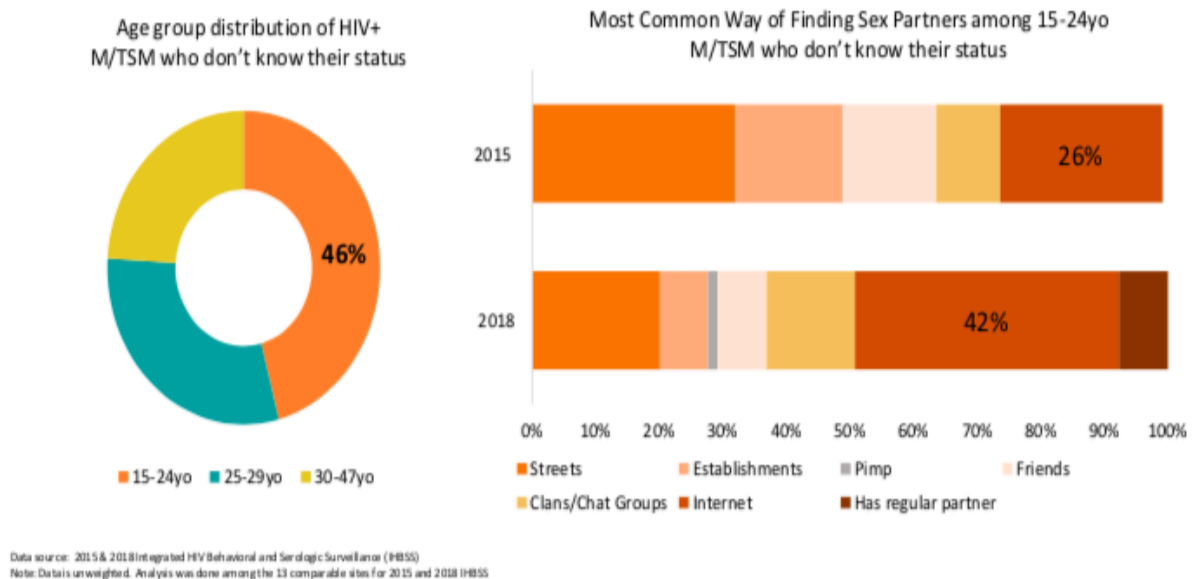
Poor knowledge of ways to prevent HIV increased the risk of infection among key populations. In particular, there is still a substantial gap in the MSM knowledge of HIV disease, particularly on how to prevent transmission. Besides MSM, the 2018 IHBSS results showed that comprehensive knowledge of HIV prevention and transmission is also low or less than 50% among TGW, PWID, FSW and young MSM.

4.1.3.5 Access to online platforms for sexual partners

Aside from the social media platforms such as Facebook and Twitter where people can meet, apps like Grindr, Blued and Tinder can also be used to link up with people instantly, including opportunities for sexual encounters. Based on reports, Grindr, which is the social networking app for homosexuals and bisexuals, over two million people from 192 countries are active on it each day since it was launched in 2009 and updated in 2013³⁶.

³⁶ *Ibid.*

Almost half of those who do not know their status are 15 to 24 yo and find partners primarily online



The 2018 IHBS findings similarly indicated that 59% of MSM primarily finds partners through online platforms; clans or chat groups while HIV+ MSM who are 25 years old or older primarily find partners through streets and establishments (43%).

4.1.3.6 Demographic changes

Changes pertaining to population mobility, migration, urbanization, and the age and gender structures of subpopulations are considered as demographic factors that may affect HIV/AIDS patterns³⁷. Each of these factors may be seen as modifying interactions between susceptible and infected persons in populations. To reiterate the 2018 IHBS findings, half of HIV+ MSM who do not know they have HIV belong to the 15 to 24 year old age group.

Many of the young key population belong to the Millennials who are considered as the most curious generation. Generation Y or Millennials in the workplace, particularly the professionals grew up in the age of the Internet and social media, where the instant-access to information allow them to explore other options and opportunities in life brought about by rapid urbanization. This category of KP are earning their own money, able to travel, and with the capacity and ambition to migrate or live in other places outside of their place of birth.

Studies indicated that the “mobile populations around the world experience higher HIV infection rates than non-mobile populations, regardless of HIV prevalence in the origin or destination

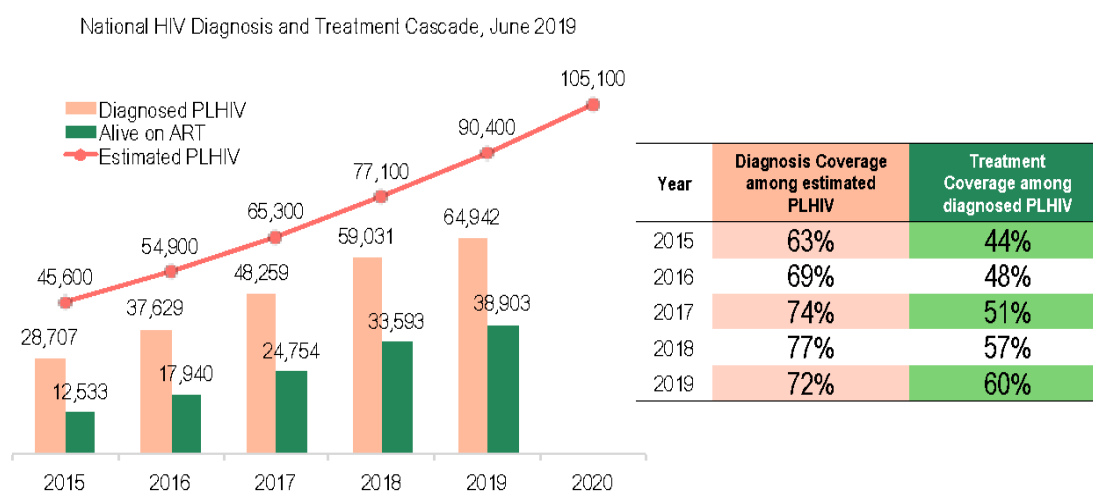
³⁷ K. E. Poundstone, S.A. et.al. Social Epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome | Epidemiologic Reviews | Oxford Academic.

location”³⁸. One example of mobile populations is the Overseas Filipino Workers (OFWs). The HARP Report highlighted that from January 1984 to June 2019, ten percent (6,760) of the total cases were OFWs. Of these, 5,844 (86%) were male. Majority (73%) of the transmission among male OFW cases were through sexual contact among MSM (2,485 male-male sex and 1,753 sex with both males and females).

4.1.4 Status of HIV Cascade for the Continuum of Care

Through the years, the Philippines has gained traction in diagnosis and treatment coverage as shown by the data below:

Figure 20. National HIV Diagnosis and Treatment Cascade, June 2019



Source:
HIV/AIDS and ART Registry of the Philippines, June 2019
Spectrum AIDS Epidemic Model (AEM), April 2019

As of June 2019, there are an estimated 90,400 people living with HIV in the Philippines. The accomplishment towards covering all bases in achieving the 90-90-90 targets are reflected in Figure 21.

³⁸ Ibid.

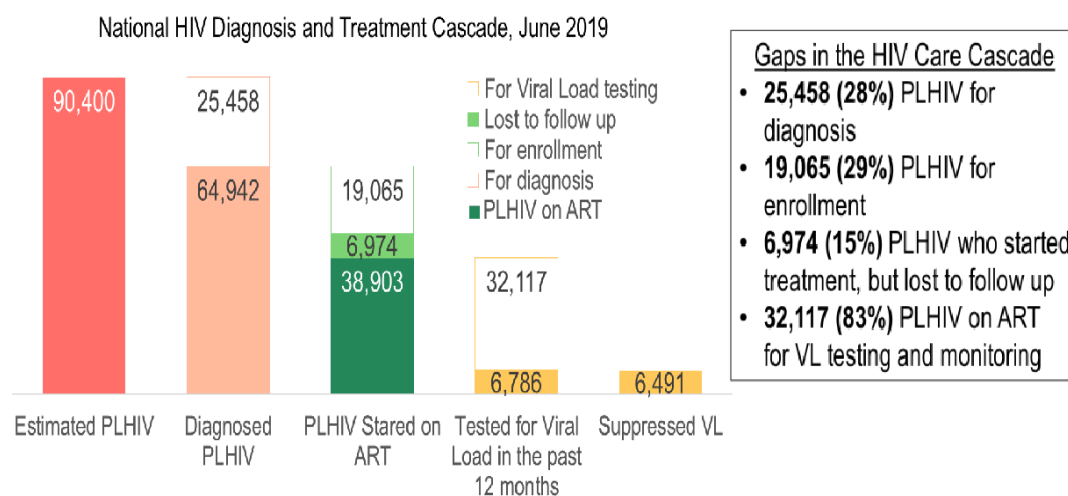
Figure 21. Status of the 90-90-90 targets, June 2019

	90% of all living with HIV DIAGNOSED	90% of all diagnosed with HIV ON ART	90% of all on ART VIRALLY SUPPRESSED	
Year	Diagnosis Coverage among estimated PLHIV	Treatment Coverage among diagnosed PLHIV	Tested for Viral Load in the past 12 months among PLHIV on treatment	Viral suppression among tested
2015	63%	44%	24%	92%
2016	69%	48%	24%	92%
2017	74%	51%	24%	94%
2018	77%	57%	18%	95%
2019	72%	60%	17%	96%

Source:
HIV/AIDS and ART Registry of the Philippines, June 2019
Spectrum-AIDS Epidemic Model (AEM), April 2019

Significant efforts have been exerted in the implementation of the Health Sector Plan to achieve the 90-90-90 targets for HIV. But the country is still losing people along the HIV care cascade. Figure 22 shows the accomplishments and gaps in the HIV Cascade of Care.

Figure 22. Overall accomplishments and gaps in the HIV Care Cascade



Source:
Spectrum-AIDS Epidemic Model (AEM), April 2019
HIV/AIDS and ART Registry of the Philippines, June 2019

4.1.4.1 On Diagnosis

As of June 2019, 64,942 or 72% have been diagnosed, and around 25,000 PLHIV remain undiagnosed for the year. As the diagnosis coverage approaches the 90% target, the importance of maintaining current efforts to diagnose the remaining PLHIV becomes more important as well as the need for innovations to capture the remaining undiagnosed PLHIV who will be harder to diagnose.

4.1.4.2 On ART Enrollment

Despite the accomplished increase in treatment coverage through the years, around 19,000 diagnosed PLHIV have never been enrolled to ART. Moreover, considering the 25,000 who are not yet diagnosed, there are around 44,000 people living with HIV who have never been on treatment in the country. These 44,000 people who have not been enrolled do not have access to life-saving ART, and will continue to fuel the epidemic and add to new infections.

4.1.4.3 On Adherence to Treatment

Among those who were enrolled to treatment, around 7,000 are currently lost to follow up meaning that they are not currently on ART. All in all, as of June 2019, only 38,903 PLHIV are currently on treatment out of the total estimated 90,400 PLHIV. This means that more than half

of the PLHIV in the Philippines are not on life-saving ART and continue to add new infections contributing to the expansion of the HIV epidemic in the country.

On Viral Load Suppression

Viral suppression among those tested show excellent figures well above the 90% target. However, the clear gap is in access to viral load testing among those on treatment or the 32,117 (83%) on ART. Only about 25% have access to VL (about 6000 tests in 2018).

4.1.5 Conclusions: Current HIV epidemiology and status of care cascade

Primary driver of current HIV epidemic. The epidemiological data presented clearly shows that the current HIV epidemic in the Philippines has been driven primarily by sexual contact among males having sex with males. The MSM are the most affected population, making up the majority of new infections. Evidence further reveals that infections are increasing among 15-24 years old MSM. They are also lowest in terms of comprehensive knowledge of HIV prevention and transmission and condom use. The habits and ways to find sexual partners have changed and the rise in new infections among MSM, particularly young MSM need to be acknowledged and considered in prioritizing sub-groups of key populations in the development of next NSP.

PWID, a “puzzle to solve”. The proportion of infections through sharing of needles is only 5% of newly diagnosed HIV cases in the country from 2010 to 2015, and concentrated in Cebu and Mandaue. Certain information is circulating on the presence of PWID in Metro Manila but no studies to quantify or categorize these risk behaviors have been conducted yet, particularly that no there was no IHBSS for this KP sub group in 2018. Currently, the recommended essential package of intervention for PWID could not be fully implemented. Hence, the coverage of the current intervention for PWID could not impact prevention or impact the epidemic.

Considering the current political situation that has driven the PWID to go deeply underground, it is even harder to reach them. The key question to answer is what is the level of HIV infection now in 2019 among PWID.³⁹ The fact that there were very few and localized prevention activities targeting PWID may lead to the assumption that incidence could be at least the same levels and even with increased mortality due to less care and prevention access. However, without epidemiological evidence it is difficult to conclude that the high levels of HIV prevalence observed in 2015 have decreased or increased. Hence, the development of HSP 2021-2025 should be able to identify the most appropriate strategy and interventions to sufficiently address PWID-related issues. Unless there is a change in the policy and political environment, it will be extremely difficult to impact and achieve any progress with the PWID HIV epidemic. It is imperative that the policy issues are addressed.

Geographic area prioritization and regional target setting. Cities and urban areas are particularly affected by the HIV epidemic. The 70 high-burden areas, including the 17 cities in

³⁹ Cited in Calleja, Jesus Maria Garcia. Epidemiology Review of HIV and STI Philippines, 2019.

Metro Manila, account for 80% of reported HIV cases in the country. The top five regions with the most number of reported cases such as NCR, Region 4A, Region 3, Region 7, and Region 11 must be prioritized.

Localized study of factors contributing to the rise in new infections among KP. The JPR findings pointed out the correlation between the increase in new infections among KPs and the following factors:

- Early onset of risky behaviors but delayed practice of protective behaviors
- Stigma and discrimination
- Lack of access to condom
- Poor knowledge of HIV prevention and transmission
- Access to online platforms for sexual partners
- Demographic changes

As new HIV infections continue to rise each year among MSM, PWID, TGW and young MSM, a more rigorous local study of contributory factors will help the HIV Program to better understand the key populations in their diversity and dynamics. For example, the next NSP may look into the benefits of conducting a local study on “Effects of changes pertaining to population mobility, migration, urbanization, and the age and gender structures of subpopulations on pattern of HIV infections among KP.”

Gaps in the HIV care cascade. Clearly much has been accomplished in the HIV care cascade, particularly with the diagnosis coverage closely approaching the First 90 target. However, the gaps in diagnosis (28%, 25,458), treatment (19,065 or 29% for enrollment and adherence – lost to follow up 19,065 or 29%) and viral load testing and monitoring (32,117 or 83%) require fast-track interventions and more innovative approaches from prevention, testing, treatment and viral suppression. Based on the 2019 AEM projections, “With the current program strategies, there will be around 20,000 new infections annually. With business as usual, the number of PLHIV will double by 2025 and triple by 2030”.

4.2 Progress in the National Program Strategy Implementation

The National HIV Program Strategy in the HSP 2015-2020 that was developed in 2014 reflected the situation of HIV epidemic at that time. The recommendations of the 2013 External Review of the National Health Sector Response to HIV and STIs were deliberated and considered in the formulation of the health sector plan. In particular, “the report calls for an important strategic shift towards investing greater resources and effort in newly affected key populations while continuing to provide essential services to sex workers – in particular those described as “freelance” and who work outside sex-oriented establishments. The report also call attention to the need for SHCs to reach out to key populations through partnerships with community-based organizations, in particular networks of people from affected communities and people living with HIV (PLHIV)⁴⁰.

⁴⁰ WHO. External Review of the National Health Sector Response to HIV and Sexually Transmitted Infections 2013, Republic of the Philippines. 2015.

Hence, the intervention and major activities in the plan were intended to address the gaps and challenges identified in the 2013 External Review for the health sector component⁴¹. These include:

- Current indicators were unable to document program outcomes
- Vertical components of program (prevention/diagnosis/treatment) implementation that limits coverage
- Communication Strategies that are targeted and focused were limited
- Quality assurance systems were inadequate
- Emerging at risk populations (prisoners, transgender) needs to be established
- Waiting period for HIV test results hinders access for timely treatment and care
- Engagement of private sector
- Tolerance/Acceptance of the community to address barriers to service delivery

In the first two years of HSP 2015-2020 implementation, it was observed that there was “a surge of HIV cases, and the estimated cumulative number of HIV deaths was 5,249 by the end of 2016. There was also a steep rise in the projection of cumulative infections due to increasing prevalence and slow improvement in protective behavior among key populations⁴².”

Program results via the implementation of Reach-Screen-Test-Enroll-Adhere (RSTEA) Strategy by Global Fund Principal Recipient (PR)-Save the Children under the New Funding Model (NFM) grant for the period 2015-2017 also showed evidence of the need for some adjustments in the intervention strategies.

Among the key observations were:

Reach Strategy	• The limitations to the Peer Educator Model (PE) affect the reach coverage and the PE’s motivations – Outreach mainly covers lower income KP who frequent community cruising sites; KPs who are school-based, working professionals, and those who use online technology to find partners are hardly reached. – Existing platforms like events and community-based organizations (CBOs). In general, the high risk KPs are not reached, as evidenced by the low positivity rate among those tested. – High turn over of PE. • In response, a shift from volunteer PE to community health outreach workers (CHOW) with enhanced prevention and screening tasks was made for the period 2018-2020. The CHOW was recruited from KP. – Condom distribution as part of PE task during outreach was expanded through placing of condom dispensers in strategic locations frequented by KP.
Screening and Testing Strategy	• Community Based Screening (CBS) and rapid HIV diagnostic algorithm (rHIVda) were piloted during the period of 2015-2017. – Rolled out in more areas to increase uptake in 2018-2020 • While Mobile HCT increased access to screening, majority of those with reactive results did not come back to the facility for their confirmatory results. Positivity rates of Mobile HCT events were low.

⁴¹ Health Sector Plan for HIV and STI 2015-2020.

⁴² Global Fund Funding Request, Philippines, 28 March 2017.

	• CBS demonstration was able to screen KP who would not go to a facility. Its positivity rate is higher than Mobile HCT. – CHOW conducted CBS in lieu of Mobile HCT.
Enrollment and Adherence	• Treat All Policy was implemented in 2018 given that not all treatment facilities offer free required baseline tests for ART enrollment. • Support was provided to 18 existing SHCs to transform their facilities into test and treatment centers in 2015-2017. Additional 21 sites were provided support to become testing and treatment centers in 2018. • Support was provided for hiring of care agents to facilitate case management aimed at helping bridge PLHIV from diagnosis to ART enrollment. • PLHIVs have limited access to viral load testing. Under the Global Fund-NFM grant, nine additional viral load machines were procured in 2017, while the government would cover the cost of viral load reagents.

It is within this context that the Joint Program Review for HIV was undertaken. The review looked into what worked and what did not work for the programs on prevention, testing and treatment during the period of 2015-2017, and which intervention strategies and activities should be continued in 2021-2025. The review also examined the epidemiological changes seen in 2018-2019, and the current trend of the HIV epidemic based on current risks and accomplishments to be modeled via AEM. The review also determined the new strategies implemented between 2018 and 2019, which could be continued, and what new innovations in prevention, testing, treatment and viral load suppression could be adopted in HSP 2021-2025.

This section presents the overall progress in the National Program Strategy implementation as of October 2019. The sub-sections on: i) Program accomplishments and gaps in the delivery of HIV services discusses the programs on prevention, testing, treatment and viral suppression as components of Strategies 1 and 2⁴³; ii) Facilitating factors pertaining to cross-cutting areas such as leadership/governance, financing, strategic information system, human resources, legal/policy/social environment, and good practices are discussed in terms of their impact to strategy implementation and as components of Strategies 3 and 4⁴⁴; iii) Key barriers to access of services are described in detail to better understand and overcome the gaps in HIV care cascade; and iv) Conclusions with regards to the overall progress of the 90-90-90 targets and program strategies appropriateness, effectiveness and efficiency are presented as basis for recommendations and way forward.

4.2.1 Program Accomplishments and Gaps

4.2.1.1 Prevention Program

Intervention Strategies and Activities

⁴³ Refer to pages 15-16 of 2019 JPR Report.

⁴⁴ Refer to pages 16-17 of 2019 JPR Report.

