PHILIPPINE HIV FINANCING SUSTAINABILITY ROADMAP 2023-2028

TABLE OF CONTENTS

List of Figures

List of Tables

I. INTRODUCTION

As part of its commitment to the 2030 Sustainable Development Goals and targets, the Philippines strives to end the epidemic of acquired immunodeficiency syndrome (AIDS) under Goal 3: Good health and well-being. Landmark policies were developed to support this but the target to reduce the number of new HIV infections (newly diagnosed cases per year) from 9,238 in 2016 to ≈ 0 by 2030[1] has become elusive as the number even escalated to 12,341 in 2021. HIV incidence in the Philippines began "low and slow" but has recently emerged to be one of the fastest growing in the Asia Pacific region[2] and the world.

The COVID-19 pandemic and its consequent economic repercussions, exacerbated by humanitarian and politico-economic crises, dampened global response to the AIDS epidemic and caused devastating effects on people living with Human Immunodeficiency Virus (PLHIV). The UNAIDS Global AIDS Update 2022 emphasized that global AIDS response is under threat: progress has been faltering, resources have been shrinking, and inequalities have been widening. This has resulted in decreased accessibility to testing centers and delivery of HIV-related health services, as well as a potential shift from concentrated cases among key populations into the general population. Furthermore, despite progress made in increasing domestic funding for HIV response during recent years, the Philippines still relies heavily on external aid, creating a significant gap between available domestic resources and what is needed to achieve global HIV goals. Hence, it becomes imperative that the government takes measures towards transitioning from development assistance to domestic financing to ensure sustainable impact on combating HIV.

This brings to the fore the following fundamental concerns: a) what type of interventions would make the most impact on reducing, and eventually ending the HIV epidemic, b) how much resources would be needed to fund such interventions, and c) how can funding be secured and sustained in a way that can lead to the reversal of the HIV and AIDS epidemic in the country.

The government of the Philippines, through the Philippine National AIDS Council (PNAC), with technical assistance from the Action for Health Initiative (ACHIEVE) Inc., pioneered the development of the HIV Financing Roadmap 2023-2028 in response to the above-mentioned concerns as well as the recent policy reforms with major implications on HIV financing, service provision and governance. It serves as the country's first medium term national strategy for mobilizing and sustaining the funds needed to attain the SDG target on HIV and the 7th AIDS Medium Term Plan (AMTP) 95-95-95 targets by 2030 (i.e. 95 percent of HIV-positive people know their status; 95 percent of people who know their HIV-positive status are on treatment; and 95 percent of those on treatment are virally suppressed).

This Roadmap examines the HIV situation as well as the policy and financing landscape in the country, and recommends specific strategies that will ensure adequate and sustained funding for core HIV and AIDS interventions deemed critical in curbing the AIDS epidemic in the Philippines by 2030. It provides options on how the country can maximize the current system

[1] National Economic and Development Authority. (2030). Retrieved from https://sdg.neda.gov.ph/goal-3/.

[2] Cousins S. (2018). The fastest growing HIV epidemic in the western pacific. Lancet HIV. e405. doi: 10.1016/S2352-3018(18)30181-4. PMID: 30102154

and recent reforms to boost domestic HIV financing - gradually transitioning away from donor funding as it moves towards stronger government and civil society collaboration on HIV and AIDS. This supports the whole-of-system, whole-of-government and whole-of-society approach pursued by the Universal Health Care (UHC) to guarantee all Filipinos greater access to quality care at affordable cost.

The Philippine HIV Financing Roadmap 2023-2028 is product of consultations with the Philippine National AIDS Council (PNAC) Secretariat, Undersecretary in charge of DOH Office of Special Concern which oversees PNAC, the DOH Epidemiology Bureau (EB), Action for Health Initiatives, Inc. (ACHIEVE), development partners from the Financing and Sustainability Technical Working Group (FAST), and other concerned stakeholders.

II. THE WORSENING HIV EPIDEMIC

From low and slow to fastest rising HIV incidence

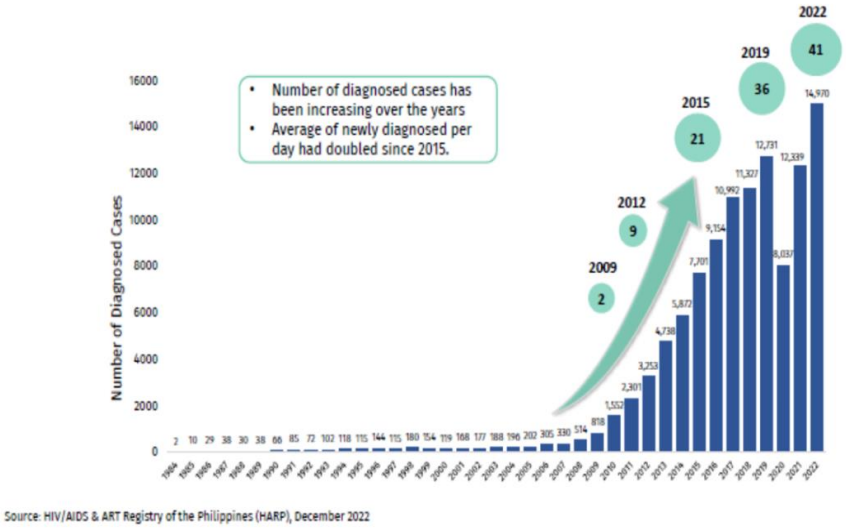
UNAIDS data showed that Malaysia and the Philippines are among the countries with rising epidemics among key populations[3][4]. The Philippines has gained notoriety in the last decade as the country with the fastest-growing HIV epidemic in the Western Pacific region[5]. While the overall trends of HIV incidence and AIDS-related deaths are declining globally, the number of diagnosed cases in the country increased by 348 percent over a decade from 2012 to 2022 (See Figure 1). A total of 109,282 cases were diagnosed in the Philippines from 1984 to 2022. This is alarming given that HIV incidence in the country had been "low and slow" for a long time (i.e. from 1984 to mid-2000s).

[3] UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people as the five main key population groups that are vulnerable to HIV and frequently lack adequate access to services.

[4]UNAIDS Data 2022. Retrieved from https://www.unaids.org/sites/default/files/media_asset/data-book-2022_en.pdf.

[5] Gangcuangco L. (2023). The State of the HIV Pandemic in the Philippines. Progess and Challenges in 2023. Retrieved from https://www.mdpi.com/2414-6366/8/5/258.

Figure 1. National trend of diagnosed cases, 1984-2022[6]



Source: HIV/AIDS & ART Registry of the Philippines (HARP), December 2022

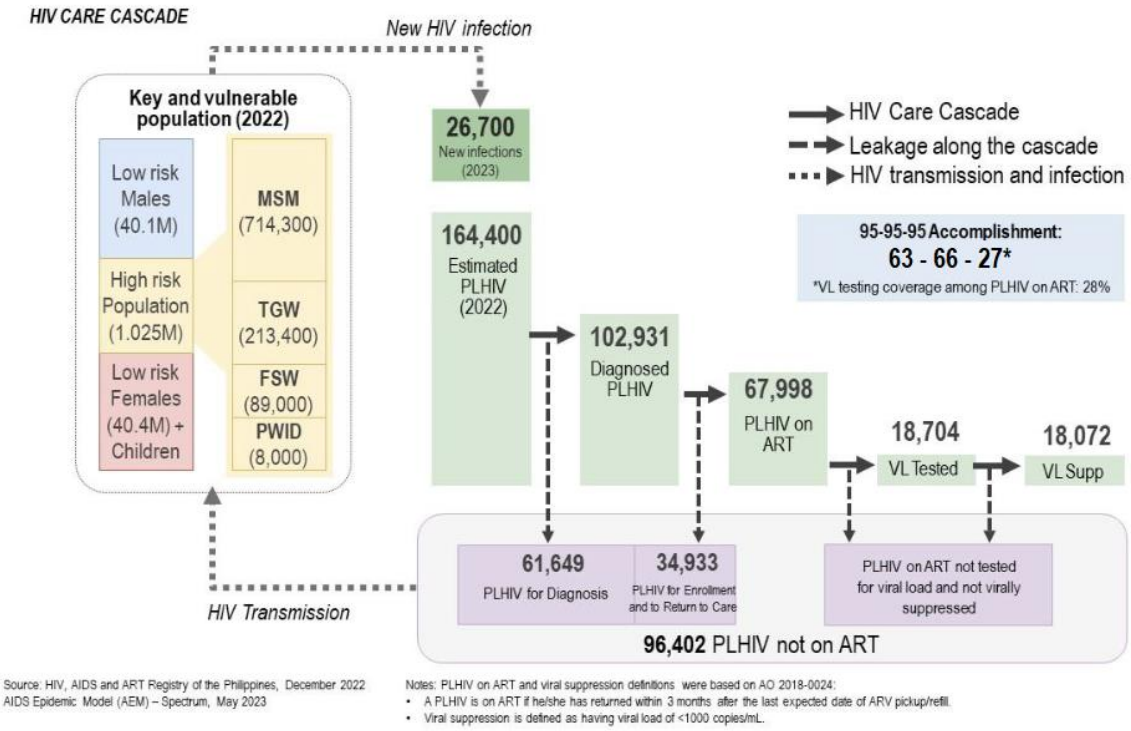
The average number of newly diagnosed HIV cases per day went up by 500 percent from 2012 to 2023 (see Figure 2). Delayed visits to health providers remain a problem as 27 percent of the new confirmed HIV cases in April 2023 had clinical manifestations of advanced HIV disease at the time of diagnosis.

