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**National Situational Assessment
of HIV Financing in**

PHILIPPINES



Executive Summary >

Sustainable HIV Financing in Transition (SHIFT) Programme is a two-year regional advocacy programme funded by the Global Fund. Beginning in January 2017 the goal is to empower civil society and communities, especially key population communities, to advocate for sustainable HIV financing in four Southeast Asian countries: Indonesia, Malaysia, the Philippines and Thailand.

To better understand the four countries' HIV financing a National Situational Assessment, which studied published data, was conducted in the middle of 2017. A total of 118 resources in English, Bahasa Indonesia and Bahasa Malaysia were reviewed, including National AIDS Spending Assessments (NASA) and Global AIDS Response Progress Report (GARPR). The availability and sufficiency of HIV financing resources, as well as how funding resources are allocated in Indonesia, Malaysia, Thailand and the Philippines was examined. The following findings provides an overview of the key themes across the four countries.

Key Findings

I. Increasing Domestic Financing of National HIV responses

The four SHIFT countries of Indonesia, Malaysia, the Philippines and Thailand are seeing a trend towards more domestic spending on HIV. Between 2010 and 2015, the Philippines' domestic spending rose 286%, the biggest funding increase of any SHIFT country, however, this increase came as new HIV infections doubled over the same period¹.

Malaysia funds the bulk of its HIV programmes, at 96% in 2015. This is followed by Thailand with 89% (2015), Philippines with 74% (2015) and Indonesia with 57% (2014)². Indonesia in particular recorded a shift from mainly international funding to domestic financing beginning in 2013, with more than half of its HIV response funded domestically by 2015³.

While the trend is moving towards greater domestic government support, a significant amount of that expenditure goes towards provision of care and treatment, ranging from 33% in Indonesia for 2014 to 67% in Thailand for 2015⁴. Compared to investing in prevention, especially for key populations, healthcare provisions for HIV care and treatment remains the predominant expenditure categories. The obvious utility of treating diseases aside, healthcare provision fits well within the mandate of the government and state as providers of healthcare, without the political sensitivity of spending on stigmatised or criminalised populations. However, this overshadows the importance of the prevention approach needed to stall and reverse the epidemic, and especially the gains made possible when investing in the most affected populations.

1. UNAIDS (2017). Press Release: UNAIDS report indicates new HIV infections in the Philippines have doubled in the past 6 years, 1st August 2017.
2. UNAIDS DataHub (2017). Country Snapshots 2017.
3. NASA Indonesia (2015).
4. UNAIDS DataHub (2017). Country Snapshots 2017.

II. Allocative Efficiency and the Issue of Investing in Key Populations Prevention

Despite the growing epidemic and the financial burden of HIV, investment in prevention spending for key populations is low. Figure 3 illustrates prevention spending across the three key populations in the four SHIFT countries. Of note in advocating for efficient, targeted investment is the current MSM prevention spending. Although 50% to 80% of new infections affect MSM in the four SHIFT countries⁵, only an average of 10% of domestic HIV prevention investment is spent on MSM.

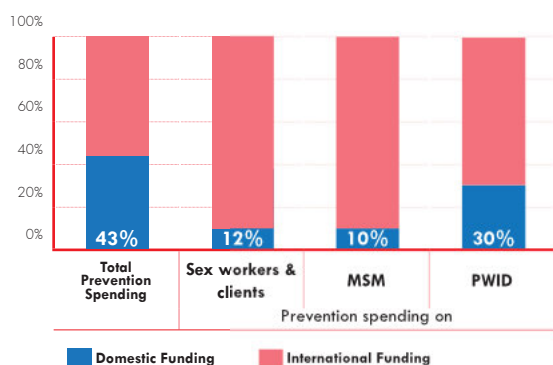


Figure 3: Distribution of prevention spending by financing source in 4 SHIFT countries, latest available year, 2014-2015⁶

HIV prevention activity delivers the biggest impact and return on investment if it is targeted at the key populations of MSM, sex workers and PWID who are disproportionately affected by the epidemic. However, countries in the region fail to allocate appropriate resources for key populations, with an estimated 8% of overall HIV spending in Asia and the Pacific going towards prevention for key populations⁷. A case worth noting is the response in the Philippines to the rapidly growing epidemic. Four out of five new HIV infections are MSM, but despite the disproportionately high risk of infection, only 8% of HIV spending was allocated to MSM prevention programmes⁸.

As seen in Figure 3 above, the bulk of prevention spending in key populations is supported by international donor funding. This raises the issue of sustainability and the potential impact on the epidemic once international donors exit and countries transition to domestic financing. This has been observed in Romania by the Eurasian Harm Reduction Network. A dramatic increase in HIV prevalence among PWID was recorded, with it rising from 1.1% in 2009 (prior to end of Global Fund support), to 6.9% in 2012 and spiking at 53% in 2013 in the years after Global Fund exit⁹. The risk of prevention for key populations to fall through the cracks in this transition stage warrants an urgent allocative efficiency analysis and evidence-based advocacy to ensure an effective response to HIV.

III. Accessibility of Domestic Financing Sources

In the SHIFT countries, with the exception of Malaysia, civil society access to domestic financing remains an ongoing challenge. Prohibitive conditions such as stringent registration criteria, CSO accreditation, absence of enabling laws and policies as well as government attitudes towards CSOs further complicates the issue.