The two main intervention strategies implemented for HIV prevention are outreach and condom distribution through access points. The Peer Educator (PE) Model was employed in 2015-2017 for outreach activities. Peer Educators are volunteers who work for 2-3 days per week and who receive a minimal stipend per month. They provide prevention information, distribute condoms and recruit clients to mobile HIV testing events or refer clients to social hygiene clinics for HCT. Based on the observations that PE was not effective in reaching high-risk KP, a shift from PE to the Community Health Outreach Worker (CHOW) Model was done in 2018. Aside from the tasks previously performed by PE, the CHOW has an enhanced prevention and screening tasks.

Awareness-raising activities included:

- HIV and STI Education
- Orientation on HIV 101
- Provision of IEC materials
- Social media campaign on HIV prevention
- Promotion of condoms and lubes

Accomplishments versus Program Targets

The two major program outcome indicators for prevention are condom use and comprehensive knowledge of HIV prevention and transmission. Condom use among MSM, TGW and YKP-MSM is defined as condom use at last anal sex within the past 12 months. For FSW its condom use with the last client, and condom use at last sex for PWID. Comprehensive knowledge of HIV prevention and transmission includes correct knowledge on all five basic questions pertaining to: a healthy looking person can have HIV; condom use prevents HIV transmission; having a faithful uninfected partner reduces HIV transmission, HIV cannot be transmitted by mosquitoes, and HIV cannot be transmitted by toilet bowls.

Based on the 2018 IHBSS, the outcome for these two major indicators are:

Table 1. 2018 IHBSS Program Outcome Indicators

Program Outcome Indicators	Target	Accomplishment				
		MSM	TGW	FSW	PWID	YKP-MSM
Condom use	80%	38%	39%	85%	15% Male 16% Female	36%
Comprehensive knowledge of HIV prevention and transmission	50%	32%	33%	48%	33% Male 35% Female	29%

Progress so far has been slow despite the various interventions implemented.

- Condom use among MSM, TGW, PWID and YKP-MSM is low.
- Comprehensive knowledge on HIV transmission and prevention among all KP is low.

As shown in the data for prevention outcome indicators, condom use is below the 80% target among MSM, TGW, PWID and YKP-MSM, while FSW is high at 85%. For comprehensive

knowledge of HIV prevention and transmission, all KPs are below the 50% target. This slow progress in achieving prevention program targets is primarily attributed to the **lack of an overall national prevention strategy** that would guide the HIV program in identifying priorities, organizing efforts and implementing the prevention program in the most effective and efficient ways. As a result, gaps surfaced and hindered the implementation of prevention program strategies and activities. Specifically, the identified major gaps are as follows:

- ***Lack of national condom promotion and distribution plan resulting to:***
 - Limited access to and unavailability of free condoms in clinics, workplaces and establishments/places frequented by KP. Condoms and lubricants were available in all sites visited in Luzon, however they were dispensed only upon request. In some NCR sites, it was observed that condom dispensers were not available in the clinics. The type of condom is an issue, especially that good quality condoms are expensive. In the Visayas and Luzon, some KPs do not want to use DOH-provided condoms. It was also noted by CHOWs that among YKPs who started having sex without condoms due to lack of access, the process of convincing them to consistently use condoms in every sexual encounter is more difficult.
 - Weak condom use education and promotion. Condoms and lubes are often described as activities that are part of outreach, and the main purpose of outreach are to test, promote SHC services, and refer clients to SHC. Condom use, as a key prevention strategy is not clear to some KPs and providers interviewed. In certain sites in Luzon and Visayas, condoms are often described as an “eye catcher” or simply an incentive for testing.
 - Stock-outs of condoms. Certain sites in NCR mentioned that procuring of condoms/lubes are not indicated in the Project Procurement Management Plan, hence they cannot procure once stock is out.
- ***Lack of comprehensive KP-specific Behavior Change Communication (BCC) Plan, hence:***
 - IEC materials were not customized per subgroups of key population and not geographically contextualized. The HSP 2015-2020 underscored the importance of “One BCC Framework”. However, no BCC Plan for the National Program Strategy was developed and implemented during the period of program implementation. IEC materials were developed on a “per need basis” as exemplified by what was conducted by GF-PR Save the Children and SHCs/DOH-CHD in non-GF sites but not as part of an overall BCC Program Strategy.

As stated by some KPs in Mindanao:

“The grasp of the nuances and context of KPs and their behaviors is lacking. MSM in Davao are different from those in Manila, but we treat MSM like they are homogenous.”

- Late adoption and weak implementation of Undetectable Viral Load = Untransmittable HIV (U=U) messaging. Some KPs and providers interviewed in NCR, Luzon, Visayas and

Mindanao have not heard of U=U at all, but once the context of the message is explained, they found it a powerful communication tool to encourage people to avail of HIV prevention, testing and treatment services.

- **Poor implementation of the developed essential packages for specific KP⁴⁵ (MSM and TG, PWID, SWs and Young People).** No specific action plan for each subgroup of KP was developed hence data is not sufficient to determine whether the essential package of services were delivered. For example, early detection and treatment of STIs should have been a critical HIV prevention strategy. Also, the lack of monitoring and assessment of the essential package of services make it difficult to ascertain whether the objective to achieve best “value for money” was fulfilled.

According to some KPs and providers in Luzon, Visayas and Mindanao:

“It is still one-size fits all”. Supposed to be there are essential package of services per KP, but only in paper. It is still the same when it comes to implementation, except for PWID. Even the TLY model can be replicated in some areas but not in all areas.”

- **Limited access of TGW and MSM to other prevention services aside from provision of condoms and lubricants:**
 - Pre-exposure prophylaxis or PrEP is offered. However, it is too expensive and not in the national policy or covered by Phil Health-OHAT. The cost of PhP 1,200 for PrEP per month is reported as prohibitive for most patients. There is no policy/guidelines to introduce PrEP for prevention at a larger scale, as well as referral mechanisms for clients opting to access PrEP.
 - Transgender services for Hormones are only available through specialty endocrinologist or obstetrician, which means TGW go underground for HRT as observed by service providers in NCR.
- **Lack of comprehensive program in addressing human rights and legal barriers affecting the delivery of prevention services to PWID and YKP.** Due to war on drugs there was difficulty in engaging PWID for HIV health promotion interventions. Service providers were unable to penetrate some areas due to security risk. While a Justice Access Learning Officer (JALO), a staff augmentation under the Global Fund grant assists with the legal or human rights concerns of PLHIV in the facility, this is not adequate given the ramifications of the current political climate on drugs. In the case of YKP, their access to condoms and lubricants is constrained by the provision in the “Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 (RA No. 10354) that prohibits minors (under the age of 18) from accessing modern family planning methods (including condoms) without a written consent from their parents or guardians”⁴⁶.

⁴⁵ Health Sector Plan on HIV and STI, 2015-2020, pp. 55-59.

⁴⁶ RH Law implementation continues despite budget cut. Retrieved from: <https://www.officialgazette.gov.ph/tag/responsible-parenthood>

- *Lack of safe spaces for KP* that could be used as venue for MSM, TWG and YKP to conduct social activities, meetings or receive PrEP/condoms/lubricants. The concept of safe spaces strategy as motivation for KP to access services was adopted in 2018-2019 but the geographic scope is still limited even in NCR and Luzon.

4.2.1.2 Testing

According to WHO, HIV testing and counseling (HTC) is the “essential first step in enabling people with HIV to know their status and obtain HIV prevention, treatment and care services. For those who test negative, HTC is an important opportunity to put those at risk for HIV in contact with primary prevention programmes and to encourage later retesting”⁴⁷.

The HSP 2015-2020 highlighted the importance of HCT process as gateway not just for prevention intervention but also for people to access treatment and care. As stated in HSP, “Increasing the numbers of people who know their HIV status, especially among key populations is key to expanding access to HIV prevention, treatment and care.

Current Status of Testing Strategies

Table 2. Current Testing Strategies

Current Testing Strategies in the Philippines⁴⁸	
HIV-1 Western blot	A confirmatory test is still included in the current HIV diagnostic algorithm in the Philippines. This is no longer recommended by the World Health Organization (WHO) and the Center for Disease Control (CDC)/Association of Public Health Laboratories (APHL) due to evidence of false positive or indeterminate results early in the course of HIV infection. WHO currently recommends the development of a nationally validated testing algorithm for HIV diagnosis.
The rapid HIV diagnostic algorithm (rHIVda)	An algorithm proposed by the Disease Prevention and Control Bureau (DPCB) of DOH, National Reference Laboratory-San Lazaro Hospital-STD/AIDS Cooperative Central Laboratory (NRL-SLH/SACCL), and the HIV National Reference Laboratory of Australia, includes rapid diagnostic tests (RDTs) that have shown comparable specificity and sensitivity and a shorter turnaround time compared with Western blot.
Community Based Screening	Defined as non-laboratory based testing done outside a health facility by a trained KP. Due to Republic Act 5527, or the Philippine Medical Technology Act of 1969, there is a distinction between screening and testing in the Philippines. Testing is done in the laboratory by an HIV proficient medical technologist; the result of which is considered as confirmatory.

⁴⁷ WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016.

⁴⁸ Rapid HIV Diagnostic Algorithm (rHIVda) for the Philippines By the Health Technology Assessment Study Group – Health Policy Development and Planning Bureau, **Advancing Health through Evidence-Assisted Decisions with Health Policy and Systems Research (AHEAD-HPSR)** operationalizes F1+ for Health’s commitment to instill a culture of research and strengthen internal analytic capacity in the Department of Health and build health policy systems research capacity within the sector.

- **Rapid HIV Diagnostic Algorithm (rHIVda)⁴⁹**

Rapid HIV Diagnostic Algorithm or rHIVda uses a combination of 3 rapid test formats done in sequence on a sample that had a reactive result in the initial test. The aim of rHIVda is to shorten the waiting time of confirmatory results and to prevent fallouts in the cascade of service. The Department of Health piloted rHIVda in order: i) to determine a good combination of screening tests (2 or 3) to be used as a confirmatory HIV test algorithm in lieu of Western blot algorithm (to be done at the peripheral certified rHIVda Confirmatory laboratories, CrCLs). Combination/s should be at par with the specificity of WB/current algorithm; and ii) Current algorithm (Centralized at NRL-SACCL): 1. (+) Screening from referring labs 2. (+/-); (+/+) 2 parallel screening tests (SACCL) +WB and or NAT.

- o *Implementation background of rHIVda:*

- 2013 – protocol development; approval; sample bank preparation collection
- 2014 – Sept start validation testing of 18 DOH-FDA approved kits
- 2015 – Feb start rHIVda pilot testing on 8 sites 3 social hygiene clinics (SHC)
 - Manila, Cebu, Davao 2 government Treatment Hubs – VSSMC, SPMC1
 - Sundown clinic – Klinika Bernardo 2 Private (NGO) Clinic – Anglo; Uni (TLYFI)

- o *Key results of rHIVda pilot implementation:*

(Feb – July 2016, MSM, TG, PWD)

Pilot sites: used recommended 3 rapid diagnostic test combination (SD, PA, Immunocomb)

NRL – SLH/SACCL: used 3 RDT+ 2IA+ WB + NAT

8 Pilot sites

- 3 SHC – Manila, Cebu, Davao
- 2 GO TH – VSSMC, SPMC
- 1 Sundown clinic – Klinika Bernardo
- 2 Pvt Clinic – LYFI (Anglo; Uni)

Target sample: 1000 initially reactive referral to SACCL in 6 months

Pilot Site	Feb-Jul'16	
	Total Tested	Screening+
Manila Health Department	1111	165
Klinika Bernardo	1626	161
RITM-Anglo	2701	379
RITM-Taft	3214	203
Cebu CHO	1695	277
VSSMC	43	27
Davao SHC	2190	146
SPMC	166	79
	12746	1437

Total # referrals: 1462



182 (12.4%) – with previous confirmatory test
1280 tested for 6 test systems at SACCL

17

⁴⁹Ribo, Maricel R. Development and Validation of a Rapid HIV Confirmatory Testing Algorithm for the Philippine Setting. Presented during the National Treatment Hub Conference, October 9-10, 2019. National Reference Laboratory-San Lazaro Hospital/STD AIDS Cooperative Central Laboratory.

rHIVda Pilot Testing results

(Feb – July 2016, MSM, TG, PWD)

Sample ID	rHIVda site result	SACCL					Final result	Remarks	Determine ICT
		RD	RD	IA	Screening	WB			
D16-02-02421(005-030)	1/3(CT)	1/3(CT)	0/2	1/5	No Band	TND	Negative	FP SD(Site/SACCL)	-
D16-02-02896(005-035)	1/3(CT)	0/3	0/2	0/5	No Band	TND	Negative	FP SD(Site), technical error	-
D16-04-05864(005-192)	3/3	3/3	2/2	5/5	Ind _{weak} +	TND(2x)	Cannot be determined	- repeat extraction; patient lost to follow-up	+
D16-04-05995(005-125)	1/3(CT)	1/3(CT)	0/2	1/5	No Band	TND	Negative	FP SD(Site/SACCL)	-
D16-04-06377(005-226)	3/3	3/3	2/2	5/5	Ind _{weak} +	Positive	Positive	WB Ind	+
D16-05-07300(004-302)	1/3(CT)	1/3(CT)	0/2	1/5	No Band	TND	Negative	FP SD(Site/SACCL)	-
D16-05-07967(005-282)	1/3(CT)	1/3(CT)	2/2	3/5	Ind _{weak} +	Positive	Positive	FN PA/Immunocomb/WB ; Early infection	-
D16-05-07963(275-046)	3/3	3/3	2/2	5/5	Ind _{weak} +	Positive	Positive	WB Ind	+
D16-06-00445(004-549)	1/3(CT)	1/3(CT)	0/2	1/5	No Band	TND	Negative	FP SD(Site/SACCL)	-
D16-06-00457(004-471)	1/3(CT)	0/3	0/2	0/5	Ind _{weak} +	TND	Negative	FP SD(Site), technical error	-
D16-07-09667(02-096)	1/3(CT)	1/3(CT)	2/2	3/5	No Band	Positive	Positive	FN PA/Immunocomb; Ind WB, Early infection	+
D16-07-10261(004-036)	2/3	2/3	2/2	4/5	No Band	Positive	Positive	FN Immunocomb	+
D16-07-10409(001-174)	3/3	3/3	2/2	5/5	Ind _{weak} +	Positive	Positive	WB Ind	+
D16-07-11173(001-182)	1/3(CT)	1/3(CT)	0/2	1/5	No Band	TND	Negative	FP SD(Site/SACCL)	+
* 1/3 positive (ICT only)									
7 = 3+/5 screening test false positive									
2 = 3+/5 - FN Immu/PA; WB -/Ind PCR+									
1 = 4+/5 - FN Immu/WB; PCR+									
4 = 5+/5 WB Ind/PCR+									

14 samples with discordant results

18

Result of rHIVda in 8 Pilot Sites

SD Bioline HIV 1/2 Ab;
Particle Agglutination Ab; Immunocomb Ab

vs

Gold standard
(2 Immunoassays + Western Blot)

3/3 100% Specificity



Issues and Concerns for the Roll-out of rHIVda:

- Of the 3-piloted RDTs, only 1 will remain for continued use (ICT-SD HIV 1/2 3.0). In 2017 Immunocomb was discontinued in 4th Quarter 2016, stocks remaining up to August 2017.
- Immunocomb was replaced by Determine HIV 1/2 Ab (as recommended by WHO Consultant), but it produces high number of false (+) in combination with another ICT (SD).
- Availability of the 3rd kit (Serodia PA) used in the algorithm was up to November 2017. The company has re-formatted the old version. The new developed kit has to undergo initial registration and revalidation to check its

suitability for the algorithm.

- The remaining rapid tests kits (6) validated for the algorithm are all ICT, not recommended due to high number of common false+ as shown in the initial validation study.
- Need to continuously look/validate new kits Kit considered as the 3rd test: **Biorad Geenius HIV 1/2 rapid test** = DOH-FDA registered, validated for the algorithm (finished July 31, 2017).

- **Community Based HIV Screening (CBS)**

Community HIV screening is conducted in non-health facility or non-clinical settings⁵⁰. Community based screening programs are generally combined with education and outreach events such as festivals, beauty contests or job fairs. Social Hygiene Clinics (SHCs) and HIV Treatment Hubs partner with CBOs in conducting CBS by providing testing resources, including test kits and trained staff members.

Save the Children (SC) is the lead implementer of CBS with grant from the Global Fund. CBS demonstration was able to screen KP who would not go to a facility for testing. Its positivity rate of 5% is higher than mobile HCT⁵¹. From its initial pilot testing in 2015, CBS was rolled-out in 2018 through the creation of 12 CHAMPION Community Centers under the Global Fund funded project “Accelerating Community Response and Engagement on HIV and AIDS Prevention (ACER)” in partnership with LoveYourself Inc. The following CBOs are doing the CHAMPION community Centers Model: PAM (JPM), CAV (CPAG 1, Cavite City), CAV (CPAG 2, Bacoor), PPS (PH4), ILO (FPOP 1), ILO (FPOP 2)*, CEB (TLY White House), CEB (Bisdak Pride, Mandaue), ZAM (Mujer)*, CDO (K-PLUS), DVO (OSD), and CEB (CURLS)* VIBE.

Accomplishments versus Program Targets

The major program outcome indicator for testing is: % of tested for HIV and know result among all KP, reactive and non-reactive. As reported in the 2018 IHBSS, all KP subgroups are below the 70% target. Forty-nine percent of those never been tested and not tested in the last 12 months are 15-24 years old MSM. Among the reasons cited for low HIV testing uptake include: KP not knowing the importance of getting tested, afraid to get tested, with disability, inaccessible facilities and inconvenient operational hours of facilities.

Table 3. Accomplishment versus Program Targets per KP

Program Outcome Indicators	Target	Accomplishment				
		MSM	TGW	FSW	PWID	YKP-MSM

⁵⁰ Community HIV Testing and Screening. Retrieved from: <https://www.ruralhealthinfo.org/toolkits/hiv-aids/2/identify/community-testing>

⁵¹ Global Fund Funding Request, Philippines, 28 March 2017.

Tested and know result among all KP (reactive and non-reactive)	70%	29%	39%	55%	18%	25%
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An increase in the proportion of HIV-positive M/TSM who know their status at 17% was observed in the 2018 IHBSS compared to 8% in 2015 (See Figure 23). In terms of geographic accomplishments, almost all of the regions have reached more than 60% PLHIV diagnosed by end of December 2018. The national accomplishment in diagnosis as of June 2019 is 72% which is close to the target of 90% PLHIV diagnosed by 2022, while almost all regions have reached more than 60% PLHIV diagnosed (Figure 24).

Figure 23. Awareness of HIV status among HIV+ M/TSM, 2018 IHBSS

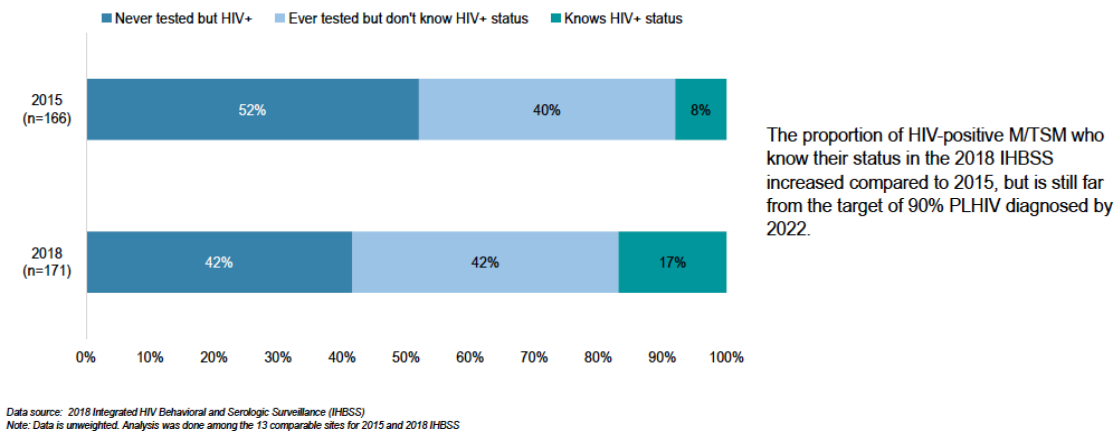
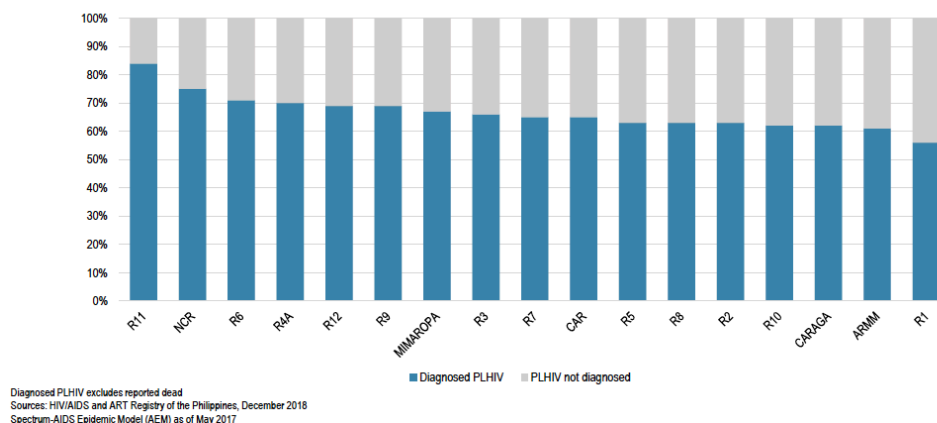


Figure 24. Status of PLHIV diagnosis in the regions, December 2018.