Prospects in meeting the 95-95-95 targets

Out of its 95-95-95 targets, the Philippines accomplished 63-66-27, i.e. 63 percent of PLHIV know their status as they have been diagnosed, 66 percent of diagnosed PLHIV are on treatment, and 27 percent of PLHIV on treatment are virally suppressed. This highlights the gaps and leakages in the HIV cascade of care (see Figure 2). Leakages in the target number of PLHIV to be diagnosed, enrolled in antiretroviral therapy (ART), put on ART, and tested for viral load (VL) suppression feed into the number of key and vulnerable population, from which the projected 26,700 new HIV infections are expected to come.[6]

[6] DOH-Epidemiology Bureau projections based on HARP December 2022 and AIDS Epidemic Model (AEM) Spectrum – May 2023

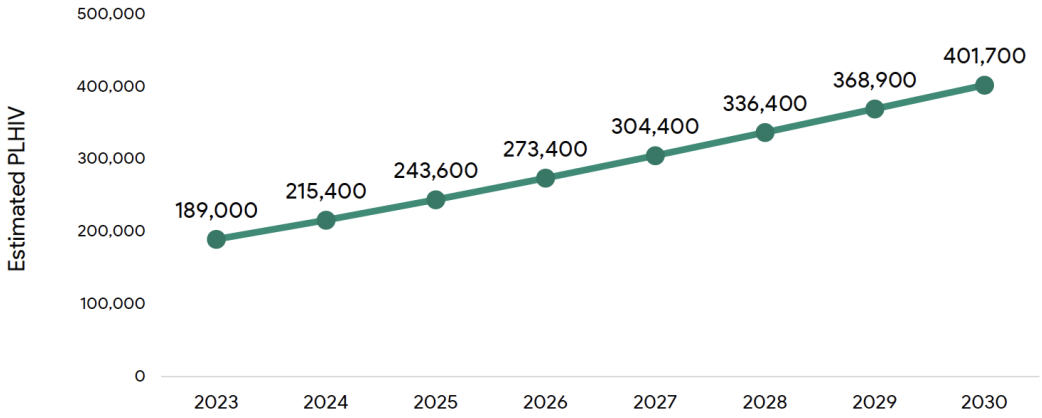
Figure 2. HIV gaps and leakages along the cascade of care, 2022[7]



The estimated 189,000 PLHIV in 2023 is projected to more than double to 401,700 by 2030 based on data from the DOH Epidemiology Bureau (EB) (Fig. 3). If the leakages and gaps in 2022 will be left unaddressed, huge amounts of resources will be needed to provide the cascade of care to a significantly higher number of new HIV infections and PLHIV in the medium to long term.

[7] Based on DOH/Epidemiology Bureau HIV and ART Registry of the Philippines, December 2022 and March 2023

Figure 3. Number of estimated PLHIV, 2023-2030

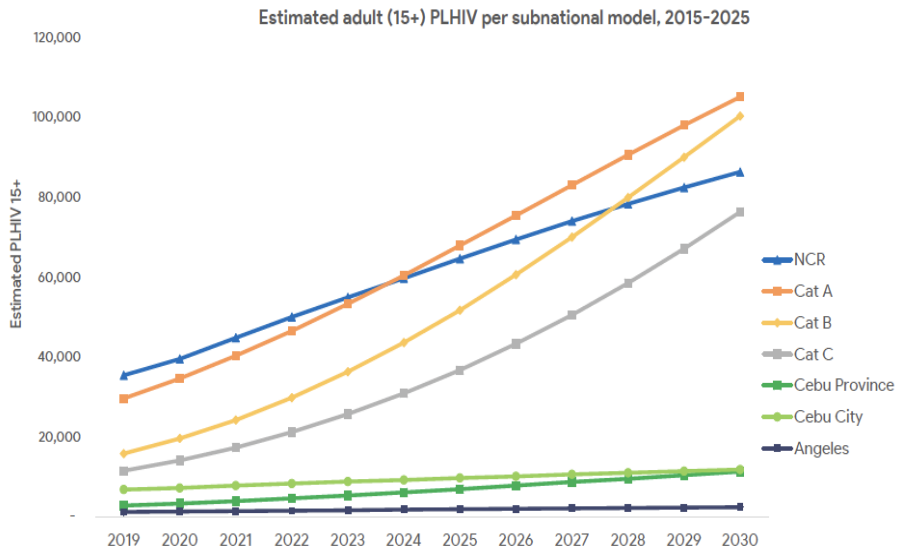


Source: AIDS Epidemic Model-Spectrum, May 2023

Projected shift of HIV burden

The DOH-EB reported that annual new infections are steadily increasing, especially among the youth. Based on its 2022 projections, nearly one-third (30 percent) of estimated new infections will be among 20-24 years old by 2030 – 16 percent of which among 15-19 years old. The 2022 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) among males who have sex with males (MSM) and transgender women (TGW) showed that both engage in sex at an early age (i.e. 16 years old - age at first sex) but practice protective behavior late (i.e. first condom use at 17 years).

Figure 4. Estimated PLHIV by category, 2019-2030



Source: AEM-Spectrum, May 2023
Note: Projections were based on observed trends for ART coverage per model and sustained 2019 prevention coverage (from 2018 IHBSS data) across models. Impact of COVID-19 on program coverage was factored in for NCR and Cebu City only.

The burden of the HIV epidemic varies not only among population groups but across different geographic areas as well. All cities and municipalities in the country are classified into three

main categories based on their level of HIV burden, as indicated by their HIV case to population ratio: Category A – high-burden areas with a 10.5 case per 10,000 population ratio; Category B – middle-burden areas with 4.8 case per 10,000 population ratio; and Category C – low-burden areas with 2.0 case per 10,000 population ratio. There are also specific areas in the Philippines with unique epidemic such as in the National Capital Region (NCR), Cebu province and Cebu City (among persons who inject drugs or PWIDs), and in Angeles City among female sex workers (FSW).

Based on DOH-EB projections, NCR will continue to bear the highest HIV burden until 2025. The estimated number of PLHIVs in Categories A and B sites is projected to overtake that of NCR by 2026 and 2029, respectively, if current trends are maintained (Fig. 4). The shift in projected trend is largely due to the varying population sizes as well as prevention and treatment coverages. While current national HIV and AIDS response is directed towards all categories, donor assistance leans heavily towards high burden sites such as NCR and Category A sites. PLHIV estimates are predicted to be lower for Cebu City and Angeles City.

III. FINANCING LANDSCAPE FOR HIV AND AIDS

A. POLICIES WITH IMPLICATIONS ON HIV FINANCING

New HIV law: Philippine HIV and AIDS Policy Act

The recently enacted RA No. 11166, otherwise known as the "Philippine HIV and AIDS Policy Act," repeals the Philippine AIDS Prevention and Control Act of 1998 and now serves as the new HIV law. It actually strengthened PNAC financing and governance through its provisions on the following: 1) Constitution of PNAC as an attached agency to the DOH, enabling it to receive and manage its own budget; 2) Adoption of a multisectoral approach in responding to HIV, which means that HIV service provision and financing are joint responsibilities of PNAC members and not the DOH alone; 3) Enhanced mandate of PNAC to coordinate, organize and work in partnership with foreign and international organizations regarding funding, data collection, research and prevention and treatment modalities on HIV and AIDS, and ensure foreign funded programs are aligned to the national response; 4) PNAC Secretariat coordination of council members' support to mobilize resources; and 5) PNAC development and implementation of the AIDS Medium Term Plan (AMTP), which includes the corresponding budgetary requirements and a corollary investment plan of each government agency specified in the AMTP, and the sources of funds for its implementation.

7th AIDS Medium Term Plan

PNAC developed various editions of the AMTP since 2000, the latest one being the 7th AMTP that will cover the period 2023 to 2028. It was formulated in line with the global goal of ending AIDS as a public threat by 2030. It aims to achieve the high-level targets of 95-95-95[8] through

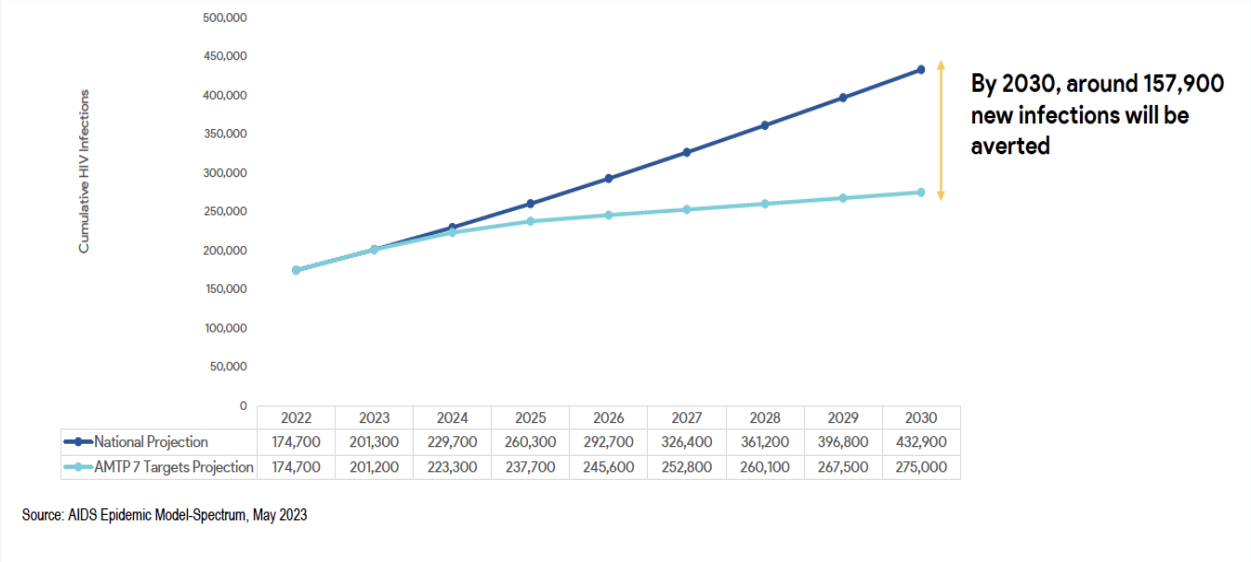
[8] This means that 95% of all HIV-positive individuals were diagnosed, 95% of those diagnosed were provided with antiretroviral therapy (ART), and 95% of those treated achieved viral suppression.

five pillars, namely: 1) PREVENTion; 2) TREATment; 3) PROTECTion; 4) STRENGTHENing of governance and leadership accountabilities, and systems for health, non-health, community and strategic information; and 5) SUSTAINing of the harmonized, fully resourced and crisis-resilient HIV response. Strategies under the latter include: 1) Increase of domestic funding for HIV and AIDS response; 2) Development of transition plan for externally funded initiatives such as Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR); 3) Harnessing of private sector partnerships to complement/augment government resources; and 4) Advocacy for policies supporting multisectoral HIV response.

Fig. 5 shows that 157,900 new HIV infections can be averted by 2030 if the 7th AMTP targets are met. Its strategies, however, have yet to be updated to consider the policy and operational implications of the latest epidemiological trends. They will then have to be translated into concrete programs, projects and activities for full costing, to guide the estimation of total resource requirements to meet the 7th AMTP targets.

Figure 5 shows that achieving the 7th AMTP targets can prevent 157,900 new HIV infections by the year 2030. Nonetheless, it is important to note that these strategies require updating to account for the most recent epidemiological developments as well as their policy and operational implications. Following this update, the strategies must be further transformed into tangible programs, projects, and activities for more accurate cost estimation of the overall resources needed to successfully attain the 7th AMTP targets.

Figure 5. Cumulative HIV infections among 15+ years old, 2023-2030



	2022	2023	2024	2025	2026	2027	2028	2029	2030
National Projection	174,700	201,300	229,700	260,300	292,700	326,400	361,200	396,800	432,900
AMTP 7 Targets Projection	174,700	201,200	223,300	237,700	245,600	252,800	260,100	267,500	275,000

Source: AIDS Epidemic Model-Spectrum, May 2023

Universal Health Care Act

Another landmark legislation with implications on HIV financing is the UHC Act, which guarantees all Filipinos financial protection. It introduced a shift in governance paradigms by encouraging the integration of local health systems into province-/city-wide health systems (P/CWHS), creation of primary care provider networks and health care provider networks (PCPNs), and setting up of an integrated fund for health at the local level through the Special

those living with HIV

Health Fund (SHF). The law emphasized strengthening of primary health care, which includes HIV related services, and the registration of Filipinos in accredited primary care providers that are linked to higher level facilities. The UHC Act mandates the DOH to fund population-based health services, and PhilHealth to cover individual-based health services. The following fund sources were identified for the attainment of UHC: 1) Health earmarks from total incremental sin tax collections; 2) Proportionate fund transfers from the Philippine Amusement and Gaming Corporation (PAGCOR) and the Philippine Charity Sweepstakes Office (PCSO) to PhilHealth to improve its benefit packages; 3) Premium contributions of members; 4) Annual appropriations of the DOH in the General Appropriations Act (GAA); and 5) National government subsidy to PhilHealth included in the GAA.

Mandanas-Garcia Ruling

Lastly, the Supreme Court ruling on the Mandanas-Garcia Cases in 2018 provides local government units (LGUs) a just share from the national taxes, which should not be limited to internal revenue taxes but to include collections (customs duties) of the Bureau of Customs and other tax-collecting agencies. This transfers to LGUs the resources commonly allocated to national government agencies providing health and related services, including those to address HIV, on the ground, supporting the devolution of health and other social services to LGUs, as mandated by the Local Government Code (LGC) of 1991.

B. SPENDING FOR HIV AND AIDS

The 2022 Philippine National Health Accounts (PNHA) showed that spending for HIV and AIDS and other sexually transmitted diseases (STDs) grew by almost 20 times from Php 272 million in 2014 to Php Php5.4 billion in 2021 before it declined significantly to Php4.6 billion in 2022 (Table 1). The latter comprised 0.4 percent of the total current health expenditure for the year. While the PNHA did not show spending for infectious and parasitic diseases by financing agent, applying the general share of the different financing agents to current health expenditures reveals that: nearly half (44.7%) came from household out-of-pocket (OOP) payments, followed by the central government (20.9%), PhilHealth (13.6%) and state/regional/local government (9.7%).

Following the passage of the Philippine HIV and AIDS Policy Act in 2018, spending for HIV/AIDS and other STDs increased significantly from Php1.04 billion that year to Php60.77 billion in 2019. However, it dipped by 93% in 2020 and remained at relatively low level until 2022 as the country struggled with the COVID-19 pandemic (Tables 1 and 2).

Table 1. Current health expenditure for infectious and parasitic diseases, 2014-2022 (in Php million)

Classification of Diseases/Conditions	2014	2015	2016	2017	2018	2019	2020	2021	2022
Infectious and parasitic diseases	118,499.05	129,674.42	142,140.10	207,491.57	169,491.82	248,341.00	134,601.98	340,683.35	205,723.63
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	271.97	433.14	517.24	673.96	1,041.98	60,773.60	4,175.84	5,419.73	4,550.87
Tuberculosis (TB)	5,428.80	6,014.33	9,592.50	13,358.41	6,849.05	7,877.97	29,048.80	5,246.81	4,352.92
Malaria	63.93	309.68	507.33	734.79	129.78	385.36	599.63	139.53	87.66
Respiratory infections	53,000.63	56,555.12	59,069.84	65,070.33	72,763.48	80,807.31	16,813.34	58,973.59	43,532.58
Diarrheal diseases	15,080.00	16,005.82	17,529.19	66,701.83	20,483.35	21,914.65	6,435.17	6,150.36	8,263.00
Neglected tropical diseases (dengue)	8,536.01	9,561.27	10,583.18	9,044.81	9,457.73	10,204.66	212.56	767.97	620.51
Vaccine preventable diseases	19,886.90	22,025.35	23,911.20	27,793.04	30,802.54	35,214.56	36,541.89	61,030.69	59,541.42
Hepatitis	0.00	0.00	0.00	0.00	25.63	23.14	335.46	262.95	65.69
Public Health Emergency of International Concern (PHEIC)	0.00	0.00	0.00	0.00	0.00	0.00	24,559.55	178,153.10	54,148.42
Disease from Coronavirus SARS-CoV-2 (COVID-19)	0.00	0.00	0.00	0.00	0.00	0.00	24,559.55	178,153.10	54,148.42
Other and unspecified infectious and parasitic diseases (n.e.c.)	16,230.83	18,769.70	20,429.64	24,114.41	27,938.28	31,139.76	15,879.75	24,538.62	30,560.58

Source: 2022 Philippine National Health Accounts

Table 2. Current health expenditure for infectious and parasitic diseases, 2014-2022 growth rates (in percent)

Classification of Diseases/Conditions	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Infectious and parasitic diseases	9.4	9.6	46.0	-18.3	46.5	-45.8	153.1	-39.6
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	59.3	19.4	30.3	54.6	**	-93.1	29.8	-16.0
Tuberculosis (TB)	10.8	59.5	39.3	-48.7	15.0	268.7	-81.9	-17.0
Malaria	384.4	63.8	44.8	-82.3	196.9	55.6	-76.7	-37.2
Respiratory infections	6.7	4.4	10.2	11.8	11.1	-79.2	250.8	-26.2
Diarrheal diseases	6.1	9.5	280.5	-69.3	7.0	-70.6	-4.4	34.3
Neglected tropical diseases (dengue)	12.0	10.7	-14.5	4.6	7.9	-97.9	261.3	-19.2
Vaccine preventable diseases	10.8	8.6	16.2	10.8	14.3	3.8	67.0	-2.4
Hepatitis	-	-	-	-	-9.7	**	-21.6	-75.0
Public Health Emergency of International Concern (PHEIC)	-	-	-	-	-	-	625.4	-69.6
Disease from Coronavirus SARS-CoV-2 (COVID-19)	-	-	-	-	-	-	625.4	-69.6
Other and unspecified infectious and parasitic diseases (n.e.c.)	15.6	8.8	18.0	15.9	11.5	-49.0	54.5	24.5

Source: 2021 Philippine National Health Accounts
***Growth rate greater than 1,000*

C. FUND SOURCES FOR HIV AND AIDS

Funds for HIV and AIDS in the Philippines come from the following sources: 1) Government – a) national government (mainly from the Department of Health or DOH and PhilHealth, and partly from other national government agencies or NGAs), and b) local government units (LGUs); and 2) Non-government sources, which consist of official development assistance and private sector funding, which also includes household OOP payments.

1. GOVERNMENT

Domestic Financing Mechanism (DFM) for Key Populations in the Philippines includes multiple sources of financing and structures. It is distinct compared to other countries due to the decentralized governance structure, vibrant civil society, and complex health financing system. The DFM for Key Populations in the Philippines includes (1) Social Contracting Grants to Key Population led organizations from the Philippines' government at the Local Government Unit (LGU) level, (2) reimbursement through the national Health Insurance system (PhilHealth) in accredited private sector and public sector facilities as well as (3) direct funding to public health facilities including Social Hygiene Clinics that cater to key populations from the Department of Health (DOH).

National government financing for HIV generally falls under two classifications, namely, subsidy through the General Appropriations Act (GAA) and the National Health Insurance Program (NHIP). National subsidy for HIV is lodged with the Department of Health (DOH), while the NHIP is managed by the Philippine Health Insurance Corporation (PhilHealth). The GAA results from a generally political process of legislation that is based on the technical budget proposal of government line agencies like the DOH. The LGU budget for HIV follows the same process, but on a smaller scale. LGUs have the mandate to formulate their own budget, but these are monitored and confined to rules and procedures.

National level

DOH

The national subsidy for HIV is part of the budget managed by DOH, as specified in the GAA. Such funds are used for the development and issuance of service delivery standards and guidelines, and procurement as well as distribution of preventive drugs, medicines, and commodities.

Specifically, the DOH manages its funds for HIV through the following units: the Disease Prevention and Control Bureau (DPCB), Epidemiology Bureau (EB), and Centers for Health Development (CHDs). Under DPCB, HIV concerns are lumped with Sexually Transmitted Infection (STI) Control and Hepatitis programs under the Prevention and Control of Communicable Disease (PCCD) budget line item. Within PCCD, these lumped programs had the second biggest fund allocation, next to Tuberculosis Control. These funds are mostly used for the procurement and distribution of preventive drugs, medicines, and commodities. In the 2023 GAA, Php5.79B was appropriated to the PCCD budget line item. Based on the 2023 National Expenditure Program (NEP), which is the basis of the 2023 GAA, the allocation for the "HIV/AIDS, STI" program is Php1.43 billion - the second highest among PCCD programs, projects and activities (see Table 3).