Gaps in Testing

Though the country is getting better at case detection with 62,942 PLHIV diagnosed as of June 2019), there are still 28% or 25,458 PLHIV undiagnosed as of June 2019 and 50% of the undiagnosed are young PLHIV within the age bracket of 15-24 years old.

This diagnosis gap is linked to the following key issues:

- **Accomplishments in reach strategy have not yet been fully translated to HIV testing as demonstrated by the data below:**

Does reach translate to HIV testing?

	All M/TSM respondents (N=4,098)	All HIV+ M/TSM (n=171)	HIV+ MSM who have never been tested for HIV (n=71)	Ever tested but don't know they are HIV+ (n=71)	HIV+ MSM who know their positive status (n=29)
Received info on HIV in the past 12 months from an HIV educator/advocate	36%	47%	20%	69%	62%
HSP Reach (received information about HIV & given condom/lubes in the past 12 months)	30%	41%	10%	66%	55%
Know HIV status in the past 12 months (including those who were not tested in the past 12 months, but have ever been tested and know they are positive)	29%	39%	-	-	17%

Data source: 2018 Integrated HIV Behavioral and Serologic Surveillance (IHBS)
Note: Data is unweighted. Analysis was done among the 13 comparable sites for 2015 and 2018 IHBS.

Results of 2018 IHBS further revealed that 63% of HIV+, who do not know they have HIV, were reached with prevention services through the provision of information on HIV transmission and prevention, and given free condoms in the past 12 months. It is important to note too that 42% of HIV+ who do not know they have HIV were unaware of the existence of social hygiene clinics in their localities.

- **Limited options and implementation of targeted testing among key population and their partners (including female partners).** On this issue, most service providers and KPs in NCR, Luzon, Visayas and Mindanao noted the lack of YPK-specific testing strategy and lack of testing strategy for hard to reach KP.

Many of the respondents in NCR sites said that partner notification is limited due to fear of breaking confidentiality. They mentioned that there is no mechanism in place for index testing or partner notification system. Some of them also pointed out the lack of data on accuracy, patient safety, and counseling for self-testing

- **Limited implementation of CBS and lack of guidelines.** Because CBS is in a community setting, it provides opportunities for reaching a broad set of people who are at risk, KPs who are less likely to visit a clinic for a test, and can be used to target KP in their place of work or residence. The piloting of CBS in 2015-2017 demonstrated its effectiveness in reaching KPs and a higher positivity rate of 5% compared with mobile HCT. However, its rollout in 2018-2019 was still limited to GF sites because the DOH guidelines for its rapid and national level implementation has been not yet been issued. A draft Guidelines on CBS Implementation has been drafted but still waiting for an official approval in the form of a DOH-Administrative Order (AO) or Executive Order (EO).
- **HIV testing is stigmatized.** Stigmatization of HIV testing is not sufficiently addressed, and a number of KPs cited incidents of KP discrimination by some health care workers in the Visayas and Luzon. In the Visayas, it was noted that straight male PWID refuse to get tested because they think of it as purely for gays or “*pang-bayot lang*”, or some partners of KP looked at HIV as mainly for sex workers.
- **Poor quality of pre and post-test counseling** was cited as one of the key issues in HIV testing. Results of the client exit interview conducted among 37 respondents in NCR, Luzon, Visayas and Mindanao (Annex 18, HTS and ART Clients’ Insights) showed that what the patients did not like most in HCT are:
 - o Lack of space for confidential pre and post-test counseling
 - o Testing process is not fully explained by the staff or at worst when pre-test counseling is not conducted
 - o No condoms and lubes provided
 - o Long waiting time (2-3 hours)
 - o Facility is not accessible
 - o Very few staff attending to clients
- **Slow turnaround time for release of confirmatory test results** was mentioned as one of the key issues in the low uptake of HIV testing in all sites of NCR, Luzon, Visayas and Mindanao. Since there was no rapid rollout of rHIVda after the pilot implementation was completed in July 2016, the regional/local health facilities and patients are still dependent on the centralized confirmatory process of diagnosis.

They have to wait for weeks or more than one month to receive the diagnostic result from SACCL or RITM.

4.2.1.3 *Treatment (Enrollment and Adherence)*

Linkage to HIV care and treatment, retention in care, and attainment of viral suppression is a challenge for people living with HIV. According to WHO, HTC is just the first step in the continuum of HIV care. It is necessary to ensure that “people are linked to and enrolled in HIV clinical care to realize the full health and prevention benefits of ART”⁵².

The HSP 2015-2020 emphasized that “treatment and care program will include prophylaxis, diagnosis and treatment for common opportunistic infections and co-morbidities particularly in diagnosis and treatment for TB, pneumonia, diarrhea, viral hepatitis, malnutrition and other clinical conditions that are more serious for people living with HIV”.

Intervention Strategies and Activities

Linkage from testing positive to initiation of treatment has been conducted through various approaches. These are the following:

- Same Day Initiation of Treatment
- Implementation of “Treat All Policy”
- Free ARV for diagnosed HIV+ in the treatment facilities
- Establishment of 151 treatment hubs and primary care
- Operation of Sundown Clinics
- Establishment of One-Stop-Shops
- Treatment Partner
- Differentiated Care Approach for MSM
- Community-Based ART Delivery

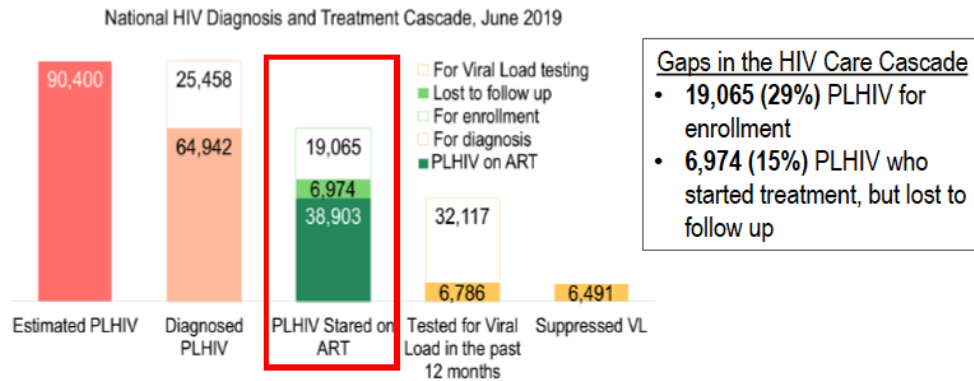
Accomplishments versus Program Targets

The program outcome target for treatment is 90% by end of 2020 for its two major indicators: i) % of PLHIV who are started on ART; and ii) % of PLHIV alive and retained on ART (12 and 24 months). There is a notable improvement in ART coverage among diagnosed from 44% in 2015 to 60% in 2019, and the “Treat All Policy” has been instrumental in the increased ART coverage.

Overall program and regional accomplishments in treatment as of June 2019 are shown in the following figures:

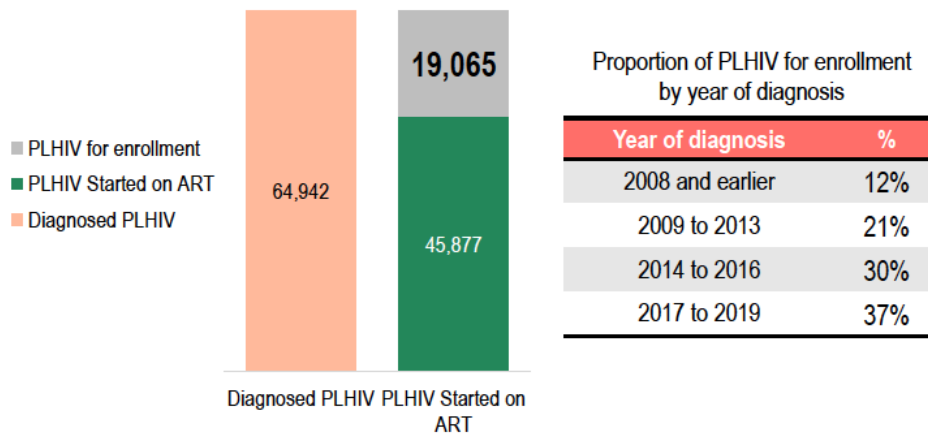
⁵²WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, Updated 2016.

As of June 2019, there are 19,065 PLHIV for enrollment and 6,974 PLHIV to return to ART



Source:
Spectrum-AIDS Epidemic Model (AEM), April 2019
HIV/AIDS and ART Registry of the Philippines, June 2019

1 out of 3 among those for enrollment were diagnosed in the past 3 years



Source:
HIV/AIDS and ART Registry of the Philippines, June 2019

Regional accomplishment as of June 2019

Region	Estimated PLHIV	Diagnosed PLHIV	Diagnosis Coverage	PLHIV on ART	Treatment Coverage
NATIONAL	90,400	64,942	72%	38,903	60%
NCR	33,580	25,321	75%	14,982	59%
4A	14,570	9,813	67%	6,011	61%
3	9,040	6,086	67%	3,653	60%
7	8,760	5,869	67%	2,556	44%
11	4,250	3,670	86%	2,293	62%
6	4,240	3,097	73%	2,048	66%
12	2,500	1,548	62%	1,020	66%
1	2,290	1,423	62%	845	59%
10	2,280	1,426	63%	860	60%
5	1,720	1,109	64%	658	59%
9	1,320	858	65%	453	53%
8	1,300	848	65%	472	56%
2	1,340	843	63%	551	65%
4B	1,180	768	65%	477	62%
CARAGA	980	635	65%	387	61%
CAR	760	515	68%	343	67%
ARMM	290	184	63%	85	46%

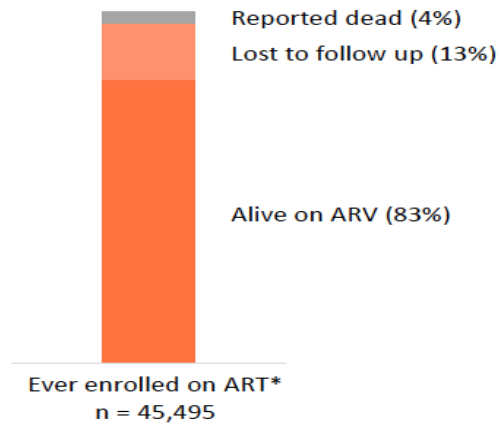
Source:
HIV/AIDS and ART Registry of
the Philippines, June 2019
Spectrum-AIDS Epidemic Model
(AEM), April 2019

□ Regional diagnosis or
treatment coverage is
greater than or equal to
the national coverage

Gaps in Enrollment to Adherence

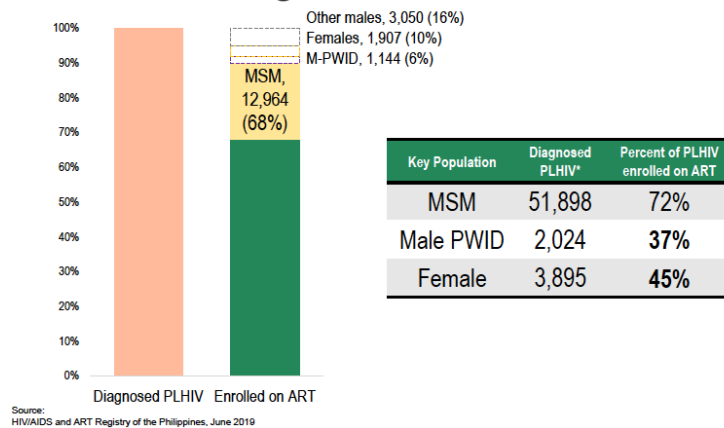
There are still 29% (19,065) of diagnosed PLHIV who have not started treatment. PLHIV for enrollment is higher at 68% for MSM, while the proportion of PLHIV enrolled is notably lower among PWID and Females. The proportion of PLHIV who did not return after initiation is 1 out of 5 (LTFU).

Among the enrolled PLHIV as of June 2019, 13% were lost to follow-up. Fifty-two percent of the LTFU had their last visit within 2018-2019.

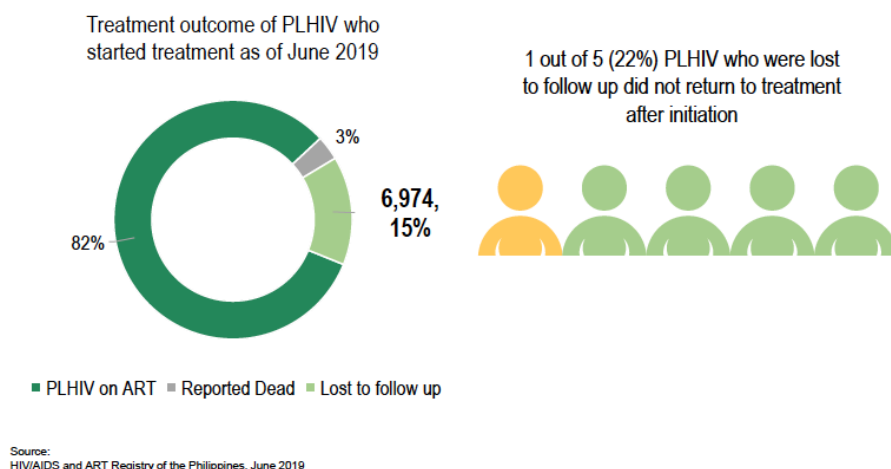


Source: HIV/AIDS & ART Registry of the Philippines (HARP), June 2019
*Includes reported deaths

68% of PLHIV for enrollment are MSM,
but proportion of PLHIV enrolled is lower
among PWID and Females



1 out 5 PLHIV lost to follow up on ART did not return after initiation



The gaps in enrollment to adherence are attributed to a number of key issues. These are the following:

On Service-delivery:

Issues with ARV supply. Most of the sites have experienced critical stock outs. Multiple emergency procurements were requested and provided by external funding eg. Global Fund and UNICEF in 2018 and 2019. NCR pointed out that critical stock-out of ARVs was due to rapid increase in clients and difficulty in forecasting. While most of the facilities visited in Luzon have practiced, or intend to practice multi-month dispensing for three months, only one-month (or even 10 days) prescription was given since 2018. Multi-month dispensing is compromised by ARV stock-outs.

Human resource constraints. The patient to health care provider ratio in the treatment facilities is imbalanced. The average number of staff in the sites is 3-4 (Medical Doctor, Nurse, Medical Technologist and Administrative/Encoder) serving 20-50 patients. In most of the sites in NCR, Luzon, Visayas and Mindanao, the number of Case Managers (CM) is inadequate or on the average 1 CM to 20 patients. Aside from case management, the CM performs other duties, which is a big factor in the poor quality of case management in the facilities. Many sites also lack permanent staff for case management. Other issues are the lack of health care workers trained on adherence counseling and the rapid turnover of HR especially CHOW/PE.

Weak capacity of some health facilities to provide comprehensive and quality services. Some facilities in the sites visited are not one-stop-shops hence they could not immediately link the patients to care or initiate same day enrollment to ART. Also, a number of them have poor referral mechanisms or no strong referral system/communication with other facilities when

transferring patients, and lacked system to track their diagnosed patients who have not started treatment.

- 52% of those not yet on ART were diagnosed from treatment hospitals and treatment primary care facilities.
- No monitoring/tracking tool and designated staff-notifying patients who are getting lost in the treatment, transferring out patients (if they are received by other facility).
- Inmates on treatment are LTFU after release from jail (SHC not notified and there is no contact number and address given).
- Inadequate supply of testing kits, reagents, CD4 cartridges and medicines for OIs is also a big concern for some of the treatment facilities.

Limitations in the testing and treatment processes/approaches such as the long turn around of confirmatory results, additional requirements for treatment of YKP (pediatric clearance and consent), and lack of differentiated approach in providing services such as community-based delivery of ARV on a larger scale and access points for women and children living with HIV. Rates of lost to follow up gradually increases as the waiting time from HIV diagnosis and ART enrollment lengthens. Differentiated care approach such as sending refills through courier service, multiple month refills, etc., is not yet widely implemented, except for SHIFT clinics and Love Yourself centers.

“Even if there are a number of hubs in an area, capacities of HACT are uneven. For example in Cebu, there are several hubs but only VSMMC has the capacity to manage Opportunistic Infections (OIs). Thus most cases are referred to the facility that in effect overburdens VSMMC HACT”.

Low quality of infrastructure facilities. *Some of the infrastructure and equipment in the sites visited are inadequate to support operations. In certain NCR sites, daily patients’ load ranges from a low of 2-5 patients to a high of 300 patients. Some SHCs have inadequate space of which one has a total of 8,000 patients, while another has no enough chairs and tables for staff on duty. In Luzon, the size of some SHCs ranges from minimum area of 30 to maximum of 100 square meters, and only one of the facilities visited found its facility adequate for the volume of clients. Counseling rooms and waiting area in some sites are old or needs repair/renovation.*

Policy and Guidelines

- ARV regimen in the country does not include Dolutegravir (DTG) – the WHO recommended 1st line drug, which is a big issue given the reported cases of drop-outs in ART or LTFU due to side effects of current ARV regimen.
- Not all treatment facilities implement the treat-all policy because some health providers in some sites visited have different interpretation of the policy.
- Insufficient implementation of the TB-HIV collaboration (i.e. referral of TB patients diagnosed with HIV, sharing of data) was noted in most of the sites during the JPR field visit.
- Limited access to Philhealth OHAT Package (individual). Benefits are not yet fully utilized by accredited treatment facilities.

- *Long and tedious process of Philhealth accreditation (facility level) which hinders SHCs from accessing OHAT Package of Benefits.*
- *Difficulty in accessing enabler support from other agencies (i.e. DSWD) which could cover transportation and meal expenditures during visits to the health facility.*
- *Lack of budget support for other treatment needs (OI drugs, nutrition, palliative care, healthy lifestyle, vaccinations).*

Psychosocial and biomedical

- *ARV side effects, hindering treatment adherence and causing drop outs. Many of the KPs and service providers interviewed mentioned ARV side effects as a major reason in PLHIV either not enrolling in ART or dropping out after the initiation of the first treatment procedure. Related to this is the issue of Pill burden cited by KPs during FGDs in.*
- *Lack of support (family and community) and self-stigma. NCR sites visited emphasized that there were no PLHIV involved in enrollment process, therefore the health providers oftentimes are not very familiar with the social or clinical needs of those enrolling on ART*
- *Depression was also highlighted by many KPs, especially for the newly-diagnosed PLHIV. Mental health issues/depression are not well covered in counseling sessions.*

4.2.1.4 Viral Suppression

Viral load is “the amount of HIV in the blood of someone who is HIV-positive. A viral load test tells how much HIV is in the blood. The goal of HIV treatment is to reduce viral load. When the viral load is very low (having less than 200 copies of HIV per milliliter of blood), it is called viral suppression. Undetectable viral load is when the amount of HIV in the blood is so low that it can’t be measured”⁵³.

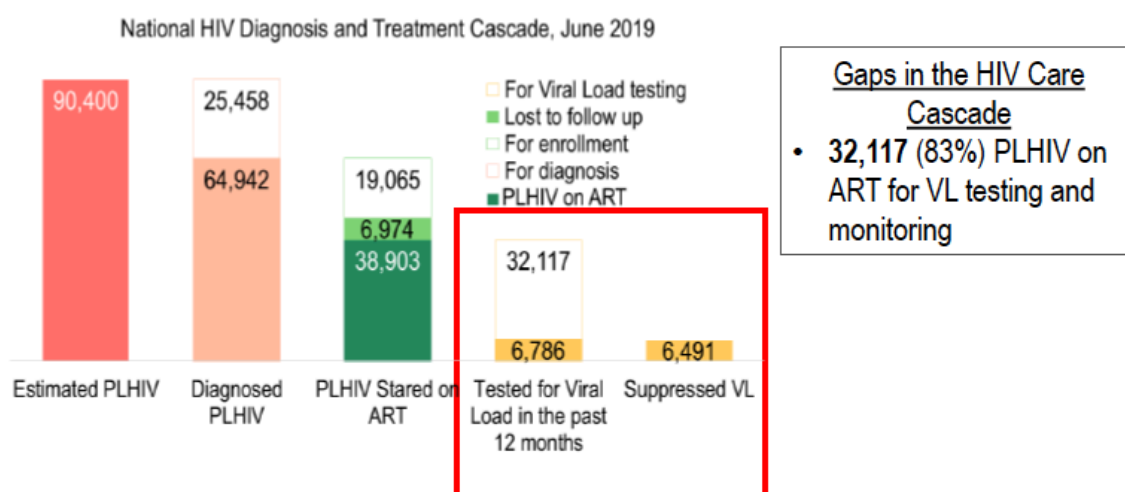
In the implementation of HSP 2015-2020, the two intervention strategies used for viral load testing are the utilization of Phil Health OHAT-Package and U=U message on viral suppression.

Accomplishments versus Program Targets

The program target for viral suppression is 90%. JPR findings on viral suppression showed that all of the visited facilities that are actively conducting viral load testing or sending samples out report high rates of viral suppression. As of June 2019, viral load suppression among tested is at 96%.

⁵³ Viral Load. Retrieved from: https://wwwn.cdc.gov/hivrisk/increased_risk/viral_load/index.html

Viral load suppression among tested is at 96%, but viral load testing is below 20%



Source:
Spectrum-AIDS Epidemic Model (AEM), April 2019
HIV/AIDS and ART Registry of the Philippines, June 2019

Gaps in Third 90, Viral Suppression

Although viral suppression is high at 96%, the coverage of viral load testing at the national level is below 20%. There are 32,117 (83%) PLHIV on ART for VL testing and monitoring. In some sites visited in Luzon, Turn-around-time (TAT) was long with one facility reporting a 2 to 3 month TAT⁵⁴.

Lack of viral load machine was the key reason cited by sites visited in NCR, Luzon, Visayas and Mindanao for the low coverage in viral load testing. There are challenges to procurement of VL machine due to operational issues and difficulty in utilization of OHAT funds at the facility level. The utilization of prevention and suppression message of U=U is another issue. It was not widely promoted or utilized in the facilities visited.

4.2.2 Facilitating Factors to the Delivery of HIV Services: Cross-cutting Areas and Good Practices

⁵⁴ From the Notes of Melinda Wilson, JPR Luzon Team, USAID Consultant.

Critical aspects in the crosscutting areas of leadership/governance, strategic information system, financing, human resource, legal/policy/social environment and good practices in program implementation facilitated the implementation of programs in prevention, testing, treatment and viral suppression. These are the following:

4.2.2.1 Leadership and Governance

The Philippines has been mounting a strong health sector response to the HIV and AIDS epidemic in the country under the leadership of the Department of Health. The current KP-targeted national program strategy demonstrates DOH's political to expedite the process of achieving "global targets of Zero new HIV infections, Zero-related deaths and Zero discrimination by focusing on cost-effective interventions that ensure universal access to prevention, treatment, care and support among key affected populations and PLHIV⁵⁵. The DOH-Disease and Prevention Control Bureau through the NASPCP led the processes of integration of programs, coordination of activities and monitoring of progress. The Center for Health and Development (CHD) in the regions through the Regional HIV Coordinators and LGUs played key roles in ensuring effective governance of HIV programs at the regional level and localities (provinces/cities/municipalities).

- ***Availability of a health sector plan for HIV as guidance document in program strategy implementation.***

The HSP 2015-2020 set the direction of intervention strategies and clarified focus of work, roles and contributions of program managers, health care providers, CBO and NGO for KP, civil society and development partners.

Consultation meetings were conducted with the target community (FSW, MSW, MSM, TG, PWID, PLHIV) for a more meaningful engagement and participation in HSP development. "This is to better understand their needs ensuring its assimilation into the updated document. The initial output to discussions with DOH, HIV TWG, and target community were then presented and validated in a national stakeholders meeting with attendees and representatives/ members from various NGO/ CBOs, faith-based organizations, private and government institutions, DOH, PNAC, developmental partners, Local government unit, health service implementers (SHC and treatment hubs), donors and medical/ allied professional societies and also those from the target community (e.g. PWID, MSM, TG)"⁵⁶.

- ***Availability of DOH Guidelines.*** Key guidelines developed and implemented by DOH to address specific concerns in HIV testing and treatment as shown by the data below:

⁵⁵ Health Sector Plan for HIV and STI 2015-2020.

⁵⁶ *Ibid.*

Table 4. DOH HIV Guidelines

No	DOH Guidelines	Purpose	Implementation Status
1	AO No: 2018-0024 "Revised Policies and Guidelines on the Use of ART among PLHIV and HIV-exposed infants.	Aims to provide standards for the use of ART among adults and children infected with HIV and infants exposed to HIV in the Philippines.	Signed on October 24, 2018
2	DOH-Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in the Philippines.	Development of model programs anchored on the principles of effective drug use and dependence treatment would help us provide quality services which are accessible and affordable aligned with our DOH "Kalusugang Pangkalahatan" / Universal Health Care High Impact Five (Hi-5) strategy. This document was developed to serve as a guide for all our health providers and stakeholders who are working in the drug use and dependence prevention, treatment and care in our country.	Issued on May 5, 2016
3	AO No: 2017-0019 "Policies and Guidelines on the Conduct of HIV Testing (HTS) in Health Facilities.	To identify the components of HTS and the protocol for each of these. To set the standards/requirements for all HTS facilities. To define the roles and responsibilities of stakeholders in the implementation of these guidelines.	Issued on September 15, 2017
4	Department Circular No: 2016-0171 All HIV/AIDS Core Team (HACT) Chairs of Hospitals. Directors of Bureaus. Services. Regional Offices, Medical Center Chiefs of DOH retained Hospitals. DOH-designated Treatment Hubs, Satellite Treatment Hubs, Key Partners from LGUs, including Social Hygiene Clinics, TB DOTS and PMDT facilities.	Enhancing Linkage to Care of PLHIV - Clients with reactive HIV screening test to immediately be assessed by Treatment hubs, satellite treatment hubs and HIV primary care clinics in order to provide early treatment and management	Issued on June 7, 2016

5	Department Memorandum No: 2018-0040	"Directory of DOH-Designated HIV Treatment Hubs and Primary HIV Care Clinics in the Philippines"	Issued on November 20, 2018
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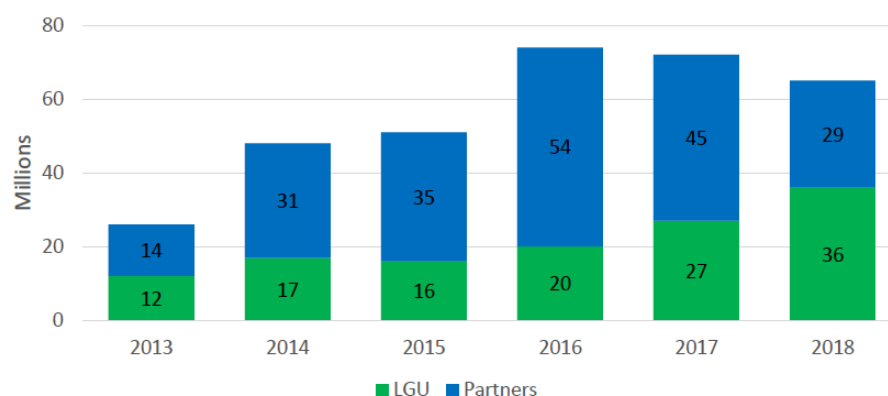
- **LGU leadership/governance of HIV program.** All the sites visited in NCR, Luzon, Visayas and Mindanao considered LGU collaboration, particularly the strong support of Local Chief Executives (LCEs) with HIV program implementers as an important element that facilitated the implementation of HIV prevention, testing and treatment strategies. In some sites in Mindanao, the strong support of their LCEs to the HIV program resulted to active operation of Local AIDS Councils (LACs) with corresponding budget that they are able to use, particularly in conducting outreach activities. They also have updated local ordinance on HIV wherein CBS is included in the Implementing Rules and Regulations (IRR) of the law.

LGU collaboration and strong support is essentially demonstrated through its level of investment in HIV program as exemplified by Quezon City-LGU:

Figure 25: Investment for HIV and AIDS, Quezon City

Quezon City, 2013-2018

QCSAC PIR 2012-2018



Investments on HIV: P65m (\$1.3 million) in 2018

55% from all LGU, 2018

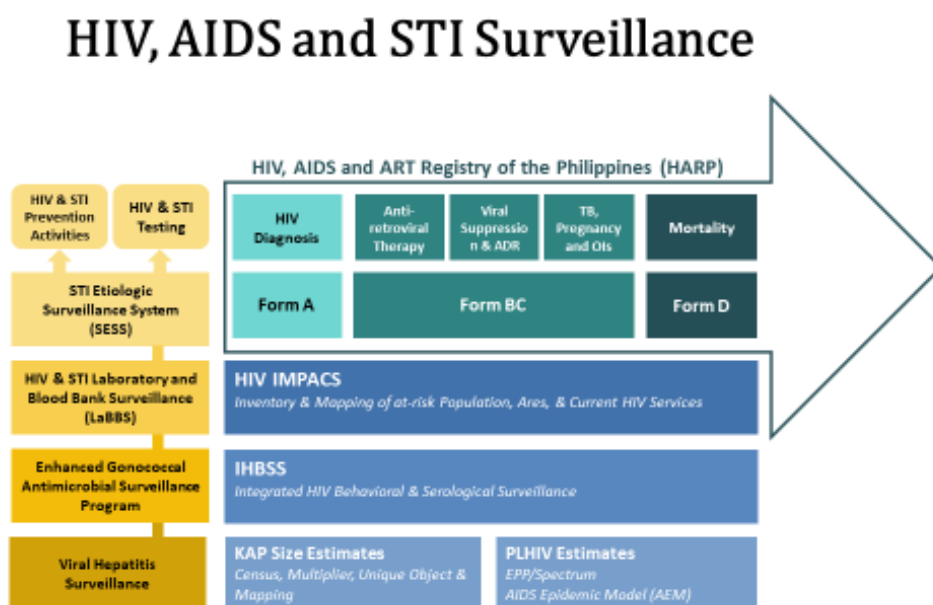
P50 million in 2013-2017 for infrastructure (3 new clinics, 3-storey)

4.2.2.2 Strategic Information Systems

The Philippines has a strong routine reporting system for communicable diseases and has developed in the last few years a very comprehensive surveillance system as presented in the graph below. The involvement of regional and local government technical staff in

implementation and use of the data to guide local decision-making is a key strength of the HIV surveillance system.

Figure 26: HIV and STI Surveillance System



Program reviews were undertaken for in 2013 and 2016, which provided recommendations on how to improve the strategic information system. Most of the recommendations made in 2013 and 2016 for SI have been implemented resulting to significant improvement in the quality of data available in the country. Currently, the main shortcoming in the information system is the still low coverage of eHARP in the country with only about 50% of the sites being able to develop the standard that was provided to by DoH-EB.

Background of the HIV Information System⁵⁷

In the Philippines, Republic Act 8504, otherwise known as the *Philippine AIDS Prevention and Control Act of 1998* legislated the establishment of a comprehensive HIV and AIDS monitoring program or AIDSWATCH under the Department of Health. Designated as the implementation arm for AIDSWATCH, the Epidemiology Bureau – National HIV/AIDS & STI Surveillance and Strategic Information Unit (EB-NHSSS) is mandated to determine and monitor the magnitude and progression of HIV infection in the Philippines through utilization of different surveillance systems. This mandate is reiterated in the new law Republic Act 11166, otherwise known as Philippine HIV and AIDS Policy Act of 2018 Article I Section 9.

⁵⁷ The discussion presented in the subsection on Strategic Information System is primarily based on the report of Dr. Jesus Maria Garcia Calleja, Consultant for HIV Epidemiological Review Philippines, 2019.

Since its implementation in 1998, the country has developed a strong surveillance system for tracking trends in HIV, based to a large degree on the principles of Second-Generation Surveillance, including facility sentinel surveillance and integrated HIV biological and behavioral surveys (IHBBS), key population size estimates (PSE), and routine data from programs and services. These data are used to:

Develop regular reports with very effective analysis, making it possible to track levels of HIV and STI, the risk behaviors and conditions of vulnerability that underlie HIV transmission, and the coverage levels of prevention, care, and treatment programs.

Through the surveillance data the DOH-EB is able to produce estimates and projections of the HIV and its impact across geographic areas and population subgroups, using the recommended tools and models developed by UNAIDS.

The surveillance system has also supported the strategic prioritization of programs through the classification of cities and regions under different categories into low, middle and high burden areas.

A limitation of the HIV surveillance system, when compared to international guidance for Second Generation Surveillance, is the limited efficiency for the reporting systems for HIV deaths. While models provide valuable projections of annual new cases and mortality, the limitations of mortality data from health facilities, due to stigma, makes it difficult to track progress toward eliminating HIV and the actual health impact of care and treatment. However, the new online HIV care and treatment digital system records events from HIV infection to death. The most recent trends of reported AIDS death from modeling work shows that is increasing in spite of an increasing coverage of ART among HIV infected population.

National HIV and STI case reporting systems (for etiological diagnosis of syphilis, hepatitis B and gonorrhea) are also in place with high coverage of health facilities. In 2018, coverage of the Sentinel STI Etiologic Surveillance System (SSESS) included 83% of public and private facilities reporting, exclusive of the Department of Health social hygiene clinics (SHC). Both the HIV and STI reporting systems capture data that allow disaggregation by age, sex and the most-at-risk groups tracked by the IHBSS. In addition, the HIV and AIDS registry captures initial CD4 and symptomatic versus asymptomatic cases to allow for disaggregation of cases diagnosed as advanced HIV infection. Tracking of HIV deaths began only in January 2013, with the introduction of national mandatory reporting of HIV deaths, so that there is currently very limited information on HIV mortality.

Contributions of HIV Surveillance and Surveys to National Program Strategy Implementation

- o ***HIV Sentinel Surveillance (HSS).*** Since 2019, facility survey has been incorporated - facility surveillance among people recently diagnosed, with the integration of a key behaviors questionnaires to the HIV case reporting form that is collected at the HIV testing facility services. Now this form is considered to be included in the eHARP registry system following recommendations from the HIV surveillance assessment conducted in 2016.

- o ***Integrated HIV Biological and Behavioral Surveys in Key Populations (IHBBS).***
Integrated HIV Biological and Behavioural Surveys (IHBBS) are important part of HIV surveillance in order to assess trends in key populations at elevated risk. KPs often face barriers to accessing services, and therefore may not be measured well by facility-based surveys.

The Integrated HIV Behavioral and Serologic Surveillance (IHBSS) exist in the current form since 2005 and consist of a range of studies in several key populations and geographical locations using Time Location Sampling (TLS) and Respondent-Driven Sampling (RDS)

- o IHBSS has fulfilled several surveillance functions in KPs:
 - Estimate HIV and STI prevalence
 - Measure levels of HIV-related risk behaviors
 - Determine levels of HIV-related knowledge
 - Assess uptake of HIV-related prevention services
 - Estimate the size of key populations (in combination with other data sources)
 - Monitor changes over time in all of the above
- o The 2015 IHBSS was the biggest so far, including 35 sites for M/TSM; 2 sites for TGW; 2 sites for male IDU; 1 site for female IDU; 1 site for Freelance FSW; 1 site for FEW; 4 sites for MEW.
- o Other elements and achievements of the HIV surveillance system in the Philippines are:
 - 2010: Rapid Assessment of HIV Vulnerability (RAV)
 - 2012: Initiation of Mortality Reporting Form
 - 2012: Laboratory and Blood Bank Surveillance (LaBBS)
 - 2013: Inclusion of ART to HIV/AIDS Registry (HARP)
 - 2014: Initiation of Linkage to Care reporting (baseline CD4 cell count) and TB-HIV reporting to the HIV Registry
 - 2014: Revision of all HIV Registry forms to include a unique identifier code (UIC)
 - 2015: Renaming of the HIV Registry to HIV/AIDS & ART Registry of the Philippines (HARP) and inclusion of viral load data & ARV drug resistance data in the reporting forms
 - 2015: Inventory and Mapping of at-risk Populations, Areas, and Current HIV Services (HIV IMPAC)
- o In 2018 a new round of IHBBS was conducted in 13 sites for MSM following the recommendations made in 2016 assessment. The following table provides an overview of the different surveillance components.

Table 5. Characteristics of the most recent IHBSS in key populations in Philippines

Key population/ vulnerable group	Operational definition	Rationale for inclusion in the IHBSS
Males and transgender women who have sex with males (M/TSM)	Sex assigned at birth is male, 15 years or older, and reported having oral or anal sex with another male in the past 12 months	Understanding behaviors of M/TSM is critical to the Philippine HIV response given that 83% of reported cases from 2015 to 2017 were among M/TSM.
Female sex workers (FSW)	Sex assigned at birth is female, 15 years or older, has accepted payment (cash or kind) in exchange for sex in the past 30 days with a male	The IHBSS including registered female sex workers has been conducted last 2013, it is necessary for an IHBSS to be conducted among this key population in order to monitor and determine any change in prevalence or risk behavior. This 2018 IHBSS also aims to explore the transition of the FSW IHBSS to a case-based surveillance.
Individuals in closed settings	Age 18 years old or older, who have been in prison for one month or more, and physically and mentally capable of providing informed consent	Individuals in closed settings were also identified as a vulnerable population to HIV by WHO in 2018. Furthermore, there is a need to generate data on the need for HIV services in jails.

Population Size Estimates of Key Populations (PSE)

UNAIDS and WHO recommend using several methods and triangulating the results, since estimating the size of KPs is one of the most challenging tasks of HIV surveillance, and all available methods have considerable statistical error and potential for bias. The country has developed a robust approach to PSEs in line with this guidance to support epidemiology and local planning and targeting of interventions. The last Philippines's population size estimates for KPs exercise was done in 2015. These estimates are within the range of estimates in the Asia and Pacific region⁵⁸. This PSE was done with mapping, unique object distribution, program multiplier and extrapolation

⁵⁸ UNAIDS: *Quick Start Guide for Spectrum* for 2018 (p. 29).