Table 3. Proposed budget for prevention and control of communicable diseases, 2023

Programs, Projects & Activities	Budget Proposal	NEP Amounts
HIV/AIDS, STI	1,433,663,932	1,433,663,932
Dengue control	306,178,000	306,178,000
Rabies Prevention and Control	715,200,000	715,200,000
Filariasis Elimination	17,003,200	17,003,200
EREID	49,180,000	49,180,000
Malaria Control	128,614,200	128,614,200
Schistosomiasis Control	111,800,900	111,800,900

Tuberculosis Control	1,969,257,850	1,969,257,850
Excess		489,438,918
TOTAL	4,730,898,082	5,720,337,000

Source: DOH Proposed 2023 Budget Presentation to the House of Representatives and Senate, 2022

A rather new national government funding source for HIV is the subsidy for PNAC. In the past, this subsidy used to be part of the DOH budget for public health. The enactment of the Philippine HIV and AIDS Policy Act in 2018 reconstituted PNAC as an attached agency of the DOH. This allows the Council to directly receive and manage its own budget, independent of the DOH. PNAC's budget increased by 47% from Php35.5 million in 2022 to Php52 million in 2023. The 2023 GAA allocated Php52 million for PNAC - Php38.8 million of which was for Personnel Services, and Php15.26 million for Maintenance and Other Operating Expenses (MOOE) (Table 4). Of the latter, which is the budget spent on the execution of programs, projects, and activities, Php4.69 million was earmarked for general administration and support.

The new HIV law also calls for the adoption of a multi-sectoral approach in responding to the HIV and AIDS situation. Thus, funds for HIV from the GAA are not anymore limited to those that are appropriated to the DOH and PNAC. They should now include even those coming from other agencies, especially members of the Council. Based on the initial data collected by the PNAC Secretariat from the council member agencies, bulk of the national government agency budget allocations for HIV and AIDS contribute to PREVENT and TREAT strategic pillars, and very little to none at all for PROTECT, STRENGTHEN and SUSTAIN.[i]

Table 4. National government budget allocation for HIV and AIDS, 2022-2023

ITEM	2022	2023
Department of Health		
Prevention and Control of Communicable Diseases [a]		
Anti-retroviral drugs (ARVs), OI and STI drugs, PrEP	383,487,623	1,433,663,932
Diagnostics and medical devices (test kits, CD4 and HIV VL POC cartridges, condoms)	367,560,000	
Philippine National AIDS Council		
Personnel services	29,262,000[b]	36,794,000[c]
Maintenance and other operating expenses	6,196,000[b]	15,259,000[c]
PhilHealth		
Outpatient HIV/AIDS packages	778,675,792[d]	593,011,014[e]
TOTAL	**1,529,723,415**	**2,034,107,946**

Sources: [a] *DOH Disease Prevention and Control Bureau*
[b] *2023 DOH National Expenditure Program*
[c] *2023 General Appropriations Act Vol. 1-A*
[d] *PhilHealth Stats & Charts 2022*
[e] *PhilHealth Stats & Charts 2023 (1st Semester)*

With regard to budget utilization, only one third (33 percent) of the Php5,054,476 adjusted appropriations for PNAC Secretariat operations in 2022 was spent.[9] The DOH's Statement of Appropriations, Allotments, Obligations, Disbursements and Balances did not specify the appropriations as well as the obligation and disbursement rates for other line items directly related to HIV and AIDS.

PhilHealth

Another national government funding source for HIV is the subsidy for premium payment and benefits development in the GAA, which is managed by PhilHealth. In the case of HIV, PhilHealth makes the Outpatient HIV Treatment (OHAT) package accessible to PLHIV needing anti-retroviral treatment (ART) (PhilHealth, 2015). Under the OHAT package, DOH-designated treatment hubs in accredited health facilities may file for reimbursement up to Php 30,000 every year or Php 7,500 per quarter for treatment, care and support services. These include drugs and medicines; laboratory examinations based on specific treatment guidelines, including Cluster of Differentiation 4 (CD4) level determination test, viral load (if warranted) and test for monitoring antiretroviral drug toxicity; and professional fees of providers (PhilHealth, 2015).

PhilHealth reimbursement of OHAT claims amounted to Php 593 million as of the first semester of 2022 (Table 4). OHAT package only covers HIV and AIDS cases confirmed by the STD/AIDS Central Cooperative Laboratory (SACCL) or the Research Institute for Tropical Medicine (RITM) as requiring treatment. It excludes the following: a) diagnosis of HIV/ AIDS with no laboratory confirmation, b) HIV/ AIDS cases with no indication for anti-retroviral therapy, c) management of patients for pulmonary tuberculosis co-infection, d) illness (opportunistic infections) secondary to HIV/AIDS requires hospitalization, and e) HIV/AIDS cases requiring confinement as these are covered under the regular inpatient benefit of PhilHealth.

The national government budget (DOH and PhilHealth only) allocated for HIV and AIDS increased from Php1.5 billion in 2022 to Php2 billion in 2023. This amount does not yet include the amount allocated by other NGAs for programs, projects and activities supporting service provision owing to difficulty in tracking budget allocations specific to HIV and AIDS. To illustrate, the Department of Education (DepEd) and the Department of Social Welfare and Development (DSWD) provide budget for certain programs that partly support HIV and AIDS awareness-raising and education, such as through the Comprehensive Sexuality Education in schools, and the routine Family Development Sessions for *Pantawid Pamilya* beneficiaries. However, their actual budgets for HIV and AIDS cannot be readily determined for lack of categorical allocations specific for the program.

[9] Based on the DOH Statement of Appropriations, Allotments, Obligations, Disbursements and Balances as of the Quarter Ending December 31, 2022. Retrieved from https://doh.gov.ph/sites/default/files/transparency%20seal/FAR%201%20-%20Wide.pdf.

Local Government Level

The LGUs are another source of funds for HIV. RA No. 7160, otherwise known as the Local Government Code (LGC), mandated LGUs to provide basic services, which includes primary health care. It is therefore incumbent upon every LGU to finance PAPs aimed at providing basic HIV services to their constituents.

Section 287 of the LGC also mandates LGUs to appropriate at least 20% of its IRA specifically to finance development projects. Commonly known as Local Development Fund (LDF), it is used to finance the priority projects of LGUs as embodied in their duly approved local development plans and Annual Investment Programs (AIP). Data showed that from 2009 to 2018, LGUs mostly spent their IRA and own-source revenues for general public services (46%), social services (21%), and economic services (15%), with capital outlays lagging behind at roughly 12% (Sicat et al. 2020a, 12-13). LGU spending was also much lower than the collected revenue. In 2019, the average surplus of provinces was 26 percent while cities and municipalities registered 22% and 17%, respectively. Moreover, LGUs have not been fully utilizing their LDFs. Based on Bureau of Local Government Finance (BLGF) data, only one in five LGUs (21.30%) registered 100% LDF utilization rate while more than a quarter (25.90%) of the 1,716 LGUs (excluding barangays) in the country have utilization rates of less than 50%. In 2019, the national average for LDF utilization rate is 73.84%, with Regions IV-B and VII performing the worst, at 55.36% and 51.84%, respectively.[10]

LGU funding for HIV is not maximized. Only a limited number of LGUs are spending to address HIV concerns - mostly highly urbanized cities or independent component cities. These LGUs serve as treatment hubs catering even to PLHIVs from adjacent LGUs within their province that do not share in the cost. The Local Government Code did not distinguish as to which LGUs should provide basic services, including primary health care. In essence, all cities and municipalities are required to provide HIV services, among others. The Department of Budget and Management (DBM) Budget Memorandum No. 85 dated June 15, 2022 entitled: *Indicative FY 2023 National Tax Allotment Shares of LGUs and Guidelines on the Preparation of the FY 2023 Annual Budgets of LGUs*[11] provided that the annual budgets of LGUs for FY 2023 shall include programs, projects and activities (PPAs) related to Gender and Development, Senior Citizens and Persons with Disabilities, Combating AIDS, and the implementation of programs for the protection of children. However, actual LGU allocations for these programs have yet to be determined.

2. NON-GOVERNMENT

Official development assistance

Official development assistance (ODA) is another funding source. The Joint United Nations Programme on HIV and AIDS (UNAIDS) convenes the UN Joint Team, which develops a biennial plan with the World Health Organization (WHO), United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF), and United Nations Office on Drugs and Crime (UNODC), together with PNAC and DOH. In addition, components of the WHO 2022-2023

[10] Senate Economic Planning Office. (2022). IRA in 2022 at a Glance. Retrieved from https://legacy.senate.gov.ph/publications/SEPO/AAG%20IRA%20in%202022__21March2022.pdf.

[11] Retrieved from https://www.dbm.gov.ph/wp-content/uploads/Issuances/2022/Local-Budget-Memorandum/LOCAL-BUDGET-MEMORANDUM-NO.85-DATED-JUNE-15-2022.pdf.

Biennium Work Plan relevant to HIV are as follows: Component 2 – Countries are enabled to provide high-quality, people-centered health services, based on primary health care strategies and comprehensive essential service packages; Component 3 - Improved access to quality essential services; and Component 5 - Improved access to essential medicines, diagnostics and devices for primary health care. Other donors include USAID and Global Fund (see Table 5).

Table 5. ODA funds for HIV and AIDS-related programs and projects

Donor	Project	Amount (in million pesos)	Period covered
WHO	WHO 2022-2023 Biennium Work Plan	743.88	2022-2023
USAID	Development Objective Agreement "Family Health Improved"	11,200	2020-2024
Global Fund	Global Fund funding for HIV	138.14 241.03 289.96	2024 2025 2026

Source: DOH Bureau of International Health Cooperation

Private sector

The private sector, which includes household out-of-pocket spending, appears to be the biggest funding source for HIV services. Applying its share in health spending as estimated in the PNHA, households shouldered nearly half or 44.7% (around Php2.03 billion) of the Php4.55 billion spending on HIV and AIDS and other STDs in 2022.