- **Model-based Estimates and Projections.** The AIDS Epidemic Model (AEM) and Spectrum package recommended by UNAIDS and WHO are being conducted in the country. The models produce estimates of the prevalence of HIV, new infections, and estimates of impact such as AIDS deaths, overall and among key populations. AEM also draws on behavioral data (e.g., condom use, number of risk partners). Much of the data used to calibrate the models is from the IHBBS and HSS surveys. AEM produces an incidence curve, which is input to Spectrum to produce a set of standard impact indicators. Program data such as number of people on ART and PMTCT also feed into the impact calculations. The most recent AEM-Spectrum estimates and projections in Philippines were conducted in April 2019. Philippines will revise nationwide model with the addition of new information provided by the IHBBS and facility survey. This will be done in October 2019.
 - The AEM model conducted so far is structured to develop 5 subnational models estimates for different regions:
 - NCR: 16 cities and a municipality
 - Cebu Province: three independent cities (Cebu, Mandaue and Lapu-lapu), six component cities, and 44 municipalities
 - Category A: 14 highly urbanized cities based on Philippine Statistics Authority (PSA); six cities with an HIV prevalence of 5% in any of the KP or higher based on the 2015 IHBSS; 27 cities and municipalities with more than 50 diagnosed HIV cases from January 2010 to June 2016
 - Category B: 174 cities and municipalities with 10 to 49 diagnosed HIV cases from January 2010 to June 2016
 - Category C: 1,341 cities and municipalities with less than 10 diagnosed HIV cases from January 2010 to June 2016
 - In addition, city-specific models were developed to provide local governments with a clearer picture of their HIV epidemic and provide them with response options. The six cities include: Angeles, Cagayan de Oro, Cebu, Davao, Iloilo and Quezon.
- **Program data and health information systems.** Data from government programs and implementing partners regarding the number of people reached by prevention and treatment services is not technically surveillance data, but represents a critical input to models on the impact of HIV and estimates of program coverage. For example, program data have allowed Philippines to document the rapid, increase in coverage of HIV testing and treatment between 2010-2018. Decentralization of HIV testing and treatment makes reporting and analyzing of program data more challenging, and therefore a more important achievement. Program-based monitoring is also challenging and not yet fully undertaken. As expressed by some providers in the Visayas: “We are not doing program monitoring yet, it is basically Global Fund project-based monitoring.”
 - Philippines produces regular monthly progress reports based on data compiled from programs. The reports contain detailed analysis, including numbers reached and percent coverage of:
 - New HIV diagnosis with trends, geographical with age and gender disaggregation
 - ART initiation and people current on ART

- Estimated modes of transmission
 - PMTCT
 - HIV related deaths
- o Operation of eHARP or the electronic system. The eHARP system allows to produce cascade of treatment with the three nineties at facility level and regions and central level can produce aggregate data. It does also include a unique identifier code that allows reduplicating and referring patients to other regions or health centers. During the field visits, the users in the centers with eHARP mentioned their utility and the low number of duplicates. Data clerks however perform a regular data cleaning and point out that was time consuming.

The eHARP has been introduced in more than 50% of the health facilities that provide ART to HIV patients and priority has been given to the facilities with the highest number of people on treatment. In two health centers visited in NCR, it was noted that the system is performing well and users are very satisfied with the progress despite the glitches

In other sites visited, the existence of an operational eHARP was mentioned though still nonfunctional for some sites because of issues with availability of internet and computer compatibility. This is a big issue for facilities lacking capacity for systematic record keeping and archiving, especially those related to the transfer of client records between HIV services.

4.2.2.3 Financing

Since 2013, the Philippine government has steadily fulfilled its commitment to increase funding allocation for HIV Program. As shown in the 2017 National Situational Assessment of HIV Financing in Philippines, the government budget for HIV accounted for 73% of total resources in 2015 compared to 26% from external sources (Global Fund, USAID and UN agencies). The government's total spending on HIV from 2011-2015 has increased mainly due to an increase in domestic spending by the central and local government and the private sector⁵⁹.

Source	2011 USD	%	2012 USD	%	2013 USD	%	2014 USD	%	2015 USD	%
Public	4,181	33%	4,655	48%	4,523	44%	11,035	61%	13,032	73%
External	3,872	31%	4,966	51%	5,810	56%	6,922	38%	4,582	26%
Private	4,593	36%	23	0.2%	18	0.2%	108	1%	195	1%
Total	12,647	100%	9,644	100%	10,351	100%	18,065	100%	17,808	100%

Table: Sources of HIV/AIDS Programme financing, 2011-2015 (in thousand USD)

As reflected in the National Objectives for Health, 2017-2022, the “total health expenditure in

⁵⁹ SHIFT. National Situational Assessment of HIV Financing in Philippines, 2017.

the Philippines grew by 39 percent to PhP655.1 billion from 2012 to 2016. Government expenditures likewise increased owing to incremental revenues from sin taxes allocated for health, which led to a dramatic increase in Phil Health coverage from 84 percent in 2012 to 91 percent in 2016. Nonetheless, the huge share of out-of-pocket (OOP) payment (52.2 percent) still dwarfed the share of government subsidies (18.9 percent) and Phil Health social insurance (16.7 percent) to total health expenditures, undermining financial protection”⁶⁰.

The NASPCP budget has historically increased by up to 200% annually. The HIV Prevention and Control Operational Plan 2018-2020 reflects an increasing government budget of US\$47M by 2018, US\$56M by 2019, and US\$ 72M by 2020⁶¹. The Philippine National AIDS Council (PNAC) is tracking HIV budget allocation and spending since 2005 through the National AIDS Spending Assessment (NASA). Despite its limitations NASA Report has provided important information to influence program planning and prioritization. The PNAC Secretariat intends to institutionalize NASA reporting by tracking agencies’ HIV expenditures through the integration of financial monitoring in the Monitoring and Evaluation Plan of the 6th AMTP The Philippine National AIDS Council (PNAC)⁶².

As clarified in the 2017 Funding Request for Global Fund grant, despite the increasing HIV budget, the national program is still facing a substantial financial gap amounting to US\$55M, of which approximately US\$24M was for 2018, US\$15M in 2019, and US\$16M in 2020. The 3-year projected national domestic resource requirement for HIV totaled to US\$324M, and of this US\$ 89M was for year 2018, US\$101M for 2019 and US\$134M for 2020. The non-GF external funding resources is \$1.4M for 2018, \$1.4 for 2019, and \$1.4 for 2020. For 2018-2020, the needed HIV funding is US\$46 M: US\$ 21M for 2018, US\$ 12M for 2019, and US\$13M for 2020.

Global Fund Contribution

Since 2004 Global Fund has been the biggest contributor to National HIV Response (See Table 6). Save the Children in the Philippines is implementing⁶³: the current grant that is focused on key population: “ Accelerating Community Engagement and Response on HIV and AIDS Prevention (ACER) with total committed funding of US\$21,232,540.65. This grant is described as having a good mix of prevention and treatment. The Global Fund Technical Review Panel (TRP) stated that:

The request “provides a strategic framework comprising Reach-Screen-Test- Enroll-Adhere to ART (RSTEA) interventions based on lessons learned from the previous Global Fund grants, acknowledges the limitations of the current prevention approach... [and] proposes ... a shift in the testing strategy to more community-based approaches and rapid methods and plans to engage community health outreach workers.” “The TRP said that in recognition of the critical importance of addressing human rights-related barriers to accessing HIV and TB services, the funding request will implement a three-prong gender-sensitive approach,

⁶⁰ Department of Health (DOH), National Objectives for Health, 2017-2022.

⁶¹ HIV Prevention and Control Operational Plan.

⁶² *Ibid.*

⁶³

www.aidsplan.org/gfo_article/philippines'-hiv-funding-requestglobal-fund-contains-good-mix-prevention-and-treatment.

which includes: (a) high level advocacy for policy reform; (b) rights-based, age- and HIV-sensitive program delivery capacity building; and (c) the expansion of legal frameworks.”

Table 6. Global Fund contribution to National HIV Response, Philippines 2004-2015⁶⁴

Type of funding	Grant Title	Duration	PR	Amount	Rating
PHL-304-G03-H	Accelerating STI and HIV prevention and care through intensified delivery of services to vulnerable groups and people living with HIV in strategic areas in the Philippines	2004-2010	Tropical Disease Foundation Inc.	US\$ 5,262,179	A1 = closed
PHL-506-G04-H	Upscaling the national response to HIV/AIDS through the delivery of services and information to populations at risk and people living with HIV/AIDS	2006-2010	Tropical Disease Foundation Inc.	US\$ 4,279,597	A1=closed
PHL-607-G08-H	Scaling Up HIV Prevention, Treatment, Care and Support Through Enhanced Voluntary Counseling and Testing and Improved Blood Safety Strategies	2007-2015	Department of Health	US\$ 19,706,935	B1=financial closure
PHL-509-G10-H	Upscaling the national response to HIV/AIDS through the delivery of services and information to populations at risk and people living with HIV/AIDS	2010-2012	Department of Health	US\$ 1,086,949	A2=closed
PHL-HIV-NFM	Philippines HIV NFM Grant	2015-2017	Save the Children Federation, Inc.	US\$ 14,047,183	B2= active
TOTAL SIGNED				44,382,843	
TOTAL COMMITTED				36,729,270	
TOTAL DISBURSED (as of December 5, 2016)				34,102,777	

Philippine National Health Insurance (Phil Health) - Outpatient HIV/AIDS Treatment (OHAT)

Overall, all the sites visited confirmed that OHAT is beneficial to clients who are Phil Health members and to Phil Health-accredited facilities. However, they also pointed out that the separate Trust Fund for OHAT has not yet been implemented which prevent the facilities/HACT Team from fully accessing OHAT.

⁶⁴ Gotsadze, T. The Philippines HIV/AIDS Program Transition from Donor Support, Transition Preparedness Assessment Country Report. Curatio InternationalFoundation, 2017.

The Philippine Health Insurance Corporation (Phil Health) was created by virtue of the National Health Insurance Act of 1995. Phil Health aims to provide health insurance coverage for all Filipinos but enrolment was not made compulsory. It was amended in 2013, expanding the contribution- based national health insurance program (NHIP) beyond formal employment to include the underprivileged, sick, elderly, persons with disabilities (PWDs) and women and children. It strengthened the roles of the LGUs and health providers in NHIP enrolment⁶⁵.

OHAT was introduced in 2010 by the Philippine National Health Insurance Corporation (Phil Health) in support of the United Nation's Millennium Development Goal number 6 and as the government's response to the prevalence of HIV/AIDs in the country. This benefit aims to increase the proportion of the population having access to effective HIV/AIDS treatment and patient education measures (Phil Health Circular 011-2015)

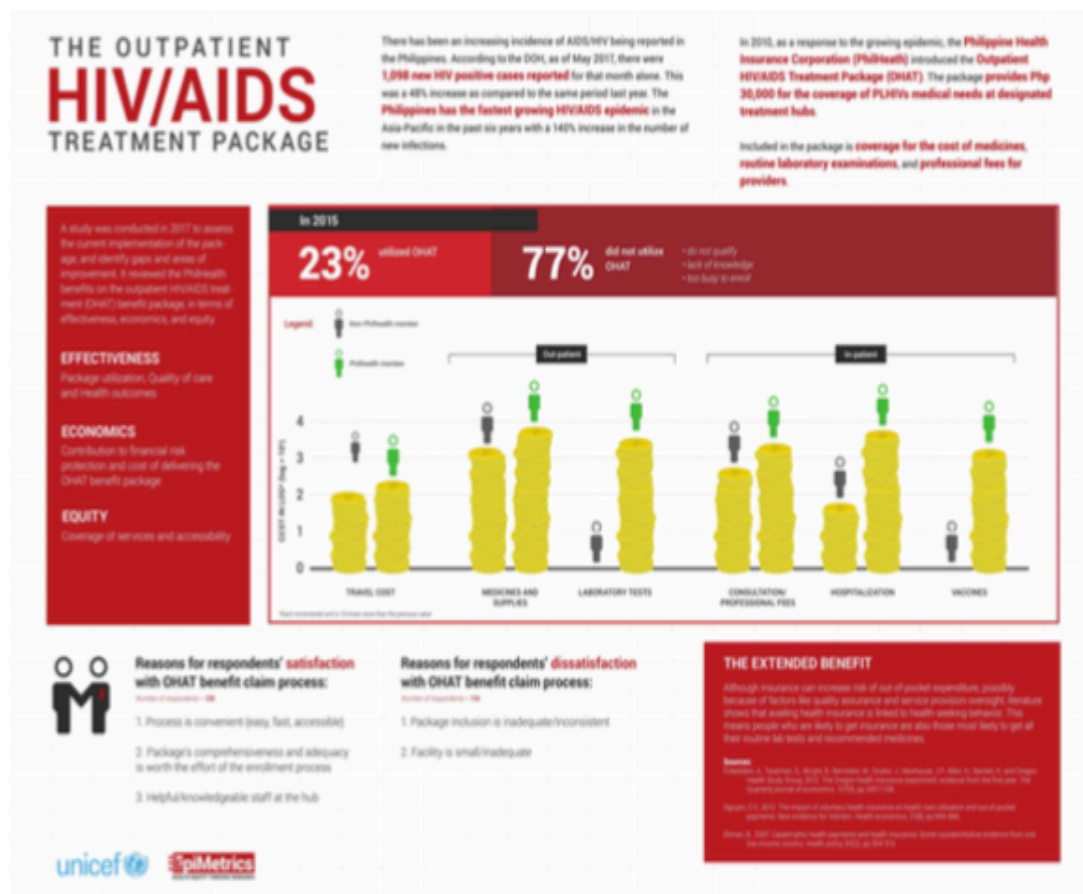
The package provides Php 30,000 annual case rate, released quarterly, for eligible PLIV's medical needs at DOH-designated treatment hubs. The guidelines for OHAT's provider accreditation and benefit delivery are defined in Phil Health Circular 19, s 2010 which was later improved and amended in Phil Health Circular 011, s 2015 to align it with their "All Case Rate Policy". The coverage included cost of medicines and laboratory examinations including the CD4 level determination test and the anti-retroviral drug toxicity monitoring test, and professional fees for providers.

Aside from Phil Health members, non-members who are indigent can avail of the OHAT package under the following conditions:

- A non-Phil Health member who is indigent and who gets hospitalized can get into the Point of Care Program of Phil Health, in which the entire year of membership is waived to avail of the OHAT package. All hospitals know this and the family members of the client just need to go to the social worker for assistance.
- A non-Phil Health member, who is indigent and wants to avail of the OHAT and is not hospitalized, can go to the Department of Social Welfare and Development and⁶⁶ have his or her name listed in the its indigent program. This list is submitted every year to Phil Health and Phil Health then waives the membership of all indigent clients in the list for a year.
- A non-Phil Health member who is indigent can request assistance from his or her local government agency for assistance. Some cities in the National Capital Region pay for Phil Health memberships to their indigent residents.
- A non-Phil Health member who is indigent can request assistance from his or her mayor, barangay captain, congressman and senator for Phil Health payments.

⁶⁵ Department of Health (DOH). National Objectives for Health, Philippines 2017-2022.

⁶⁶ Project Red Ribbon. Living with HIV in the Philippines. Retrieved from: pozzeipinoy.blogspot.com/2017/01/philhealths-ohat-package-benefits.html.



In 2017, a study called “Epimetrics: OHAT Review” was conducted to assess the implementation of OHAT and identify gaps and areas of improvement. Among the reasons of respondents’ satisfaction with OHAT benefit claim are convenient process, comprehensive and adequate package, and helpful and knowledgeable staff at the hub. On the other hand, inadequate package inclusion and small facilities are the reasons cited for dissatisfaction with OHAT.

Through the review, it was found that PLHIV benefit from the package in terms of access to services and medications and is effective in covering for first line of treatment and for the primary need for laboratory tests. All PLHIV are eligible to avail of the OHAT package regardless of Antiretroviral Therapy (ART) status or insurance membership, provided they received confirmation from the STD/AIDS Cooperative Central Laboratory in San Lazaro Hospital, and were 18 years old and above. ART is offered free of charge by DOH but is only available at designated hubs or satellite clinics. These baseline lab tests are crucial for PLHIVs to qualify and provide them access to the OHAT package.

Table 7. Comparison of out-of-pocket expenditure and Phil Health Membership⁶⁷

CHARACTERISTICS	PhilHealth Non-Member (n=33)	PhilHealth Member (n=326)	Total (n=359)
	Mean ± SD		
Incidence of Out-of-Pocket* (n(%))	25 (9)	266 (91)	291 (81)
Travel Cost	102.8 ± 89.5	175.2 ± 223.8	168.8 ± 216.1
Travel Time (in minutes)	52.2 ± 52.3	113 ± 110.6	107.6 ± 108.1
Out-of-Pocket Cost***	2154.9 ± 3.6	7963.6 ± 4.9	19116.05 ± 45637.1
BREAKDOWN OF OUT-OF-POCKET COSTS			
Medicines and supplies***	1134.9 ± 2580.9	7155.6 ± 18040	6586.3 ± 17271.6
Laboratory tests***	1026.1 ± 1156.7	3552.1 ± 6435	3305.5 ± 6168
Consultation/professional fees	560.6 ± 798	2773.7 ± 14312.5	2555 ± 13603
Hospitalizations	62.5 ± 353.6	6757.9 ± 27085.1	6118.4 ± 25830.4
Vaccines	0	1177.2 ± 2950.7	1066.3 ± 2828.8
Others, specify	140	8764.1 ± 14035.3	8389.2 ± 13830
NOTE: *Reported by n(%)			
***The log of out-of-pocket cost (direct medical only), medicines and supplies, lab tests were calculated to be different between member and non-member (p<0.0005). Reported values were also computed to normal (non-base).			

4.2.2.4 Human Resources

All respondents in the sites visited consider the presence of KP-competent staff essential. The human resource-facilitating factors gathered during the review include the following:

- Case Managers are available beyond office hours; meet clients in neutral place where anonymity is secure.
- Peer counselors who are part of the KP are included in testing resulting to a KP-friendly environment.
- Availability of CBS trained community outreach workers.
- Peer counselors conduct targeted KP community-based screening, which is beyond their job description.
- Readiness of the facility to implement rHIVDA.
- Presence of KP competent staff who has awareness of how to reach KP and the importance of HIV Care package.
- Capacity for integration of HIV Education in maternal, TB Program and adolescent and sexual reproductive programs (ASRH).
- FSW and Male Sex Worker program are in place.
- Trained staff in facility-based screening.
- Gender sensitivity in the clinic.
- Conduct of quality assurance through client satisfaction form and annual evaluation.

⁶⁷ Review of OHAT Package of PHIC. Retrieved from: <https://www.epimetrics.com.ph/projects/phic-ohat>

4.2.2.5 Legal/Policy/Social Environment

Contributions of National Laws to National HIV response

Philippine AIDS Prevention and Control Act or R.A. No. 8504 (1998) - passed into a law on February 13, 1998. It defines Acquired Immune Deficiency Syndrome (AIDS) and the extent of its gravity. The law emphasizes the need for strong state action, e.g. promotion of public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV/AIDS through a comprehensive nationwide educational and information campaign, and extension of support and full protection of human rights and civil liberties to every person suspected or known to be infected with HIV/AIDS.

Among the key contributions of R.A. No. 8504 are⁶⁸:

- Institution of a nationwide HIV/AIDS information and educational program (Section 2 a, Article I, Sections 4-11), education and information (Section 2 a, Article I, Sections 4-11);
- Promotion of safety and universal precautions in practices and procedures that carry the risk of HIV transmission (Section 2 c; Article II, 12, 13, 14);
- Eradication of conditions that aggravate the spread of HIV infection (Section 2 d);
- Provision of health and support services to persons with HIV-AIDS (Article IV);
- Establishment of a comprehensive HIV/AIDS monitoring system (Article V); and
- Strengthening the Philippine National AIDS Council (Article VIII)

Universal Health Care Law or R.A. No. 11223, An Act Institutionalizing Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System – passed on February 20, 2019 with the objectives to:⁶⁹. a) Progressively realize universal health care in the country through a systemic approach and clear delineation of roles of key agencies and stakeholders towards better performance in health system; and b) Ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and protected against financial risks

- Important contributions of UHC Law are⁷⁰:
 - UHC clarified the roles of the Department of Health and LGUs, which is the delivery of 'Population Based Services' e.g. Interventions, such as health promotion, disease surveillance, and vector control that address population wide concerns; while Phil Health covers 'Individual Based Services' which refers to services that can be accessed within a health facility or remotely and can be definitively traced back to one recipient⁷¹.
 - "Immediate eligibility" for Filipinos and have access to the full spectrum of health

⁶⁸ de Jesus, Armando F. et al. National and Local Policies Related to AIDS and Drug Use: Content Review and Assessment, December 2012.

⁶⁹ Republic of the Philippines, Congress of the Philippines. R. A. No. 11223. Manila, 23 July 2018.

⁷⁰ Ranada, Pia. Duterte signs universal health care law, 20 February 2019. Retrieved from <https://www.rappler.com/nation/223942-duterte-signs-universal-health-care-law>

⁷¹ NEDA. Universal Health Care Law and what it means to PH development, June 18, 2019. Philippine Information Agency. Retrieved from <https://pia.gov.ph/news/articles/1023412>

- care - preventive, promotive, curative, rehabilitative, and palliative care for medical, dental, mental, and emergency health services.
- o Patients would be registered with a primary health care provider of their choice, for outpatient care, medicines, and laboratory tests - included in Phil Health's primary care benefits package.
- o Direct contributory members would also get more benefits as premiums increase -intended to encourage those who pay higher premiums and those who are voluntarily paying.
- o Membership rates would also gradually increase by .5% yearly, while income ceilings for contributions would go up by P10,000 per year.
- o Phil Health payments for local government unit (LGU) hospitals would be set-aside in a special fund to improve the health facilities in LGUs.

Republic Act No. 10606, An Act Amending Republic Act No. 7875, Otherwise Known As The "National Health Insurance Act Of 1995", As Amended, And For Other Purposes – established in 1995 to adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost and to provide free medical care to paupers. Towards this end, the State shall provide comprehensive health care services to all Filipinos through a socialized health insurance program that will prioritize the health care needs of the underprivileged, sick, elderly, persons with disabilities (PWDs), women and children and provide free health care services to indigents.

Its major contribution was the implementation of an outpatient HIV/AIDS treatment package. This benefit aims to increase the proportion of the population having access to effective HIV/AIDS treatment and patient education measures.

Republic Act No. 11166, An Act Strengthening the Philippine Comprehensive Policy on Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Prevention, Treatment, Care, and Support, and, Reconstituting the Philippine National Aids Council (PNAC), Repealing for the Purpose Republic Act No. 8504, Otherwise Known as The "Philippine Aids Prevention and Control Act of 1998", and Appropriating Funds Therefor – passed on December 20, 2018, and the Implementing Rules and Regulations was signed on 22 February 2019. One of the most important provision of RA 11166 is allowing teenagers from 15 to 18, or even younger if they are pregnant or engaged in high-risk behavior to undergo HIV testing without parental consent⁷².

Further the new law ensures protection of PLHIV's basic human rights, which include the affordable access to health services without the fear of being discriminated. RA 11166 also addresses stigma through education and awareness not only to prevent the spread of the disease but also for destigmatization. Bullying and discrimination of PLHIVs based on actual, perceived, or suspected HIV status will be prohibited. PLHIVs right to fair employment and livelihood, protection and confidentiality, and peer-led counseling, support, and case management are guaranteed under the new law.

⁷² Beyond the new HIV and AIDS Law. Read more: <https://opinion.inquirer.net/118930/beyond-the-new-hiv-and-aids-law#ixzz63zX2UfJu>

Local Ordinances on HIV and AIDS

The implementation of the provisions of national policy lies at the local level lies and largely on the shoulder of local government units. For this to happen, the provisions of national law “need to be worked into the local legislation so that the local responses to the AIDS problem would not only gain legitimacy but also obtain the needed budgetary support”⁷³.

Ordinance/Resolution/Executive Order	Year of Promulgation
On HIV and AIDS	
▪ City Ordinance No. Sp 1053, S. 2001, Quezon City	2001
▪ Resolution No. 02-2140, Approving Ordinance No. 1952, Cebu City	2002
▪ City Ordinance No. 041-02, Series of 2002, Davao City	2002
▪ City Ordinance No. 23421, Series of 2002, Pasay City	2002
▪ Executive Order No. 30 Providing for The Rules and Regulation Implementing the Davao City Aids Ordinance 2002 and for Other Purposes, Davao City	2003
▪ City Ordinance No.2003-053, City of Naga	2003
▪ Municipal Ordinance Number 5, Series of 2004, Bauang, La Union	2004
▪ Municipal Ordinance No. 2005-05, Isabel, Leyte Province	2005
▪ Resolution No. 41 S. 2005, Municipality of Matnog, Sorsogon Province	2005
▪ City Ordinance No. 2005-026, City of San Fernando, Province of Pampanga	2005
▪ Resolution No. 338, Series Of 2005, Enacting City Ordinance No. 002, Series Of 2005, City of Sorsogon	2005
▪ City Ordinance No. 03-2005, Tabaco City	2005
▪ City Ordinance No. 249, Series 2006, Surigao City	2006
▪ Resolution No. 1734-2006, Enacting Ordinance No. 320-2006, Lapu-Lapu City	2006
▪ City Ordinance No. 1896-2007, Dagupan City	2007
▪ Municipal Ordinance No. 28, Series of 2008, Maribojoc, Bohol Province	2008
▪ City Ordinance No. 8179, City of Manila	2009
▪ Provincial Ordinance No. 04, 2010, Province of Guimaras	2010
▪ City Ordinance No. 298, S-2011, Angeles City	2011
▪ Provincial Resolution No. 295-2011, Province of Cebu	2011
▪ Resolution No. 2011, 226. Sipalay City	2011
▪ Executive Order 96-12 of Ilocos Norte	2012
▪ Makati City	Undated
On Drugs	
▪ Resolution 779 approving Ordinance No. 1427, Sangguniang Panglungsod ng Cebu City	1992

4.2.2.6 Good Practices

Central to the good practices mentioned by program managers, health care workers, KPs and PLHIV in all the sites visited is the engagement of CBO-KP and the strong collaboration among the National Programs (NASPCP and EB), Regional CHD, LGUs, CSO-KPs. The good collaboration

⁷³ De Jesus, Armando F. et al. National and Local Policies Related to AIDS and Drug Use: Content Review and Assessment, December 2012.

between CBOs and Treatment hubs in outreach through Conduct of regular HIV IEC activities in schools, barangays, city jail, police personnel, work places and entertainment establishments is considered a key ingredient in the progress of the program.

Some of the examples cited here are meant to highlight their contributions in the implementation of program intervention strategies and activities.

- **Utilization of Peer Education approach.** This provides support to the client especially for those who are hesitant to access the service, and this was facilitated by the availability of Volunteer pool to provide the peer-to-peer approach. As pointed out by respondents in Mindanao, NCR and Luzon, the peer education activities implemented in 2015-2017 were very useful because the provider is part of KP and understands the need of the KP.
- **PrEP Pilot project implementation**
 - WHO is supporting the HIV clinic of the Research Institute of Tropical Medicine (RITM) of the Department of Health (DOH) to implement a PrEP pilot project in a peer-driven HIV testing clinic in Manila. In November 2015, WHO conducted site assessments and meetings with relevant government and nongovernment stakeholders, including DOH, Philippines Food and Drug Administration, The Joint United Nations Programme on HIV and AIDS, LoveYourself Inc.⁷⁴.
 - Another initiative on PrEP was the demonstration project conducted between 2017 and 2019 by LoveYourself, which showed that this new HIV prevention method is safe and effective. This was undertaken with the DOH, Research Institute for Tropical Medicine, The Global Fund to Fight Against AIDS, Tuberculosis and Malaria, amfAR, UNAIDS, and the World Health Organization.
 - The facilities in Region 3 have begun to recommend PrEP to eligible clients. One of the facilities provides free clinical consultations and all labs free of charge. Better pricing has been negotiated with a local pharmacy. PrEP posters were displayed in appropriate areas, and all testing clients were advised on PrEP. The cost of PhP 1,200 per month is reported as prohibitive for most patients. Several providers mentioned that community based PrEP would be well accepted⁷⁵
- **Community Based Screening (CBS)** is mentioned in all sites visited where it is being implemented as a good practice for its effectiveness in reaching KPs for HIV testing. The table below shows the accomplishment of Save the Children in CBS for MSM in 2018.

⁷⁴Strengthening the fight against HIV in the Philippines. Retrieved from:

http://www.wpro.who.int/philippines/mediacentre/features/strengthening_fight_against_HIV_Philippines/en/.

⁷⁵ From the notes of Dr. Melinda Wilson, Consultant USAID/PEPFAR, member JPR Luzon Team, September-October 2019.

Table 8. Save the Children Global Fund Accomplishment, 2018 National MSM



2018 National MSM

	Row Labels	CBO	LGU	Total		Row Labels	CBO	LGU	Total	% Contribution to Testing			
Facility	Tested	10,750	11,353	22,103	Facility	Tested	10,750	11,353	22,103	Facility	58%	20%	30%
	Reactive	1,393	1,072	2,465		Reactive	13.0%	9.4%	11%	Outreach/Community	8%	59%	46%
	Unlinked to Care	714	792	1,506		Unlinked to Care	51%	74%	61%	CBS	35%	21%	24%
	Enrolled to Treatment	456	565	1,021		Enrolled to Treatment	33%	53%	41%				
Outreach/Community	Tested	1,408	33,124	34,532	Outreach/Community	Tested	1,408	33,124	34,532				
	Reactive	23	301	324		Reactive	1.6%	0.9%	1%				
	Unlinked to Care	4	123	127		Unlinked to Care	17%	41%	39%				
	Enrolled to Treatment	3	85	88		Enrolled to Treatment	13%	28%	27%				
CBS	Tested	6,450	11,519	17,969	CBS	Tested	6,450	11,519	17,969				
	Reactive	238	187	425		Reactive	3.7%	1.6%	2%				
	Unlinked to Care	153	109	262		Unlinked to Care	64%	58%	62%				
	Enrolled to Treatment	132	65	197		Enrolled to Treatment	55%	35%	46%				

- **ART Delivery through Electronic Consultation.** The experience of Sustained Health Initiatives of the Philippines (SHIP) on delivery of ART is worth examining to address adherence to treatment issues⁷⁶:

ANTIRETROVIRAL THERAPY – ELECTRONIC CONSULTATION (ART-EC)

SHIP Clinic: Established in 2013 as an HIV primary care clinic that has provides testing, laboratory facilities, medical consultation, and antiretroviral dispensing, with the aim to bridge gaps in the HIV healthcare system.

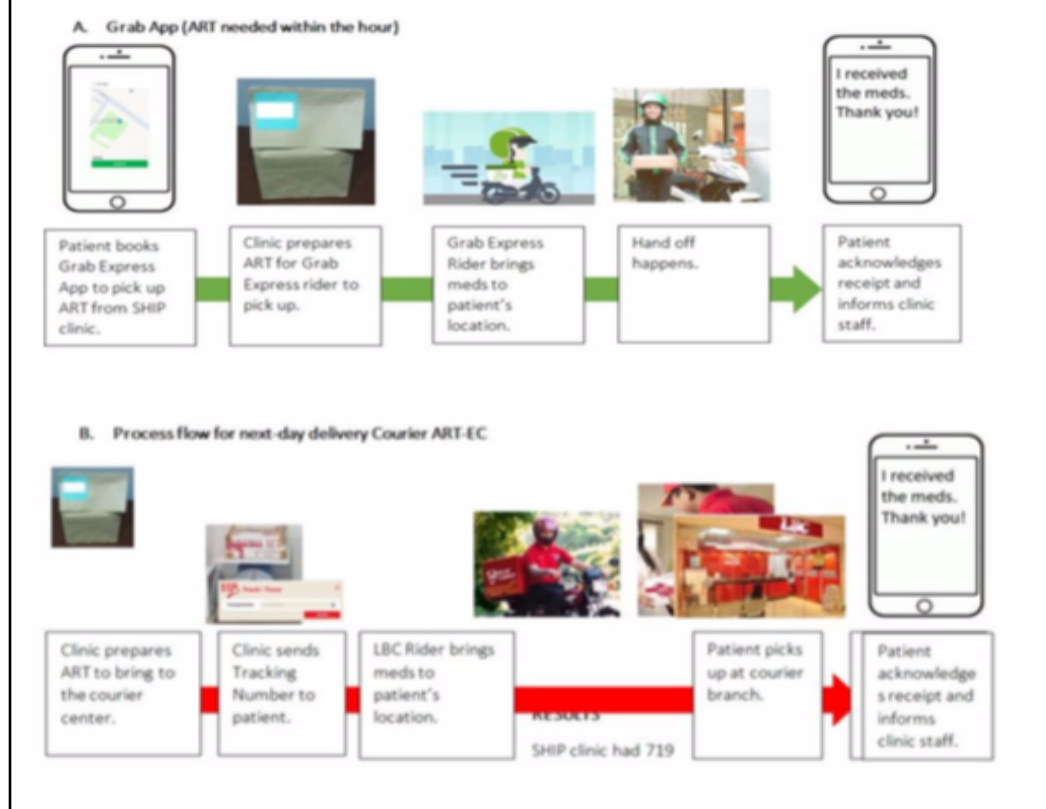
ART Refill Delivery in 2014 - SHIP Clinic started to offer ART refill delivery via courier service to clinically stable clients and as needed medical consultation via telemedicine (ART-EC). Clients from Metro Manila, Visayas and Mindanao have benefited from the ART refill delivery via courier service as well as telemedicine via popular messaging apps such as Skype, Viber and Zoom. Initially offered to clients who reside outside the city or abroad and to clients who cannot make their appointments and run out of ART due to unforeseen circumstances.

Documentation and roll-out of ART-EC - International AIDS Society Differentiated Service Delivery project provided such an opportunity to explore the benefits of ART-EC beyond distance medicine, and possibly provide an escape from the everyday crippling traffic in the Metro Manila area that presents another barrier to healthcare access.

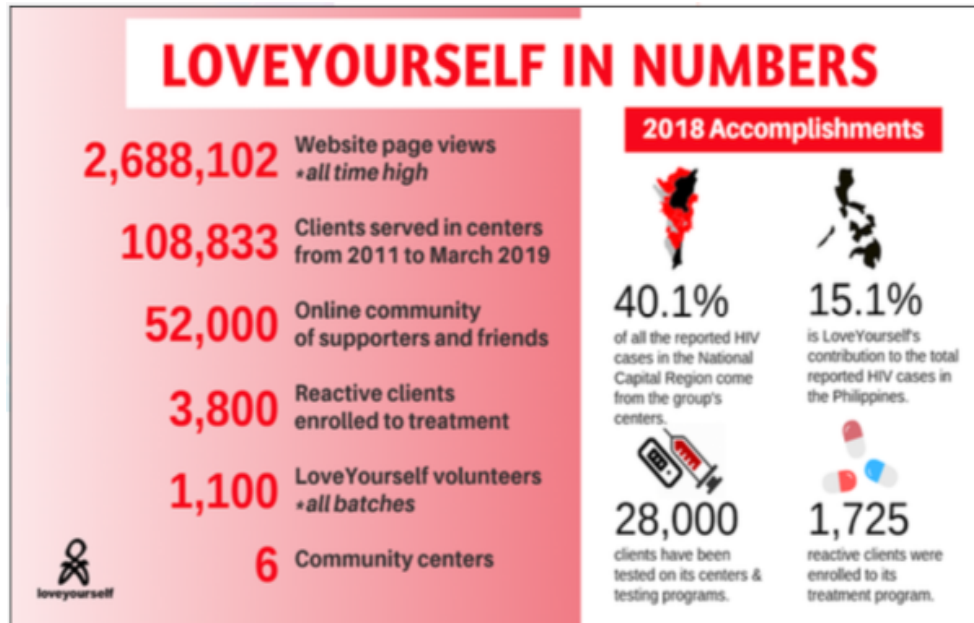
Procedure - Clinically stable patients are seen at the clinic every 6 months for routine consultation, laboratory tests and ART refills. On routine follow up, the clinic case manager offers to clients the option to have their next follow up schedule as an e-consultation. The

⁷⁶ SHIP. Antiretroviral Therapy – Electronic Consultation (ART-EC). Retrieved from: www.ship.ph/art-ec/

ART refills are provided as out-of-facility individual model. ART refills are delivered at the clients' registered address by a local courier service, or picked up at a courier branch of the client's choosing.



- **Differentiated Care Approach for MSM.** In the Philippines, LoveYourself is implementing a differentiated care approach for MSM with good results:



- Social Media.** Currently, there is an increased use of social media through Facebook among HIV treatment hubs, social hygiene clinics, community-based organizations (CBOs) and NGOs for the implementation of their prevention and treatment interventions. Below are some examples of Facebook account on HIV prevention and treatment programs.



- DOH Condom Safe Places** – a program that offers free condoms and lubricants. It also serves as a referral mechanism to the nearest testing/screening facility in the area. The characteristics of a safe place are as follows:
 - Can be a private or government owned establishment voluntarily agreed to become a DOH Safe Place.

- o Accessible not only to patron clients but also to the general public especially to the member of the Key Population.
- o Must have an ideal location and working/ operational hours.
- o The process of identifying the ideal Safe Place include:
 - DOH Community Mobilizers will scout/ identify an establishment as potential partner.
 - Offer and explain the purpose of a safe place to the owner or management of the establishment.
 - Submit profile including location, contact person and contact detail to the Regional HIV Program Staff.
 - Program staff will validate and assess the area/ establishment.
 - Conduct short orientation to the owner/ management. Give supplies and assign community mobilizer/s for monitoring, follow-up and refill of logistics.

Below is an example of Safe Places in Baguio City⁷⁷.



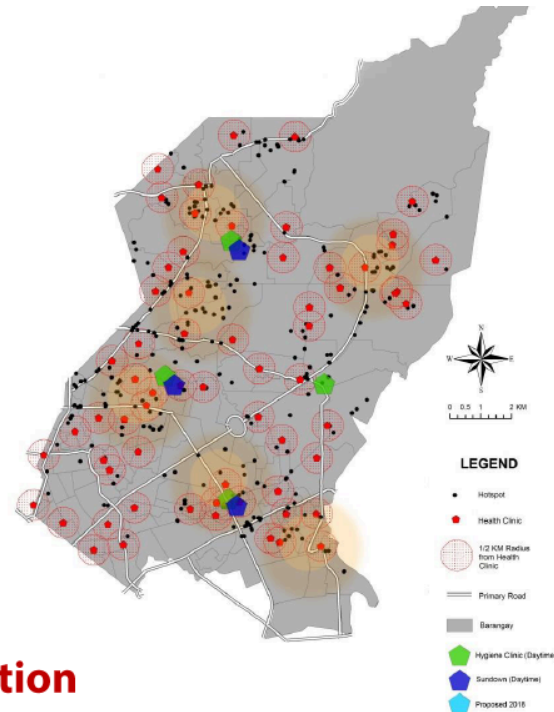
- ***Sundown clinic*** is another good practice identified by KPs and providers in sites visited that are operating this type of intervention.

⁷⁷ Babon, Darwin F. STI, HIV and AIDS Updates. DOH-Center for Development, Cordillera Administrative Region (CAR)

2014-2018

**4 Sundown
Clinics**

3pm-11pm



Strategic Information for Action

4.2.3 Key Barriers to Access of HIV Services

Barriers to access of HIV care and services that were identified during the review include: health system factors, financial constraints, psychological and social barriers, and legal/policy-related barriers.

4.2.3.1 Health System Factors

According to WHO⁷⁸, “key operational issues need to be considered and addressed in order to improve linkage to care, including better partnerships between community and clinical providers and increased efforts to improve the quality of services”.

In this review, the following health systems-related barriers affected the implementation of HIV program strategies:

Procurement and Supply Management (PSM) Issues

⁷⁸ WHO. Consolidated Guidelines on The Use of ARV Drugs for Treating and Prevention of HIV Infection. Recommendations for a Public Health Approach, Second Edition, 2016.

Critical stock-outs of ARV and inadequate supply of HIV testing kits, reagents and condoms in 2018 to early part of 2019 were identified in all the sites visited for data collection. Some KPs in NCR, Luzon, Visayas and Mindanao said that the “Low stocks of ARV resulted to rationing, thus requiring frequent visits for refill. This in turn led to more time away from work and increased expenditure on transportation cost”, discouraging KPs to go through HIV testing or forcing the PLHIV to either delay ART enrollment or drop-out of the treatment.

As a component of the JPR, the Philippines sourcing, procurement and supply chain management (PSCM) for the HIV commodities and diagnostics was reviewed and analyzed⁷⁹ to better understand the issues affecting the implementation of HIV program strategies. Findings on PSM issues are presented below:

- ***Overall situation with Access to medicines and diagnostics in the Philippines.*** Since the country’s adoption of the Universal Health Care Act, the PSCM is in motion in and numerous Technical Assistances (TA) have been provided to DOH by international organizations and development partners to identify strategic areas of support on PSCM in aligned with the UHC. Best practices have been implemented in the country in the area of PSCM especially in the area of accountability. All these changes have resulted in streamlining most of the processes but have also generated some challenges which require better definition of roles and responsibilities and key performance indicators that are simple, measurable and that the function controls. In this process, the focus is on the procurement and supply chain management but for the country to achieve the 90-90-90 targets lots of work need to be done on the First 90.