IV. RESOURCE REQUIREMENTS FOR HIV

Using the 2023 AIDS Epidemic Model (AEM), the DOH-EB estimated the resource requirements for HIV and AIDS reduction/elimination under four case scenarios: 1) **current national projection** - coverages were based on current observed trends and assumes that by 2025, prevention coverage is sustained at 26% and treatment coverage is at 51%; 2) **AMTP 7 Scenario** – assumes that by 2025, prevention coverage is at 95% and treatment coverage among estimated PLHIV is at 90% (similar to 95% of diagnosed PLHIV are on ART); 3) **Prevention Scale-Up Scenario** – assumes that by 2025, prevention coverage is at 95% while current projected treatment coverages in the national projection are sustained; and 4) **Treatment Scale-Up Scenario** – assumes that by 2025, treatment coverage among estimated PLHIV is at 90% while current prevention coverage is sustained at 26%.

The 2023 AEM was enhanced through the incorporation of data from multiple sources, including the 2022 HIV/AIDS & ART Registry of the Philippines (HARP), the 2022 Integrated HIV Behavioral and Serologic Surveillance (IHBSS), the 2019 and 2020 Online Survey among Males having Sex

with Males and Transgender Women (MSM & TGW), the 2019 Facility-based Survey, the 2022 Laboratory and Blood Bank Surveillance (LaBBS), the 2020 Population Census, the 2015 Key Population Size Estimates, and various other program-related information. The development of estimates for People Living with HIV (PLHIV) involved an extensive process of consultation, validation, and review, which included input from technical experts representing organizations such as the East West Center, UNAIDS, WHO, as well as key stakeholders at national, regional and local levels. These projections may be subject to adjustments as new data becomes available with the annual updating of information.

The DOH-EB forecasted that, based on current trends (business as usual), the resource requirements for addressing HIV will range from Php3.2 billion to Php6.8 billion annually from 2023-2028. In contrast, the scenarios involving the scale-up of prevention and treatment as well as the implementation of the 7th AMTP, will necessitate annual budgets of Php3.9 billion to Php9.4 billion during the same period. Notably, the AMTP 7 scenario is expected to demand the highest initial investment due to its ambitious objectives (see Figure 7). However, investing in this scenario is anticipated to yield significant socioeconomic benefits. By the year 2035, the substantial reduction in annual new infections among individuals aged 15 and above, as envisioned in this scenario, is projected to free up additional HIV resources. Table 6 shows that the financial requirements in the AMTP 7 scenario will already be among the lowest by this year, and the lowest among all scenarios by 2040 – thus making it the most cost-effective option.

Table 6. Projected resource requirements and outcomes on HIV and AIDS under different case scenarios

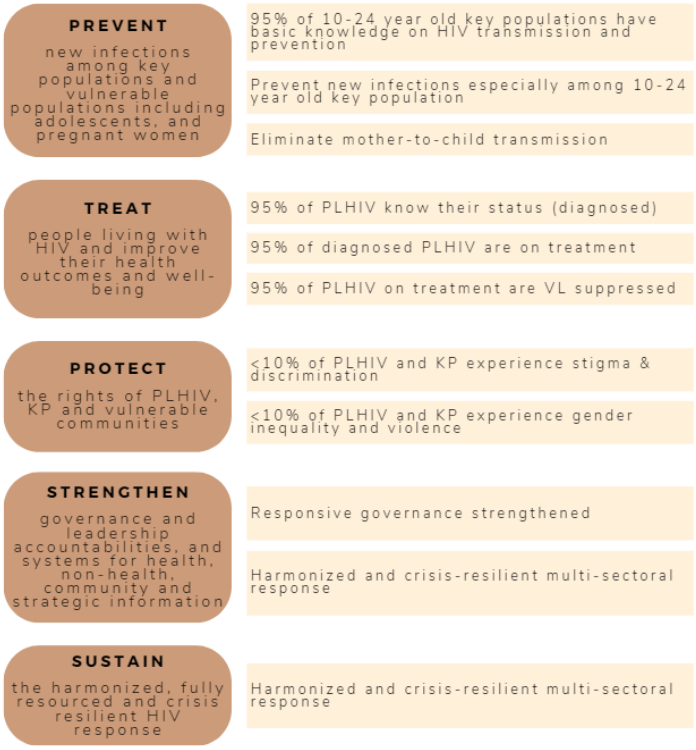
Year	2023	2024	2025	2026	2027	2028	2029	2030	2035	2040
Estimated Resource Needs for Prevention and Treatment (PhP) [a]										
Current National Projection	3.2 billion	3.7 billion	4.3 billion	5.1 billion	5.9 billion	6.8 billion	7.6 billion	8.6 billion	13.3 billion	17.6 billion
AMTP 7: 95-95-95 by 2025	4.6 billion	6.7 billion	8.8 billion	9.0 billion	9.2 billion	9.4 billion	9.6 billion	9.8 billion	10.7 billion	11.7 billion
Prevention Scale-Up by 2025	3.9 billion	5.1 billion	6.4 billion	6.8 billion	7.3 billion	7.8 billion	8.3 billion	8.8 billion	10.9 billion	12.4 billion
Treatment Scale-Up by 2025	3.9 billion	5.3 billion	6.9 billion	7.2 billion	7.5 billion	7.9 billion	8.3 billion	8.7 billion	10.7 billion	13.0 billion
Epidemiological Outcomes among 15+ [b]										
Estimated PLHIV										
Current National Projection	185,900	211,700	239,400	268,600	298,900	330,000	361,500	393,400	548,700	690,200
AMTP 7: 95-95-95 by 2025	185,800	205,400	216,900	222,300	227,900	233,500	239,200	244,900	273,100	299,900
Prevention Scale-Up by 2025	185,900	206,000	222,500	235,500	248,000	260,000	271,500	282,500	329,500	366,100
Treatment Scale-Up by 2025	185,600	207,400	224,800	237,300	249,700	262,700	276,000	289,700	363,400	444,800
Annual new infections										
Current National Projection	26,500	28,500	30,600	32,400	33,700	34,800	35,500	36,100	35,900	34,900
AMTP 7: 95-95-95 by 2025	26,500	22,200	14,400	7,900	7,200	7,300	7,400	7,500	7,700	7,100
Prevention Scale-Up by 2025	26,500	22,800	19,400	16,200	15,900	15,600	15,200	14,800	12,800	11,600
Treatment Scale-Up by 2025	26,200	24,300	19,900	14,900	14,300	14,800	15,300	15,800	18,300	20,700
Annual AIDS deaths										
Current National Projection	1,900	2,100	2,200	2,400	2,500	2,700	2,800	2,900	3,700	4,500
AMTP 7: 95-95-95 by 2025	1,900	2,100	2,100	1,800	1,000	900	900	900	1,100	1,300
Prevention Scale-Up by 2025	1,900	2,100	2,200	2,400	2,600	2,700	2,800	2,900	3,100	3,300
Treatment Scale-Up by 2025	1,900	1,900	1,800	1,600	1,100	1,000	1,100	1,100	1,400	1,800

Source: DOH Epidemiology Bureau AIDS Epidemic Model - May 2023

Items that were cost out were mostly on direct service delivery, with the addition of 20% overhead cost for non-direct items such as operations, program and social enablers, quality improvement, and monitoring and evaluation based on the 2013 UNAIDS Costing Study. Investment needs on HIV include those on prevention (HIV information, condom, and HIV & STI testing) for key populations and PLHIV 15 years old and above. It did not yet include the

cost for PrEP and coverage for children, pregnant women, and mother-to-child transmission (MTCT). A standard cost for prevention and treatment (based on the 2022 AEM unit costing) was used in the projections, and does not yet factor in inflation.

Figure 7. 7th AMTP 2023-2028 Targets



The TB-HIV Co-Financing Plan for 2024-2026 showed a much higher estimate of the investment requirements for HIV at Php45.6 billion for the three-year period (Table 7) – nearly double the P24.5 billion estimated by the DOH-EB for the 7TH AMTP scenario for the same years. Around 44.3% of this estimated amount goes to prevention strategies like distributing condoms, introducing PrEP and PEP, community outreach, and mental health integration. Testing gets 19.8% of the funds for various testing methods. Treatment gets 34.6% to improve treatment and care, with a focus on a person-centered approach. The remaining 1.2% goes to strengthening the health system, including training, supply management, and community support. Based on historical spending, commitments and potential funding received as of January 2023, the TB-HIV Co-Financing Plan projected domestic and external funding for HIV for 2024-2026 to reach a total of Php23.2 billion. Given its estimated three-year resource requirement for HIV at Php45.6 billion, there is a funding gap of Php22.4 billion for the program.

Variations in cost estimates for HIV may arise from disparities in service delivery standards, cost components and units, health system infrastructure, time horizon, data sources and quality, and policy and regulatory environment.