Key PSM issues identified:

- **Forecasting and Quantification of HIV medicines and diagnostics**

The country is facing shortages of major ARV and is rationing the distribution of ARV to health facilities to avoid major stock outs while already facing stock out for pediatric ARVs, especially oral suspensions. The same goes with diagnostics tests. This situation is due to poor data quality (data used for quantification not cross validated with the inventory data) resulting in poor quantification and forecasting thus shortages and stock outs. Related to this issue are the main bottlenecks identified below:

- **Data collection processes is not optimal**
 - a. Facility send the data to the Center for Health Development and the CHD to the central level;
 - b. Data validation is the sole responsibility of the regional coordinator who does not always cross validate;
 - c. Lack of physical inventory validation;
 - d. Lack of integrated system for data collection (electronic LMIS);

⁷⁹ From the Technical Assistance Report of Clearing House Manager AIDS Medicines and Diagnostic Services HQ/CDS/HIV/SIP World Health Organization, Geneva. JPR Consultant for the review and analysis of the Philippines sourcing, procurement and supply chain management for the HIV commodities and diagnostics, 14-21 October 2019.

- e. Warehouses issues with accurate and timely report of inventory of the Center for health Development and HIV treatment center;
 - f. Quarterly review of the forecast to correct the trajectory;
 - g. The CHAI forecasting tool is the most used tool in the world and is working elsewhere. The updated version is available and will be shared with the forecasting team.
- **Procurement of HIV medicines and diagnostics**

The procurement of the ARV and diagnostics is the cause of most bottlenecks observed in the review. Some of the bottlenecks are due to the process and others due to laws and regulations. Some serious actions need to be taken to ensure the vision and the mission of the Procurement and Supply Chain Management Team (PSCMT).

The main bottlenecks for the procurement of HIV Medicines and diagnostics are:

- **Normative bottleneck**

The procurement of HIV commodities does not always follow the National guidelines especially for pediatrics. The national guidelines recommend the 4 in one (ABC+3TC+LPV/r). This is ever hardly procured and the same with the adult formulations where a plethora of single formulations which do not add up is observed. This needs to be looked into as this fragmentation complicates the procurement and the sourcing while reducing the national capacity to get good deals due to low volumes.

- **Regulatory and legal bottlenecks**

- a. The Philippines FDA. The FDA has as a mission to ensure that all Medicines and diagnostics entering the Philippines are registered and have a CPR. This process is to guarantee the quality of products and is also very costly for those who choose to go through. The FDA is planning to strictly enforce this law from 2020. The issues are with products that are not economically viable and very low volume.

The enforcement of this law will put the pediatric ARVs in danger, as there is no one registered in the Philippines. UNICEF who does emergency procurement or procurement of commodities for the country was not able to secure through opened tender, and the agency has said they will not be able to do procurement if the law will be enforced;

- b. Duplication of efforts between the central government (DOH), the local government (LGU) and reference Laboratories such as SACCL. The concomitant procurement of HIV Medicines and diagnostics by those 3 entities has generated more confusion than solution resulting in lack of storage space in warehouses and also lots of

expiries in product. The roles and responsibilities need to be clearly define and a greater sharing of information and data to adjust or cancel over orders;

- c. Tendering process. The national tendering process does not allow the Procurement and Supply Chain Management Team (PSCMT) to fulfill their mission and their vision as only suppliers that have their products registered in the country and are present in the country can participate. This regulation reduces the competitiveness of the bid and increases the risk on having unsuccessful bidding, which may create tension in the PSCM. The bidding process with bidding failure delays the procurement process, which may end up with stock out. The cost becomes higher with few ARV suppliers.
- d. Tender award process. The winner takes it all (only one supplier per formulation) due to the low of non-splitting funds is a major risk in the supply chain management. A default from the supplier leaves the country with no other solution but emergency procurement. The DOH should revise their position and adopt the international best practice, which consist of selecting 3 bidders per formulation to hedge the supply risk and splitting the volume among them. This will keep them interested in the country and ready to step in in case of default.

– Processes bottlenecks

- a. The Philippines FDA. The FDA should be at the services of disease programmes and working to meet their need. This relation should work through the Expression of Interest (EOI) by which the programme share their needs and their priority list of drugs and diagnostics that needs to be fast track and approved and their prioritization should be the FDA prioritization.

The country need to adopt their algorithm for blood screening, HIV diagnostics and screening and the role of the FDA will be to focus on those product instead of working on product that will never be used by the country in the idea of free trade market. For example when the HIV diagnostic algorithm is defined and the 3 tests chosen, there is no need for continuous evaluation of new diagnostics when it is clear that they won't be used and burden the reference laboratory with assessment of this additional task.

- b. Cost of registration of formulations. The cost of registration of a formulation is around PHP 1 million. This is prohibitive for low volume and low value products. For pediatric ARVs the cumulative procurement value from august 2019 till June 2021 per formulation is barely equal to PHP 2.5 million for the highest value volume formulation. This exposes the country to the risk of stock outs and the same for some adult formulations.
- c. Registration time of formulations. Registration length takes 2+ years for the non-WHO prequalified products to obtain a CPR in the Philippines and minimum 6 months for the WHO- prequalified medicines to get the same, which is a long time.

FDA should streamline the process to get the needed product faster in the market and to increase the competition.

- d. UNICEF Procurement. UNICEF may not be able to procure for the Philippines from 2020 going forward if the government issues no waiver, as they cannot register a product in the country. They are neither consignees nor representative of the manufacturers but service render, therefore cannot bring a product in the country. If the UNICEF will continue doing procurement for the Philippines in 2020, they would like to be informed in January-February and at the same time the money should be put at their disposal for them to make a better procurement plan.
- e. Procurement contract. The procurement contract is on annual basis, which does not give lots of visibility to the PSCM. The Philippine may negotiate long-term agreement with suppliers to compensate the fact that they could only financially commit for a year at a time.

- **Warehousing and distribution**

The challenges for the Philippines' logistics management are: the lack of storage space and lack of coordination between all the parties doing procurement (central and local); the lack of integrated LMIS for easy access to information as to the availability of stocks; lack of standard operating procedures; and lack of trained human resources. There is a need to construct new warehouses (regional hubs). The country's general infrastructure was not designed for storage, as rooms are too small in the health facilities. In all the facilities visited, medicines and diagnostics were stored in the corridors or store without consideration of the Good storage practices. Because of the above-mentioned deficiencies, the delivery is on a "need basis" as the space is problematic.

- **Warehousing and distribution issues**

The lack of space has generated the below issues:

- a. *Rejection* of consignment and commodities due to lack of storage space by warehouses causing pressure on stocks at facilities level;
- b. Region *asking* facilities to come and pick up their consignment instead of the distribution process in place;
- c. Issue with good storage practice programme now taking responsibility to distribute their medicines which should be supply chain;
- d. No feedback system in place to check if they have received their consignment allocation;
- e. No in place early warning indication for stock out;
- f. The distribution process is very long. NASPCP receive the product and transfer it to SCMO, and SCMO to regional warehouse. The regional warehouse does the regional allocation to the treatment facilities; and

- g. The delivery timeline of SCMO and Courier is around 3 months based on NASPCP internal workflow.
- **Logistics Management Information System (LMIS)**

The country does not have an integrated nationwide LMIS and whatever system is available does not work. This makes the PSCM a titanic task. Some of the bottlenecks will need to be dealt with by the regulators with the inclusion of the consumption data as there is a law against contact tracing.

MTaPS is working with the government to procure an off shelf LMIS which will be a nationwide tool. It is important to make sure that the tool works at all level on and offline. That it covers inventory management, drug expiry management in central warehouses and regional level, and do auto computation and distribution of replenishment quantities to the service delivery unit. It should also read barcodes. MtaPs is compatible with all the data management platforms.

Human Resource-related Barriers

The effective and efficient program strategy implementation is highly dependent on human resource capacity. This means having adequate, appropriately skilled and incentivized health workers with the right expertise, and training and operational support for the program.

Among the human resource-related barriers identified in the review are:

- ***Lack of permanent staff for sustainability of program operations.*** At the national and local levels the employment status of health care workers is a major concern for sustainable program implementation and continuity. Current staffing includes Job Orders and GFATM project staff. In the National AIDS and STI Prevention and Control Program (NASPCP), only the Program Managers are permanent employees of the DOH, while the rest are project staff funded by the Global Fund HIV grant. Likewise with the current 11 staff of the Epidemiological Bureau (EB) whose salaries also come from the Global Fund grant. This is also a big issue with GF-supported SHCs and treatment hubs. One site in NCR is concerned that half of the GF-funded staff might not be employed by 2020, thus affecting the continuity of services provided.
- ***Limited human resources but high demand for services.*** The Staff who are usually involved in HIV testing are the Community Health Outreach Workers (CHOWs), PEs and RMTs. For the ART enrollment and dispensing, doctors, nurses and pharmacists are involved. All SHCs have Nurses, MT, Case Managers, CHOWs and doctors involved in HIV testing. They are either LGU payroll or Global Fund support. ARV consultation and refill services are provided by nurses, combination meds (CMs) and doctors. Clients are required to get their monthly medications for the first three

months and thereafter once when there are no other adherence-related concerns are revealed.

In many HIV facilities, there is an Imbalanced provider-to-patient ratio. Usually the average ratio is 3-4 HCW for 20-50 (including pregnant women) patients per day for HCT and treatment. One of the HCWs interviewed expressed that they have inadequate staff in the SCH to cover all the barangays in the city. They need an additional Medical Technologist as their current MT is shared with other TB and MNCHN Programs. They have informed the Mayor's Office of their need for staff complement but no approval yet because of budgetary constraints. KP volunteers compensate for the lack of staff however, most of them do not have enough training

or competency for the required tasks such as peer counseling or CBS. Findings in some of the Mindanao sites revealed the lack of focus in program implementation due to overburdened staff and HACT Leader's multiple priorities.

Some SHCs shared the predicament of having too many patients:

"There is inadequate staff to cover the entire province. Hence, we cannot do as much outreach as we want to. But we noticed that more and more people are walking into the SHC for testing. There are also more and more sites asking to be visited for outreach."

- **Quality of health care workers.** The results of the client interview for patients who have just undergone HCT and ARV refill showed that client satisfaction of services provided is a big factor in enrollment and adherence to treatment. Most of the PLHIV and KP interviewed mentioned that the approach of HCW could be a deterrent to access of HIV services. They cited that unfriendly attitude among HCW further discourages an already depressed newly diagnosed PLHIV. For those who had a positive confirmation test but did not enroll on ART afterwards, the main reasons cited are poor counseling and poor treatment by medical personnel. Providers noted that LTFU are occurring mostly during initial counseling period and among TB patient referrals.

4.2.3.2 Financial Constraints

Access to services, particularly ARV treatment adherence is affected by the financial situation of key population. Factors that inhibit enrollment in HIV care, particularly for newly diagnosed PLHIV include Indirect costs such as transportation expense, travel time to the treatment facility and inability to miss work to attend to clinical appointments or the fear of losing a job/employment. In all the sites visited in NCR, Luzon, Visayas and Mindanao, "Out-of-Pocket" expenses (OOP) are often cited as reason for delaying treatment.

Many clients are not Phil Health members hence they cannot avail of the OHAT Package of Benefits for individual members. However, a range of out of pocket (OOP) expenses pose

difficulties even among OHAT utilizers. It varies for patients but it can be explained by multiple reasons such as: i) exclusion of baseline lab tests from the package; ii) vague rules on package inclusion; and iii) price differences of services between public and private treatment hubs and throughout regions.

Among the barriers to access of OHAT benefits⁸⁰ are:

- The differences in the accessibility and location of these treatment centers where baseline lab tests are done can directly affect out of pocket expenses, such as for travel, by potential utilizers.
- There is a privacy issue in the confirmatory tests performed by experts in San Lazaro and RITM wherein a patient will be listed as HIV positive, further discouraging PLHIVs from accessing OHAT. There are only two other private hospitals – Makati Med and the Medical City -- that have HIV specialty ward where these baseline tests are being done but it comes with significant costs.
- The vague rules in the package inclusion are another barrier. Although the circular stated that the OHAT package include routine drugs, laboratory exams and professional fees, it does not cover cost of ART and other Opportunistic Infections (OI) or other vulnerabilities due to immunosuppression which many PLIVs suffer from. OIs are increasingly more expensive to diagnose and treat, increasing out of pocket costs for most patients.
- There are also disparities in the charge for services and medications received by PLHIVs across the different treatment hubs in the Philippines. The differences in the coverage of services between public and private treatment hubs and across different regions usually entail OOP for patients. As Phil Health did not mandate a definite menu of benefits, and laboratory tests are not uniformly available at hubs, what is included in each claim is highly dependent on the discretion of the health provider

In view of these barriers, a Position Paper from the PLHIV Support Groups on the Phil Health-OHAT Services was presented to Global Fund Philippine Country Coordinating Mechanism on May 2019 for the following reasons⁸¹:

- Asserting the standardization of the Phil Health – OHAT Package.
- Implement a guideline or process in decentralizing treatment for PLHIV's.
- To fast track the decentralization of HIV confirmatory test by having a Regional Treatment HUB in compliance with DOH Administrative Order 2019-0001 – Guidelines on the Implementation of Rapid HIV Diagnostic Algorithm (rHIVda).

4.2.3.3 Psychological and Social Barriers

⁸⁰ Review of OHAT Package of PHIC. Retrieved from: <https://www.epimetrics.com.ph/projects/phic-ohat>

⁸¹

Stigma and Discrimination

The stigmatization of people with HIV is considered as the biggest challenge to improving reach and coverage of services. “There’s the stigma that those who are vulnerable face – the MSMs [men who have sex with men], the transgender, the injecting drug users”⁸². Forms of stigma include self-stigma/internalized stigma, governmental stigma, healthcare stigma, employment stigma and household and community stigma.

In February 2018, Human Rights Watch reported that workers and employees in the **Philippines** living with HIV who suffer workplace discrimination often do not seek redress. The story of “Kevin,” 36, a call center agent from Cagayan de Oro who was diagnosed with HIV in March 2015 is a case in point. His company forced him to resign and he had no idea what he could do. He said: “I lost not only my employment but also the benefits due me after I left,”⁸³

Some KPs who participated in the FGDs mentioned that some physicians are not even happy with the AIDS law because they think that the law is pro-patient. According to them, one medical doctor said that: “It’s all about rights, and what about their responsibilities? What about the rights of health care providers? What about our responsibility if we know of KPs not practicing safe sex, do they have penalty under the law?”

Issues on stigma and discrimination among health workers toward the client were recurring theme in the FGDs and KIIs with KPs. Based on their experience there are physicians who demand to know the client status to be able to decide on client management process. In one site, a KP shared that he filed a complaint with the Commission on Human Rights (CHR) after his HIV testing was disclosed publicly resulting to discrimination even within his LGBT community and being disowned by his family. He said that, “I filed the case because I would like to find out where the leak came from, and to send a message that privacy and confidentiality of information in HCT should be upheld and respected at all times”.

Transgender women are underserved and also stigmatized. The WHO Policy Brief: Transgender Health and HIV in the Philippines highlighted that there are no specific health services or guidelines for care directed to transgender people in the Philippines. With stigma and discrimination appearing to be major barriers to access to health services⁸⁴.

Depression, Myths about Treatment Options and Family Support

The UNDP case study in the Philippines emphasized that⁸⁵:

“Reasons why clients do not follow up an initial reactive result to HIV testing to get

⁸² Human Rights Watch. Discrimination Against Workers with HIV. Cited by Jonas Bagas, a Filipino lesbian, gay, bisexual and transgender (LGBT) rights activist. Retrieved from:

<https://www.hrw.org/news/2018/02/09/philippines-discrimination-against-workers-hiv>

⁸³ *Ibid.*

⁸⁴ Retrieved from: <https://iris.wpro.who.int/bitstream/handle/10665.1/13435/9789290617815-eng.pdf>

⁸⁵ UNDP. “MISSING IN ACTION Loss of clients from HIV testing, treatment, care and support services: Case studies of gay men and other men who have sex with men in Manila. May 2017.

a confirmation test and CD4 testing included denial, and, again, fears about side effects of ARVs. Some worried about being stigmatized by family and friends.”

The study further cited a number of psychological and social barriers, particularly on ART enrolment counseling. Particular reasons include:

- Depression - a recurring reason to interrupt or stop ART;
- Side effects - fears about side effects of ARV medicines led some to try to stay off ARVs for as long as possible;
- Myths about treatment options - A few men thought they could treat themselves with good nutrition or with certain traditional medicine, such as black oil seed, and mentioned this as a reason to stop ART; and
- Family support - Some research participants mentioned their family as a factor in discontinuing or delaying the onset of their ARV treatment, related to the requirement to have a “treatment buddy”. Treatment-related fears of disclosure to the family and a desire not to be a “burden” on their family.

4.2.3.4 *Legal and Policy Barriers*

Legal barriers could be “laws, as well as the institutions and practices involved with their creation, implementation, and interpretation. Burris et al. argue that laws can affect health in two ways: 1) they may be a pathway through which social determinants affect health, and 2) they may contribute to social conditions associated with health outcomes”⁸⁶.

- **On Drug Problem.** An important observation in RA 11166 is the omission of a provision on needle exchange program”⁸⁷. According to the study of de Jesus et al, “The overall Philippine policy stance towards the drug problem has traditionally tilted towards the prohibitionist approach. From the Revised Penal Code of the Philippines which became operative in the Philippines in 1930, to The Dangerous Drugs Act of 1972 (RA 6425), to the present Comprehensive Dangerous Drugs Act of 2002 (R.A. 9165) the national policy has relied on the twin strategy of criminalization and punishment as the main mechanisms of drug control.”⁸⁸
- **On Condom Use.** The Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 (RA No. 10354) prohibits minors (under the age of 18) from accessing modern family planning methods (including condoms) without a written consent from their parents or guardians. Young adolescents who have begun sexual activity before reaching 18 years old are affected by this policy provision.

⁸⁶ K. E. Poundstone, S.A. et.al. Social Epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome | Epidemiologic Reviews | Oxford Academic.

⁸⁷ *Ibid.*

⁸⁸ De Jesus, Armando F. et al. National and Local Policies Related to AIDS and Drug Use: Content Review and Assessment, December 2012.

Consultations with stakeholders also identified lack of legal protection for program implementers of PWID and young KP who face harassment and lawsuits for providing HIV services as obstacle to expansion of prevention, testing and treatment interventions.

Harm reduction and HIV health promotion interventions have been seriously affected by the “War on Drugs”. In particular, “advocacy for investment and services for PWID is significantly silenced in the current political climate, impacting the ability for the response to address the needs of key populations”⁸⁹.

4.2.4 Conclusions: Appropriateness, Effectiveness and Efficiency of the National Program Strategy

4.2.4.1 *On Prevention*

Progress in achieving the program targets in prevention has been slow as indicated by the low condom use among MSM, TGW, PWID and young MSM, and low comprehensive knowledge in HIV prevention and transmission among all KPs.

The two main prevention strategies are outreach among KPs primarily through the CHOWs and PEs, and condom distribution via access points. Review findings show that these strategies along with the use of social media channels and other online applications are appropriate and effective for the KP population. However, these strategies were found limited in effectively responding to the needs and situations of hard-to-reach KPs among MSM, TGW and PWID. More importantly the prevention efforts are not linked to an overall national prevention strategy, therefore, allocation of prevention resources was not targeted according to the sites where the epidemic is highest and to KPs at greatest risk such as young MSM. Also, other effective strategies were not prioritized and widely implemented.

The limitations in funding constraint the adoption and implementation of new innovations in prevention programs and the hiring of sufficient and skilled human resources necessary for the efficient implementation of prevention services.

An appraisal of the key recommendations for prevention in the 2013 External Review of the National Health Sector Response to HIV and STI showed that some of them have either been partially addressed or not yet addressed:

- The comprehensive packages for key populations should be reassessed, and a minimal package of prevention interventions should be defined and accompanied with a concrete quality-assurance mechanism (partially addressed in the HSP 2015-2020 implementation but not the QA mechanisms).
- National surveillance for PWID should be strengthened by covering more of the NCR sites (Manila and Quezon City) to detect epidemics early, while continuing to

⁸⁹ SHIFT. National Situational Assessment of HIV Financing in Philippines, 2017.

monitor the high level of needle-and-syringe sharing behavior (not addressed due to “war on drugs” policy – no IHBSS for PWID conducted in 2018).