Table 7. Funding Gap for the HIV Program, 2024-2026

	2024	2025	2026	Total
Projected funding for HIV	**6,538,934,874**	**7,839,596,500**	**8,824,478,613**	**23,200,010,187**
Domestic				
DOH	4,161,481,702	5,358,654,391	6,117,660,018	15,637,796,111
PhilHealth	1,029,798,735	1,184,268,545	1,361,908,827	3,575,976,107
LGU	405,940,888	446,534,977	491,188,474	1,343,664,339
Others	7,090,774	7,445,312	7,817,578	22,353,664
External				
TGF	536,203,260	444,273,760	443,273,260	1,420,750,780
USAID	356,310,100	356,310,100	356,310,100	1,068,930,000
Others	42,109,415	42,109,415	46,320,356	130,539,186
Estimated resource requirements for HIV	**14,272,360,154**	**14,815,074,258**	**16,428,407,379**	**45,615,841,791**
Prevention	6,540,545,541	6,385,213,509	7,288,512,034	20,214,271,084
Testing	2,885,606,296	2,993,849,051	3,160,676,332	9,040,131,679
Treatment	4,774,440,777	5,247,514,004	5,771,871,550	15,793,826,331
HIV-Specific Resilient and Sustainable Systems for Health	71,767,540	188,497,694	207,347,463	567,612,697
Funding gap	**7,733,425,280**	**6,975,477,758**	**7,603,928,766**	**22,415,831,604**

Source: TB-HIV Co-Financing Plan for 2024-2026

V. CHALLENGES

Cost implications of fast-rising HIV incidence exacerbated by tight fiscal space. The country is in a tight fiscal space, which is mainly a consequence of the COVID-19 pandemic, rising inflation, and other global economic and political crises. While the Administration prioritizes health in its development priorities, the budget pie for health, particularly for HIV, will be smaller. As explained in this report, HIV will have to contend with other public health concerns of the country. At the national level, the funds for HIV will continue to be incorporated with STI in the budget for the Prevention and Control of Communicable Diseases program of the DOH. Most, if not all, of such funds are for the bulk procurement of specified drugs, medicines and supplies for HIV related service provision. Like with other programs, no substantial increase in funding can be expected over the medium term.

Lack of updated service delivery standards and metrics for reaching the 95-95-95 AMTP targets. The 7th AMTP 2023-2028 targets of 95-95-95 have not been effectively translated into tangible outcomes through clearly defined strategies articulated by programs, projects, and activities that can be accurately costed. Without updated service delivery standards on HIV, measurable outcomes and specific milestones and strategies, articulated in the form of programs, projects and activities, implementers may find themselves engaged in recurrent programs, projects, and activities without a clear target in sight, lacking a coherent framework outlining the path to reaching the 2030 targets. There is a noticeable trend wherein stakeholders implementing the cascade of care for HIV incorporate diverse activities and cost items. Unfortunately, this practice is likely to persist until all stakeholders reach a consensus on HIV standards, outcomes and targets.

Constrained PNAC Secretariat oversight functions and skills. The PNAC Secretariat, based on the new HIV law, is now constituted as an attached agency of the DOH. Therefore, from being a mere administrative office of the DOH, it is now elevated to a policy development unit that should function like the National Nutrition Council (NNC), i.e. able to manage and address complexities associated with HIV by providing technical guidance and strategic direction in combating the HIV epidemic. PNAC is now mandated to at least develop the AMTP and ensure its implementation; develop and implement guidelines and policies related with AMTP; monitor implementation of the AMTP; and mobilize funds for the AMTP (RA 11166). The law even requires it to establish a secretariat consisting of personnel with necessary expertise and capacity to, among others, assist the council in identifying and building internal and external networks and partnerships, and coordinate and support council efforts to mobilize resources (RA 11166). These are tall tasks to accomplish given the current capacity of PNAC, which originated from the old secretariat that used to operate as a unit of DOH-DPCB. Thus, PNAC needs to be capacitated to operate like NNC at least in order to live up to the mandate of the new law and expectations of stakeholders.

Fragmented budgeting and procurement for HIV. As described earlier, the budget for HIV, especially those coming from the government, comes from various autonomous sources. The use of such funds, especially with respect to procurement, follows their respective owners, i.e. national government via the DOH-DPCB, PhilHealth and PNAC, and the LGUs. Funds from these sources, except for PhilHealth, are used for the procurement of goods and services. As explained, national government financing and budget execution for HIV are independent of that of the LGUs. More so, national government procurement using funds managed by the DOH-DPCB is actually executed by a separate DOH unit, which is the Procurement Service (DOH-PS).

LGUs, for their part, execute their own procurement of goods and services using funds, which they themselves have allocated through the enactment of their respective general appropriations ordinance. However, allocating funds for HIV is generally unpredictable. While the LGC mandates LGUs to provide basic health services to their constituents, HIV would have to contend with other primary care services that are provided by local health facilities. LGU funds for HIV, aside from being budgeted and executed independently from that of the national government, are limited and may not be the priority of many LGUs.

Weak planning, budgeting, and procurement linkage. Through the years, the national budget for HIV is allocated for bulk procurement along with logistics management. By practice, the utilization or spending of such appropriations is assigned to a focal person under the management and supervision of the Director of DOH-DPCB. However, actual procurement is exercised by the Procurement Service (DOH-PS), which is headed by a separate Director. On the other hand, disbursement or actual spending is the responsibility of the DOH Finance and Management Service (FMS). The processes within each of these DOH offices are independent of each other, which sometimes result in delays in utilization due to processing or turnaround time. Historically, big ticket procurements, like that for HIV, suffer from delay and even cancellation resulting in low fund utilization or spending.

Work planning for the utilization of appropriated amounts in DOH is rather weak. Its execution within the Department is quite unclear and left in the hands of a focal person in

DOH-DPCB. Budget preparation proposal development is actually an internal DOH process. In practice, a work plan based on the budget proposal is adopted as the actual work and financial plan (WFP) as soon as the GAA gets enacted. The WFP becomes the basis for all PAPs that will be executed. The DOH budget execution is based on PAPs implementation. All the processes leading to actual budget disbursement are all internal concerns of the DOH. Anecdotal account shows that the utilization of funds for HIV is left in the hands of a focal person, who is answerable to the director of DOH-DPCB.

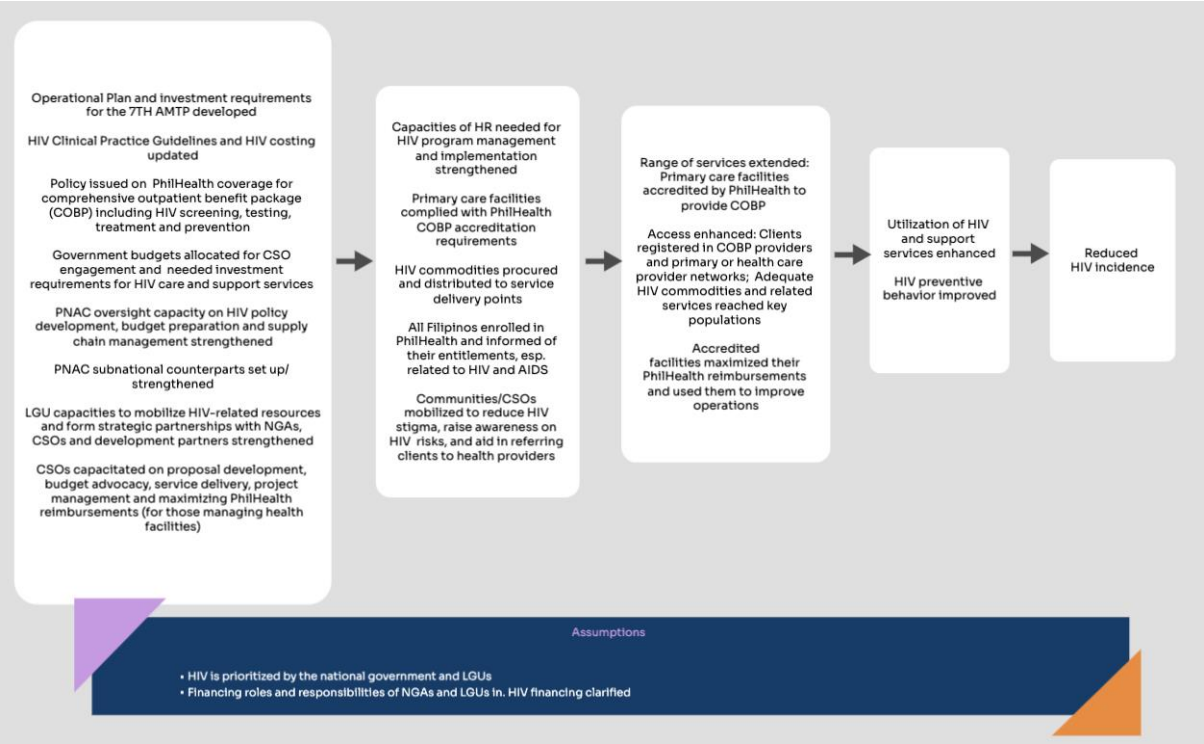
Inadequate social health insurance coverage for HIV. PhilHealth makes the OHAT package available to PLHIV needing ART (PhilHealth, 2015). Spending by PhilHealth is triggered by individual claims of members for the OHAT package. Despite the scope of the package, it is still not enough to cover all the needs of PLHIVs. Aside from inadequacy, the total PhilHealth expenditure for HIV in a given year depends on the number and frequency of claims against the OHAT package. This demand side concern should also be coupled by the supply side intervention of ensuring the availability of accredited health providers that can provide the packaged services. This aspect also requires budgeting on the part of the government or the private sector. PLHIV availment of OHAT would also require an efficient information campaign.

VI. STRATEGIES

To help achieve the country's SDG target of eliminating or reducing HIV incidence by 2030, the HIV Financial Sustainability Roadmap identifies strategies that will allow the country to translate its HIV policies into concrete actions and results, ensuring that the necessary resources are available to implement them effectively. Fig. 8 shows the HIV value chain, where policies and budgets are translated into inputs necessary to produce the target outputs, eventually leading to desired outcomes and creating a meaningful impact on the growing epidemic in the Philippines. Applying the health system value chain on HIV and AIDS allows stakeholders to see the prerequisites along the various elements that need to materialize to arrive at the ultimate goal of reducing HIV and AIDS incidence in the medium term.

The value chain assumes that HIV is prioritized by the national government and LGUs in their policies and budgets. It further assumes that the financing roles and responsibilities of concerned national government institutions, PhilHealth, LGUs and other development partners in the provision of HIV care and support services are clarified and adhered to.

Figure 8. HIV Value Chain



This Roadmap identifies the following strategies, which are focused on policy and financing, to support the sustainable funding of HIV care and support services in the Philippines:

1. **Develop standard HIV care pathway aligned with the latest healthcare advancements and the needs of the population**

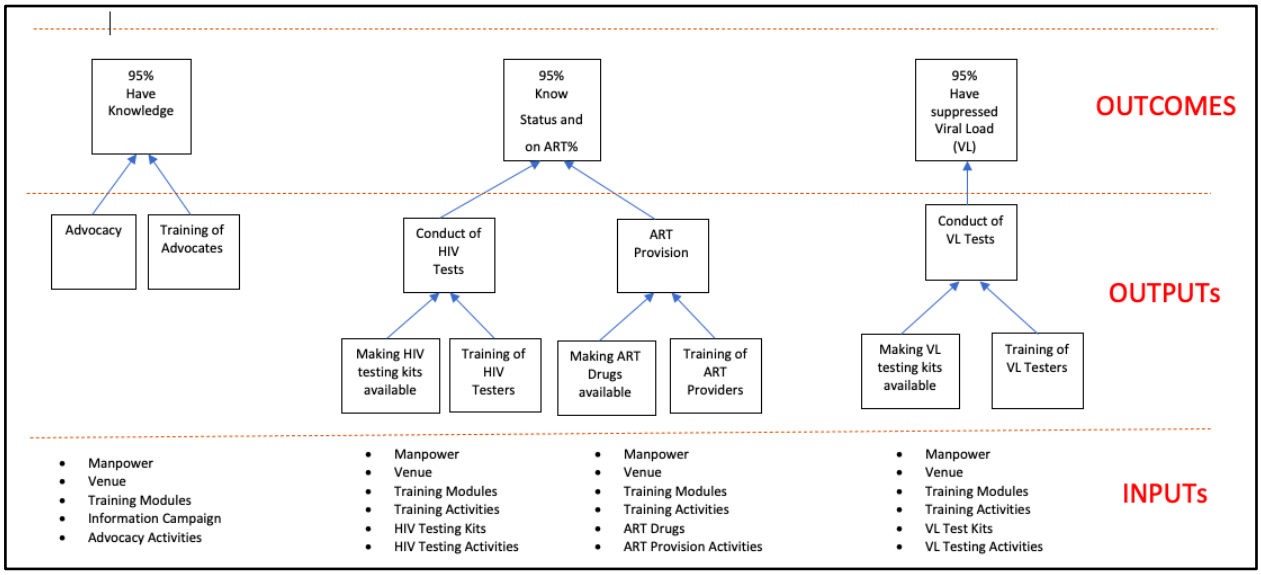
Updating the standards for HIV patient care pathway is critical in ensuring accurate costing of HIV care and support services, and sustainable financing for HIV in the Philippines. This entails a comprehensive review of existing guidelines, incorporating global good practices in HIV care and evidence-based interventions for more expansive HIV prevention strategies (e.g. scaling up of HIV self-testing and PrEP), more accessible and streamlined screening and diagnosis, improved HIV treatment and patient-centered support services. Collaboration with experts, healthcare providers, policy- and decision-makers, and community representatives will have to be ensured to obtain diverse perspectives and foster a sense of ownership in the updated standards. By determining the standards as well as their corresponding cost elements, and updating the cost units, policymakers and program managers will be guided in identifying HIV interventions of best value, help them understand the cost of and benefits from the strategy, and set more realistic budget for HIV.

2. **Translate the 7th AMTP into an operational plan with investment requirements**

Once a standard HIV patient care pathway is developed, and the standards as well as the cost elements and units are updated, the 7th AMTP may be translated into an operational plan with concrete programs, projects and activities, investment requirements and measurable as well as more realistic targets linked to specific outcomes.

Technical assistance will be provided to PNAC as it leads the translation of the 7th AMTP 2023-2028 targets into concrete strategies or interventions. These strategies will then be developed into clear and realistic programs, projects and activities with well-defined priorities and accountabilities. This will be the basis of concerned institutions in estimating their resource requirements for HIV, and the Department of Budget and Management (DBM) in determining appropriate budget allocations to concerned agencies – consistent with their HIV-related mandates and accountabilities. The clarification of AMTP targets will also allow the PNAC to determine current funding requirements as well as gaps in the implementation of the AMTP interventions. Through this process, inputs that will enable the implementation of strategies can be costed out, allowing PNAC and concerned stakeholders to estimate and plan for the needed resources for HIV to attain the 7th AMTP targets. Fig. 9 illustrates the basic inputs needed to deliver the core outputs on HIV advocacy and service delivery. This may be expanded consistent with the standard HIV patient care pathway to be developed.

Figure 9. Costing framework for 95-95-95 strategy of the 7th AMTP 2023-2028



3. Expand PhilHealth support value for HIV services

PNAC will play an active role in examining the existing PhilHealth benefit packages to ensure increased support for HIV services. This involves considering the incorporation of diagnostics and preventive care for HIV into pertinent packages, such as OHAT and the Konsulta/Comprehensive Outpatient Benefit (COPB) package, and HIV treatment in relevant case rates. There is also a need to raise awareness among PhilHealth executives about the urgency and significance of averting the HIV epidemic, positioning it alongside their current priorities, including All Case Rates (ACR), End Stage Renal Disease (ESRD), Stroke and Pneumonia, Heart Disease and Kidney Transplant, including Peritoneal Dialysis, Z Benefits for various conditions, Mental Health, Selected Orthopedic Implants, and Other Z Benefits. The extensive nature of this list highlights the importance of incorporating HIV into PhilHealth's policy agenda.

While advocating for improved PhilHealth benefits for HIV, efforts will also be directed at informing the general public about the existing OHAT package and other available PhilHealth benefits for individuals with HIV. CSOs will be mobilized to enhance awareness among PhilHealth members regarding their health entitlements and obligations, and facilitate their connection with PhilHealth-accredited primary care providers and healthcare networks.

4. **Strengthen technical and budget advocacy for HIV in national and local level planning platforms**

PNAC will develop evidence-based plans and budget proposals to better advocate for higher HIV funding in Congress and among concerned government agencies. It may anchor its advocacy on the urgent need to address the HIV epidemic, and the Philippine Development Plan (PDP) 2023-2028 prioritization of HIV as a primary health concern. Support will be provided in beefing up the capacities of PNAC and concerned DOH units in developing their respective budget proposals for the subsequent year (discussed at length in the next strategy). CSOs and other concerned stakeholders may be engaged to support PNAC in its technical and budget advocacy for increased funding for HIV programs, projects, and activities.

PNAC will work on ensuring that the DOH HIV budget allocation and expenditure consider the consolidated Local Investment Plans for Health (LIPHs) from the different provinces and highly urbanized cities. Stakeholders operating in these localities will be actively involved in the LIPH development process and Regional Development Council meetings, often chaired by the DOH Regional Director. Stakeholders will be guided towards identifying budget line items that can be tweaked for the implementation of HIV related activities. The information will help them as they lobby for additional funding for HIV.

One possible fund source is the Gender and Development (GAD) budget. Introduced in the 1995 GAA as the "Women's Budget" and subsequently affirmed by RA No. 9710, otherwise known as "The Magna Carta of Women," it directs all government departments and agencies to allocate a minimum of five percent (5%) of their total annual budgets for gender programs, projects, and activities.[12] The Philippine HIV and AIDS Policy Act provides for the use of the GAD funds and other sources for HIV and AIDS education in communities conducted by the Department of Interior and Local Government (DILG), leagues of provinces, cities and municipalities. In line with this, the DOH will coordinate with the Philippine Commission on Women (PCW) in reviewing policies and budget guidelines for the development of agency GAD Plan and Budget, and identify entry points for HIV and AIDS.

5. **Upskill PNAC for its stewardship role in HIV financing**

Under the newly enacted HIV law, the Philippine HIV and AIDS Policy Act, PNAC is now established as an attached agency of the Department of Health (DOH). In this capacity, PNAC is entrusted with managing its own budget and serving as the government's policymaking body for HIV matters. It is crucial for PNAC to guide its national government agency members in supporting sustainable financing for HIV-related activities aligned with the 7th AIDS

[12] https://pcw.gov.ph/gad-budget-report/

Medium-Term Plan (AMTP) targets. Rather than soliciting contributions from the Council members, PNAC will present a comprehensive action plan showing specific actions/inputs expected from concerned PNAC members. These will be aligned with the applicable activities of the agencies to facilitate financing through their respective budgets. PNAC's capacity to perform oversight functions on HIV and provide guidance to concerned national government institutions, LGUs, and other stakeholders in integrating HIV financing into their policy agenda and budget will be strengthened.

Experts will be engaged to guide PNAC – through learning-by-doing modality – in efficient HIV investment programming, budget execution, supply chain management and resource tracking. PNAC will likewise be assisted in the development, monitoring, and evaluation of its strategic and operational plans aligned to the 7th AMTP. These plans will be used to leverage for higher LGU spending on HIV. PNAC will also be assisted in engaging Council members, especially NGAs, with significant funding capacities for implementing HIV-related activities. Support will be provided in guiding these agencies into mainstreaming needed HIV activities/inputs from them into their regular agency plans and budgets.

At the subnational level, support will be provided to PNAC in establishing or designating regional counterparts to carry out its functions regionally, consistent with the law. As a fully-fledged agency of the Department of Health (DOH), PNAC is anticipated to function autonomously from the DOH, akin to the National Nutrition Council (NNC) and PhilHealth. With its legislated charter, PNAC holds a more independent position compared to the Food and Drug Administration, which operates as an organic unit within the DOH. The establishment of regional PNAC offices will facilitate concerted regional initiatives for financing HIV-related programs, projects, and activities.

6. Mobilize subnational funding support and resource sharing for HIV

PNAC will maximize linkage with high-level inter-agency governance structures like the Regional Development Councils (RDCs) and Metro Manila Development Authority (MMDA), the highest planning and policy-making body in the region, in assessing local HIV needs and in planning, financing, implementing and monitoring subnational HIV and related programs, projects and activities aligned to the 7th AMTP 2023-2028 targets. These committees are instrumental in revitalizing Local AIDS Councils and in issuing the needed local ordinances for enjoining LGUs to provide support for HIV.