- A transgender-specific programme, informed by the forthcoming findings of a study in Cebu, should be created in consultation with transgender community representatives (partially addressed in terms of consultation).
- A national condom strategy should be developed. Policies on correct and consistent condom use in sex work settings should be in place, and the policies should be supportive of community empowerment for the work norm of “no condom, no sex”. Condoms should be made available through a variety of channels: free of charge distribution, a condom social marketing approach and private sector promotion. Condoms should be easily available and accessible for registered sex workers based in sex venues. Outreach activities should be scale up to offer free distribution of condoms and water-based lubricants to FFSW, MSM, PWID and transgender people (No national condom strategy has been developed; certain aspects of condom distribution partially addressed).

4.2.4.2 *On Testing*

The country is getting better at case detection at 72% or 62,942 out of the estimated 90,000 PLHIV in the country. However, there are still remaining 28% or 25,458 PLHIV undiagnosed as of June 2019, and 50% of them are 15-24 years old young PLHIV.

The HIV-Western blot is no longer recommended by the WHO “due to evidence of false positive or indeterminate results early in the course of HIV infection”. Review findings confirmed that CBS is an appropriate and effective testing strategy for KPs, and with a higher positivity rate of 5% compared with mobile HCT. However, its implementation has not yet been scaled-up due to lack of DOH guidelines for its rapid and nationwide implementation.

A key recommendation on testing in the 2013 External Review was: “A three rapid-test algorithm for screening and confirmatory testing with immediate results should be considered during the validation of the new HIV testing algorithm. The availability of quality systems to support the implementation of a three rapid test algorithm for screening and confirmatory test with immediate results in non laboratory facilities such as SHCs and HIV testing and counseling centers should be explored”.

The availability of rapid test protocols such as rHIVda is recognized as critical to the objective of bridging the gap in diagnosis. But rHIVda has not been rolled-out yet after the pilot project was completed in 2016 despite the readiness of many facilities for its rapid implementation.

Case finding is becoming increasingly challenging given the limitations in current HIV testing strategies being implemented and the stigmatization of testing. The weakness in the prevention program, particularly the absence of an overall BCC Strategy limited the achievement of significant changes in risky behaviors or adoption of preventative behaviors. HIV testing as prevention is not yet maximized as a key message during outreach activities.

Given the current epidemiological trends among KP, particularly young MSM the testing strategies need to be targeted and expanded. New innovations in targeted testing while improving CBS and implementing rHIVda in a decentralized approach are necessary to achieve efficiencies.

4.2.4.3 *On Treatment*

There is a significant increase in ART coverage from 44% in 2015 to 60% in 2018 but more efforts need to be done to reach the Second 90 and Third 90 targets implying that linkage to care needs rapid improvement. There are still 19,965 of diagnosed PLHIV who have not started treatment and 13% lost to follow-up as of June 2019. Consistent late enrolment based on low CD4 of <200 is common⁹⁰.

Guided by the “Treat All Policy”, same day initiation of treatment is an appropriate and effective strategy for facilities that have implemented this because the diagnosed PLHIV were immediately linked to care and preventing, thus avoiding drop-outs after the release of confirmatory results. Treatment facilities that are “one-stop-shops” and using social media for communication were more effective and efficient in ART enrolment and adherence. Findings of the review have demonstrated that one-stop-shop facilities have lower LTFU cases. The differentiated care approach for MSM from counseling, testing and treatment that is being implemented by LoveYourself has proven its appropriateness, effectiveness and efficiency in reaching hard-to-reach KPs. This model can be further replicated in sites with the highest burden of epidemic but the full evaluation of this strategy as currently practiced is necessary to ensure that the package of services is cost-effective. Other strategies for ART delivery, particularly the community-based approaches have shown potential in bridging the gaps in ART enrolment and adherence.

The identified barriers to accessing of treatment services have greatly affected the achievement of program target. Issues with ARV supply/critical stock-outs, inadequate number of skilled health care workers (particularly case managers), limitations in HIV testing options and treatment processes, low quality of infrastructure facilities, gaps in policy and guidelines (ART regimen, OHAT benefits, Standard Operating Procedures on Treat All Policy, etc.), and psychosocial/medical concerns require immediate attention to increase treatment coverage.

4.3 Recommendations and Way Forward

The HSP 2015-2020 has contributed to setting the direction of HIV response based on the epidemiological situation and reinvigorated the program interventions and activities at the national and local levels. The Health Sector Plan has decisively addressed the recommendations of the 2013 External Review that called for: “An important strategic shift towards investing

⁹⁰ HARP, June 2019.

greater resources and effort in newly affected key populations while continuing to provide essential services to sex workers (in particular freelance sex workers)”.

Some challenges remain around prioritizing target key populations, sites and intervention strategies, and more work is still required in prevention, testing, treatment and viral suppression. The set of recommendations presented in this Joint Program Review Report aims to assist the DOH in developing the HSP 2021-2025. The list of recommendations emphasized the need to “build on the gains of the old, and embrace the new innovations in HIV response” that would facilitate the country’s achievement of the 90-90-90 targets.

4.3.1 Key Recommendations

4.3.3.1 *Prevention*

Implement a comprehensive national “Combination Prevention Strategy” with KP specific interventions. In line with this key recommendation, the following measures/actions need to be done:

- a. **Develop and implement a National Condom Promotion and Distribution Plan.** The Philippine National AIDS Council (PNAC) should develop and issue a resolution to its member agencies to implement a National Condom Promotion and Distribution Plan to improve access to and use of condom.
- b. **Develop a KP-specific and geographically appropriate national Behavior Change Communication (BCC) Plan.** Key messages in the plan should focus on adoption of preventative behaviors and awareness of HIV prevention and transmission. The plan should ensure the use of all possible communication channels, particularly social media and online applications in delivering key messages for HIV testing, treatment and viral suppression.
- c. **Monitor, assess and improve the implementation of essential package of services per KP (YKP, TGW, MSM, PWID, sex workers).** A full evaluation of the implementation of the essential KP-specific package of services in the HSP 2015-2020 is necessary as basis for improvement in the next HSP. A cost-effectiveness component should be included in the redesigning of the essential package of services.
- d. **Develop and implement a comprehensive package of services for PWID and YKP with a special focus on addressing barriers to access to reach these subgroups.** This should address issues concerning human rights, gender and stigma and discrimination.

- e. **Establish more safe spaces for KP to access HIV services.** Review findings showed the effectiveness of safe spaces in the provision of prevention, testing and treatment services, especially among young MSM.
- f. **Introduce PrEP as a key targeted prevention strategy.** As testing becomes more targeted and case finding is improved, multiple models for PrEP should be expanded and supported as a key targeted prevention strategy. The DOH should develop implementation guidelines on access and pricing.

Endorse U=U messaging as part of the national health promotion in the HIV implementation.

U=U messaging should be widely utilized and promoted because Viral

4.3.3.2 First 90, Diagnosis

Bridge the diagnosis gap by diversifying and expanding testing strategies in order to reach the remaining undiagnosed PLHIV. To do this, the HIV program needs to build on the current good practices in HIV testing, improve the low yielding strategies and adopt new innovations. Specifically, the following measures are proposed:

- a. **Diversify targeted testing options.** Targeted testing should be rapidly expanded using both facility and community based testing and linkage to treatment. In line with this, there is a need to
 - Scale up CBS implementation. Community and School based HIV awareness events should be conducted to promote CBS.
 - Introduce new testing strategies such as Index testing and self-testing. Rapidly expand and regularize index partner testing for MSM and TG for both facility and community based testing, as well as for enrolled PLHIV. Determine the usefulness of self-testing screening for partners of PLHIV as case finding for those who would otherwise not be tested.
 - Develop YKP specific testing strategies to close the gap in testing among 15-24 years old YKP.
 - Expand MSM and TGW targeted testing at all hotspots.
 - Scale-up the utilization of social media to reach high risk KPs for testing.
- b. **Rapidly roll-out rHIVda implementation.** The implementation of rHIVda should be decentralized using all potential facilities (SHCs, public and private treatment hubs, and CBO Centers). This should also include rapid expansion of rHIVda testing protocol for pregnant women.
- c. **Rollout legal literacy training for duty bearers (providers) and rights holders (KPs and clients)** to address stigma and discrimination.
- d. **Conduct client satisfaction survey** to evaluate the quality of pre and post test counseling. Review findings cited poor counseling as one of the reasons for drop-outs in enrollment and treatment adherence. A sound analysis of the root causes of poor pre

and post test counseling should be done for improvement. Counseling and should be widely scaled for prevention and client management.

4.3.3.3 *Second 90, Treatment*

Approaches for immediate linkage to treatment and care should be rapidly expanded and regularized to ensure follow up for all newly diagnosed PLHIV, whether identified in facilities or through community based programs and to prevent having lost to follow-up cases. In line with this key recommendation, the following should be undertaken:

- a. Address PSM-related barriers at the central, regional and local levels to ensure uninterrupted supply of ARV supply. The three month distribution of ARV for eligible and enrolled PLHIV should be continued.
- b. Address the service delivery constraints (human resources and infrastructure) affecting the quality, efficiency, and effectiveness of treatment services. The government should invest in the provision of permanent health human resource at the central (NASPCP and EB), regional, and local levels (CHOWS/PEs/Case Managers) for sustainability and continuity. The infrastructures should be improved to increase uptake of counseling, testing and treatment services.
- c. Fast track the transition to Dolutegravir (DTG) to address ARV side effects issues resulting to delayed enrolment and non adherence. The planning and measures to ensure preparedness for TLD transition should be continued within an actionable timeline.
- d. Promote and expand the establishment of more one stop shops. Service delivery network should be strengthened to facilitate ART enrolment and adherence. This should include monitoring the implementation of treat all policy in all treatment facilities.
- e. Implement a differentiated approach to providing HIV treatment, care, and support services. Full service CBO programs that are effectively implementing this approach should be expanded to those areas in need and not reached by government treatment hubs (the LoveYourself Model can be adopted for this purpose).
- f. Improve quality of case management in terms of team composition, roles and responsibilities, and processes of implementation to address psychosocial and biomedical issues.
- g. Develop information system with client tracking capability to track enrolment and lost to follow up.
- h. Improve TB-HIV collaboration through joint program implementation review.
- i. Improve access to PhilHealth OHAT Package of benefits. Facilities should be supported in their accreditation processes. Monitoring of the utilization of OHAT funds for PLHIV

treatment needs should be conducted on a regular basis. HIV/AIDS Core Team should have a designated PhilHealth Officer.

4.3.3.4 *Third 90, Viral Suppression*

Viral load testing should be rapidly scaled-up to increase coverage at the national level to reach the Third 90 target. The following measures need to be undertaken:

- a. Ensure all treatment facilities have access to point-of-care viral load machine and cartridge. A lab optimization review should be conducted to improve distribution and availability of viral load testing machines and reagents.
- b. Ensure viral load literacy.
- c. Regularize minimal turn around times for viral load monitoring.
- d. Regularize the use of u=u at each opportunity in both facility and community programs for both prevention and suppression.
- e. To improve the capacity (human and lab equipment) of regions for VL testing in the 7 regions that represents 75% of number of people on ART.

4.3.3.5 *Crosscutting Areas: PSM and Strategic Information Systems*

Procurement and Supply Chain Management⁹¹

The procurement practices in the Philippines are not optimum and this is due to laws and regulations in the country and its misinterpretation. Also, there is the lack of coordination, communication and flow of budgets to enable the DOH to fully take advantage of the TRIPS flexibilities and the inclusion of the Philippines in the list of country beneficial of access prices and access to generic version of medicines. For this to happen the Philippines will need to:

- Amend, change or create some flexibilities around the FDA law on CPR:
 - Waiver on registration price for pediatric formulations, low value and volume products;
 - Fast tracking registration for programmes priority products;

⁹¹ From the Technical Assistance Report of Boniface Dongmo Nguimfack, Clearing House Manager AIDS Medicines and Diagnostic Services HQ/CDS/HIV/SIP World Health Organization, Geneva. JPR Consultant for the review and analysis of the Philippines sourcing, procurement and supply chain management for the HIV commodities and diagnostics, 14-21 October 2019.

- o Shorter registration time for products that are WHO prequalified or stringent regulatory approved Max 3 months; and
 - o Fast tracking registration of formulation that international bidders have bid for/or won the tender to facilitate their procurement
- Amend, change or create some flexibilities around the tendering process to allow international tender and bidding:
 - o Automatically open for international bidding formulations that have less than 3 suppliers register in the country;
 - o Automatically open or transfer procurement to UN agency for those products that have zero registration in the country;
 - o Award tender for each formulations to at least 3 suppliers at the rate that DOH will define 60% 30% 10% is the most observed distribution as this will hedge the risk of supply disruption;
- For diagnostics to adopt a national algorithm for each stream of screening and testing and focus resources on training staffs on their use instead of registering test and tools that will never be procured or used in the country.
 - o Quantification and procurement of this need to happen at the central level.
- Train, motivate and retain staff at all level of the supply chain.
- Acquisition, customization of the Nationwide LMIS tools. This tool should help to visualize the full PSM and also pipeline of order placed. It should be compatible with all the PSCM tools existing in the country at central, local level and should cover:
 - o inventory management
 - o drug expiry management in central warehouses and regional level
 - o auto computation and distribution of replenishment quantities to the service delivery unit
- Efforts need to be invested in the definition of roles and responsibilities throughout the chain of stakeholders with supportive key performance indicators (KPIs) and rewarding mechanisms.

To address PSM-related barriers in service delivery, the following should be undertaken:

- a. Equip facilities with adequate data sources, implement and optimize e-Harp /Integrated procurement and LMIS.
- b. Quarterly review of the forecast to correct the trajectory /CHIA Tool Evaluation.
- c. Adopt the international best practice standard which Consist of selecting 3 bidders per formulation.
- d. The DOH together with FDA and the disease programs should make a list of formulations and diagnostics that need a registration fee waiver and CPR.
- e. Develop terms and conditions for fast tracking / exemptions
 - Expedite CPR for WHO PQ products within 3 months
 - Waiver for UN organizations /Develop performance indicators

- f. A need to construct new warehouses (regional hubs).
- g. Optimize the distribution chain/implementation of LMIS.

On Strategic Information System

- **On Routine Data**
 - **HIV mortality data could be improved through:**
 - Coordination with the Central Statistics Office program to request breakdowns of HIV death data (age, sex, geography, etc);
 - Annually triangulate mortality data from available sources and track trends including the vital statistics, inpatient deaths, modelling output, and program data from eHARP.
 - **HIV co-infection with TB program**
 - Increase the testing rates for HIV among TB patients
 - Improve understanding of the relationship between TB and HIV, compare the geographic, age, and gender distributions of burden of disease (mapping Routine and survey data).
 - Strengthen interaction/discussion/regular meeting between TB and HIV program focal points to improve collaboration.
 - **HIV case reporting**
 - To include Male to female ratio trends in the analysis
 - To continue monitoring trends of CD4 at the first HIV diagnosis by age, gender and location
 - To monitor HIV diagnosis / ART initiation by month
 - **STI surveillance**
 - Monitoring of syphilis among KPs should be continued.
 - To continue to include STIs monitoring through facility surveys and/or IHBBS (syphilis, chlamydia, gonorrhea) in KPs
 - **PMTCT**
 - To strengthen tracking system to monitor HIV+ pregnant women and exposed babies until confirmation of HIV status or up to 18 months.
 - To reinforce the information system to monitor criteria needed to monitor elimination of MTCT. (ANC Coverage, HIV testing among ANC >95%, ART coverage > 95%, MTCT, < 5%)
 - **Care and treatment**
 - To continue to expand eHRP to all sites providing ART.
 - To improve quality assurance and monitoring & evaluation components of eHARP
 - To develop a plan for toxicity monitoring as a part of ART (e.g., through sentinel sites)

- o **Prevention:**
 - Requires clear policy guidance re: confidentiality and security of information (i.e., identity management for implement Unique ID across continuum of services: outreach/prevention, testing, care and treatment.
 - To continue with online BBS surveys for young KP
- **Routine Surveillance and Surveys**
 - o **Continuation of Facility Surveillance and IHBBS**
 - Incorporate analysis by age groups and geographical locations
 - Consider expanding coverage of facility surveys to additional sites to detect HIV among KPs outside of current focus regions/states
 - Continue triangulation of program data, HSS and IHBBS, at lower levels
 - To continue Pilot test online surveys using social media (dating apps, FB, esp. among MSM)
 - Advocate to include more HIV-related risk behavior questions in the DHS
 - Consider incorporating network scale up for size estimation in the DHS
 - o **Key population size estimations:**
 - To update PSE and focus in the 7 regions that contribute 80% of HIV case reporting
 - To Incorporate uncertainty range into PSEs.
 - o **Surveillance of drug resistance:**
 - To set up a clear strategy HIV drug resistance on a regular basis
 - Incorporate toxicity monitoring in two main tertiary hospitals (WHO toxicity guidelines).
 - o **Use of HSS and IHBBS for estimation and projections:**
 - Enter data into AEM on overlapping risk behaviors (MSM-M/TSM-PWID) as it becomes available, in order to understand the impact on projections.
 - Disaggregate new HIV infections among “low-risk” females from AEM output worksheet to understand route of transmission to them (partner of PWID, partner of MSM, partner of client, other).
 - Add breakdown to AEM report to improve understanding of the source of these infections.
 - Disaggregate Spectrum projections for Remaining Areas
 - To continue to develop regional and cities estimates adding uncertainty ranges
 - o **Plans, Reports, Evaluations:**
 - To continue monthly progress reports
 - To continue undertaken the program evaluations as the Prevention, cascade for KP
 - Plan to evaluate the effect of interventions on KPs
 - To continue capacity building for data sharing with regions and LGU

4.3.2 Way Forward for the Development of HSP 2020-2022

Use the JPR findings as basis for updating the Health Sector Plan for HIV and STI 2020-2022. In view of this, revisit the priority areas based on the new spectrum estimates, PSE for KP and HIV case reporting rates. Consider how to tailor to the country context the innovations that are being proposed for the programs on prevention, testing and treatment. As we strive for scale and quality of intervention, we should ask ourselves on “how do we scale up in the right quality⁹².”

Invest in multi-stakeholder and joint development of the health sector plan. During the JPR site visits, many of the respondents were not aware of the HSP 2015-2020 and the overall strategies for HIV response. The planning process should enable the regions to understand the value of a coordinated and collaborative HIV response based on a National Program Strategy. It should also develop their capacity to analyze their own epidemic profiles and where possible come up with a region-based HIV care cascade order to improve response at regional level.

Engage the key populations in the identification of priority sites, key issues, appropriate, effective and efficient strategies and interventions. Their participation in HSP development is essential to putting into actual context the various recommendations provided in the JPR. “What have been done with the CBOs? Build on the good practices but rethink how the low yielding strategies could be improved.” “We need to change: let us ask our clients or the end users to think for themselves. Perhaps we should change the way we are doing things. Let us not decide for them. Let the youth decide for themselves⁹³.”

Build on the current initiatives of donor agencies and development partners on projects pertaining to innovations in prevention, testing and treatment, for example PrEP “but let us not forget to address the barriers for the old, like why are we still struggling in condom use.”

Maximize the opportunities offered by the UHC⁹⁴ Act and some institutional changes in the DOH for HIV Program Integration. The creation of the health promotion bureau provides opportunity for integration of HIV BCC Plan in the overall health promotion program of the DOH.

⁹² Feedback from Global Fund representative during the November 12 high-level meeting - presentation of JPR findings.

⁹³ Feedback from DOH Undersecretary Myrna Cabotaje during the November 12 high-level meeting - presentation of JPR findings.

⁹⁴ From the PhilHealth OHAT Treatment Package, presented during the HSP strategic planning for 2021-2025 and JPR dissemination, 20 November 2019.

UHC Law is an opportunity...

GAPS by the JPR	Opportunities in the UHC
Access to PhilHealth by individuals	Every Filipino shall be enrolled to PhilHealth Immediate eligibility
Barriers to accreditation	Contracting of health services
Barriers to screening	Expansion of primary care benefit Designated primary care provider for everyone
Missing cases – screening to treatment	Health care provider network Technical integration - HIS
Lack of health care services in the facility (e.g. viral load)	Clear standards in licensing (function of DOH) Performance driven payment
Utilization of PhilHealth benefits	Prospective payment Managerial and financial integration

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ANNEXES