To encourage higher LGU funding for the program, PNAC will work with the DILG for the inclusion of "cash and non-cash resources allocated for HIV implementation" as an indicator in the Seal of Good Local Government (SGLG) Award. In parallel, DILG should be convinced that there is a big funding gap in addressing the HIV problem and that LGU financing is a critical resource for this. The different NGAs and private sector members that compose the RDCs and MMDA will be tapped to contribute funds/share their resources in the implementation of the national/subnational HIV response. Such resources may be used to outsource CSO services or expand their involvement in HIV advocacy, service delivery and financing.

Advocating support for HIV among LGUs will be intensified to maximize potential funding for HIV care and support services at the localities. The cumulative budget of all LGUs in the country constitutes the biggest financing opportunity for HIV. However, because of local government autonomy, DOH, PNAC, and HIV advocates will have to be content with maximizing the reach and effect of information and exhortation. HIV services are generally provided at urban centers, mostly at the capitals of provinces. This practice however does not mean that financing should only come from these centers. Advocacy with these LGUs will focus on financing service delivery type inputs, these may be in the form of drugs, medicines, and commodities. On the other hand, advocacy with the rest of the LGUs, particularly those adjacent to these centers, will be on support or indirect type inputs like transportation of patients, additional human resource for health, and food allowance.

7. Maximize UHC Act opportunities for HIV funding

Section 19 of the UHC law endeavors local government units to integrate their health systems into Province- or City- Wide Health System or what DOH refer to as P/CWHS. These systems are expected to be composed of Primary Care Provider Network or PCPN, which are expected to provide primary care services like those included in OHAT. Such networks, when linked with end referral hospitals or Apex hospitals, will be referred to as Health Care Provider Network (HCPN). Many local health systems, even if converted into PCPNs, lack the capability to provide HIV services. Actually, there is only one rural health unit in every local health system, which has to provide primary care services to its constituents. This circumstance can actually function as an opportunity especially for CSOs that provide HIV services.

The DOH, through its CHDs, can advocate for public-private arrangements for the provision of HIV services within an HCPN. This strategy is actually well in line with the establishment of mixed HCPN, which is expressly provided for by the UHC Act. Instead of building competencies in providing the service, existing CSO providers of HIV services in the area can be included in the network. This therefore translates to CSO engagement with access to financing. Including CSOs in a mixed HCPN would enable them to access financing opportunities via the Special Health Fund (SHF), when it becomes operational. There is much room to work on towards this end. Since DOH is duty-bound to come up with operational HCPNs until 2025, i.e. when it has to report to Philippine Congress regarding UHC implementation, PNAC may consider developing CSO engagement schemes based on this context of UHC implementation.

8. Guide the allocation and use of ODA resources for HIV

The DOH Bureau of International Health Cooperation (BIHC) and PNAC will develop a plan for ensuring a harmonized provision of ODA on HIV, maximizing foreign aid in areas with funding/resource gaps. Donor support, together with available resources at the central level - including those from the national government, donors and other stakeholders will be used as leverage for higher LGU spending on HIV.

PNAC will have to steer the technical assistance that it receives from bilateral and multilateral engagements of the country for HIV. It should be able to use its strategic plan to guide donor agency driven technical assistance. PNAC should ensure that all of these assistance are

strategically placed in areas that receive less support from government and other local sources, whether it be in-cash or in-kind.

VII. MILESTONES

This table shows the period in which activities will be undertaken for the attainment of indicated milestones.

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
GAA budget line item for the implementation of HIV related programs, projects, and activities aside from those appropriated for commodities procurement	Mainstream HIV and AIDS in NGA and local development plans and budgets	Review policies and budget guidelines on the development of the GAD Plan and Budget of government agencies; identify entry points for HIV and AIDS; and, coordinate the appropriate policy adjustment with the Philippine Commission on Women (PCW) and the National Economic and Development Authority (NEDA).								PNAC and DOH particularly the Disease Prevention and Control Bureau (DPCB) and Health Policy Development and Planning Bureau (HPDPB)
		Advocate for the tweaking of identified budget line items in NGAs for the implementation of HIV related programs, projects, and activities								PNAC and its Finance Committee and Policy & Planning Committee
		Develop and implement a plan for ensuring a harmonized provision of								PNAC and DOH particularly Bureau of

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
		ODA on HIV, maximizing foreign aid in areas with funding/resource gaps								International Health Cooperation (BIHC)
	Strengthen technical and budget advocacy for HIV among legislators and concerned NGAs	Develop evidence-based plans and budget proposals to better advocate for higher HIV funding in Congress and among concerned government agencies								PNAC and DOH particularly Disease Prevention and Control Bureau (DPCB) and Health Policy Development and Planning Bureau (HPDPB)
		Offer technical assistance to the focal person in charge of HIV in DOH-DPCB, undersecretary in charge of PNAC, and the Executive Director of PNAC in developing their respective budget proposals for the subsequent year.								PNAC Finance Committee and Policy & Planning Committee

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
		Engage PNAC member NGAs with regard funding programs, projects, projects and activities through their annual work and financial plans and use the same in streamlining the operational plan of PNAC for efficient spending.								PNAC assisted by its Finance Committee and Policy & Planning Committee
Regional PNAC established.	Upskill PNAC for its stewardship role in HIV financing	Assist PNAC in developing its capacity in policy making, as specified by RA No. 11166, and steerer of PNAC member NGAs towards financing activities relevant to the attainment of the 7th AMPT 2023-2028 targets.								PNAC Finance Committee and Policy & Planning Committee
		Develop the regional presence of PNAC to ensure consistent policy implementation from national to local levels								PNAC and its Finance Committee and Policy & Planning Committee

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
HIV related programs, projects and activities specified in Local Health Investment Plans for Health (LIPHs) of provinces	Advocate HIV financing in national and local level planning platforms	Advocate to PNAC member NGAs the appropriate number of goods and commodities, as well as necessary activities that they could include in their respective budget proposal for the subsequent year.								PNAC and DOH particularly Disease Prevention and Control Bureau (DPCB) and Epidemiology Bureau (EB)
		Leverage the PNAC operational plan with LGUs through performance-based schemes								PNAC and CSOs operating at the local levels
		Maximize linkage with high-level inter-agency governance structures like the Regional Development Councils (RDCs) and Metro Manila Development Authority (MMDA) - the highest planning and policy-making body in the region - in assessing local HIV needs and in planning, financing, implementing and monitoring subnational HIV and related programs, projects and activities aligned to								PNAC and CSOs operating at the local levels

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
		the 7th AMTP 2023-2028 targets.								
		Encourage higher LGU funding for the program and work on the inclusion of “cash and non-cash resources allocation for HIV related project implementation”								PNAC, specifically DILG as a council member
7th AMTP 2023-2028 Strategic Plan implementation	Tighten linkage of HIV planning, budgeting, and procurement with the 7th AMTP 2023-2028 targets	Translate the 7th AMTP 2023-2028 targets into concrete strategies or interventions, as described into clear and realistic programs, projects and activities with well-defined priorities and accountabilities.								PNAC and its Finance Committee and Policy & Planning Committee

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
Budget for HIV related programs, projects, and activities specified in the Local Appropriations Ordinances of LGUs	Mobilize subnational funding support and resource sharing for HIV	Advocate the inclusion of LIPH specified HIV related programs, projects, and activities in the Local Appropriations Ordinances of LGUs								PNAC, DOH, and CSOs operating at the local levels
Increased total PhilHealth reimbursements from OHAT (as shown by the number of public and private health facilities providing HIV services)	Expand PhilHealth support value	Review of current PhilHealth benefit packages where HIV services are or may be included e.g., OHAT Benefit Package, Konsulta/Comprehensive Outpatient Benefit Package, to determine gaps in utilization and challenges in the provision of high support value								PNAC and DOH particularly Disease Prevention and Control Bureau (DPCB) and Health Policy Development and Planning Bureau (HPDPB)
New HIV related PhilHealth benefits packages implemented (e.g., PrEP mong	Maximize Universal Health Care (UHC) Law opportunities for HIV funding	Advocate on including diagnostics and preventive care for HIV in appropriate PhilHealth benefits packages.								PNAC and DOH as assisted by the PNAC Finance Committee and Policy & Planning Committee

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
the services covered by the Primary Care Benefits Package of PhilHealth)		Propose new benefit packages to increase support value on HIV and, in the process, bring HIV into the consciousness of PhilHealth executives.								PNAC and DOH as assisted by PNAC Finance Committee and Policy & Planning Committee
CSOs engaged by NGAs and LGUs (e.g. outsourcing or mixed HCPN as provided by the UHC Law) for the implementation of programs, projects and activities (e.g. service delivery, advocacy, and social mobilization)	Exploit UHC Law opportunities for CSO engagement	Develop policies that consider public-private arrangements for the provision of HIV services within a Health Care Provider Network (HCPN)								PNAC and DOH as assisted by the PNAC Finance Committee and Policy & Planning Committee
		Assist LGUs in engaging LGUs for the delivery of HIV services pursuant to the UHC Law's operational polices								PNAC, CSOs, and LGUs
Low to zero out of pocket payment for OHAT (as shown by decreased or zero Out-of-	Link key population, especially PLHIVs requiring OHAT, to PhilHealth-accredited primary	Develop systems for registering and referring PLHIVs to the appropriate PhilHealth-accredited primary care providers and HCPNs								PNAC and CSOs especially those operating at sub national level

MILESTONES	STRATEGIES / INTERVENTIONS	ACTIVITIES	2024	2025	2026	2027	2028	2029	2030	CONCERNED ENTITY
Pocket payment)	care providers and HCPNs									
Increased number of HIV tested key population	Inform the general public about the OHAT package and all other PhilHealth benefits that PHIVs can avail of	Mobilize CSOs to increase awareness of PhilHealth members on their health entitlements and obligations.								PNAC and CSOs especially those operating at sub national level

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[ii] Not all concerned member government agencies submitted data to PNAC Secretariat, hence, this is not conclusive.