Feedback from country partners noted key constraints between CSOs and governments. There is a lack of government trust in CSOs, largely due to concerns over financial management and issues of corruption. In the Philippines the pork barrel corruption scandal involving government officials establishing fake NGOs to channel funds illegally has resulted in a crackdown and tightening of NGO laws¹⁰, resulting in more stringent rules and barriers to CSO registration¹¹. CSO and country partner representatives distrust government agencies to make evidence-based decision in HIV financing, especially when it relates to financing key populations who are potentially criminalised or marginalised.

5. UNAIDS DataHub (2017). Men Who Have Sex Men 2017 Slides.
 6. UNAIDS DataHub (2017)
 7. WHO (2016). HIV financing status in selected countries of the Western Pacific Region (2009-2015).
 8. UNAIDS DataHub (2017). Philippines Country Snapshot 2016.
 9. Eurasian Harm Reduction Network (2016). The Impact of Transition from Global Fund Support to Governmental Funding On The Sustainability of Harm Reduction programmes.
 10. Francisco, K & Geronimo, J (2013). Why fake NGOs got away. <https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away>
 11. Philippines country partner ACHIVE noted that organisational registration can take up to 2 years.

Furthermore, understanding budget processes and meaningful engagement in budget advocacy has been limited. This is reflected in the complex structures and power brokers of the budgetary process that CSOs have traditionally been excluded from. However, in Indonesia and the Philippines budget advocacy and accountability NGOs, such as Seknas Fitra and Social Watch Philippines, have led community level engagement to 'democratise' the budget process. This has made complex information more widely accessible allowing CSOs to undertake and engage in budget advocacy.

An exception to the rule of domestic financing channels is the case in Malaysia, where a government-operated NGO - the Malaysian AIDS Council (MAC) was set up to allocate funds to CSOs¹². However, even as MAC supports CSOs and actively includes key population representatives in its decision-making structures, many CSOs who are recipients question MAC's ability and willingness to advocate on complex issues and to represent civil society in its engagement with the government. As noted by other SHIFT country partners, a principle function of CSOs rests in its ability to advocate on behalf of the communities it represents, as well as serving as a watchdog to hold governments to account on delivering meaningful CSO engagement on national HIV responses.

Government funding may create a conflict of interest and put the CSO's independence at risk and make it a toothless watchdog. As one community respondent put it: "you don't bite the hand that feeds you"¹³.

IV. Socio-Cultural and Political Contexts

In Asia, and especially in the SHIFT countries, illiberal governments and populist policies impact the ability of CSOs to advocate for their needs. Elements of military and religious governance operate in the SHIFT countries, hampering the ease of advocacy especially for key populations who are criminalised or discriminated against.

Criminalisation further marginalises key populations. It prevents organisations representing them to fully engage, both on the legislative front, where they are unable to legally participate as political citizens, as well as on the socio-political front, where perceptions and conservative ideologies dominate the decision-making and resource-allocation table.

This is especially observable in the Philippines with the "War on Drugs" – a populist policy criminalising drug use - effectively rules out any investment and advocacy for PWID and their programmes¹⁴. In Indonesia and Malaysia, gay people and LGBT issues are routinely targeted under conservative Islamic justifications, in addition to being used as political instruments to demonise and advance dominant political influence during election periods^{15 16}. This situation presents a major challenge for CSOs to advocate for investment in key populations, especially MSM and transgender people. It makes these communities, and their need for greater domestic HIV financing, invisible.

A further socio-cultural challenge is governments viewing CSOs with suspicion. CSOs are often perceived, as antagonistic towards governments, given that successes generated by CSOs imply a certain loss of face for the government and implies the government failed to meet the needs of their citizens¹⁷. This demonstrates the need for an advocacy strategy that shifts the relationship from adversarial to a mutually beneficial one, focused on the bottom line of controlling the country's HIV epidemic.

In particular, the economic argument for investment in key populations, the return on investment and the potential to mitigate the epidemic escalating are advocacy in-roads that warrant further exploration. The SHIFT programme will explore these ideas by analysing the cost of criminalisation and country case studies, in order to inform advocacy initiatives in the SHIFT countries and will share findings across the region with key partners and stakeholders.

12. Ministry of Health Malaysia (2016). The Global AIDS Response Progress Report 2016.
13. Pers. Comms. (2017). Regional Forum on CSO Financing Mechanisms and Progress Review, 4 – 6 September 2017.
14. Human Rights Watch (2017). "License To Kill". <https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killing-dutertes-war-drugs>
15. Azlee, A. (2016). Anthropologist: Solidarity the only way to stop victimisation of LGBT. The Malay Mail Online. <http://www.themalaymailonline.com/print/malaysia/anthropologist-solidarity-the-only-way-to-stop-victimisation-of-lgbt>
16. Hutton, J (2017). Indonesia's Crackdown on Gay Men Moves From Bars Into the Home. The New York Times. <https://www.nytimes.com/2017/12/20/world/asia/indonesia-gay-raids.html>
17. Kingston, J. (2017). Civil society across Asia if flowering but fragile. The Japan Times. <https://www.japantimes.co.jp/opinion/2017/04/29/commentary/civil-society-across-asia-flowering-fragile/#.WIDvyBOCzOQ>

Philippines

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I. Background Trends

Health expenditure per capita (current USD)	2014	135.20
Share of public health expenditure in government expenditure	2014	10.01%
Share of public health expenditure in total health expenditure	2014	34.3%
Share of total health expenditure in GDP	2014	4.7%

As a lower-middle income country, health expenditure per capita in the Philippines is about average for the region. With a population of 103 million, the per capita health expenditure is USD 135.20, ranking third among the SHIFT countries. The share of total health expenditure in GDP is also average for the ASEAN region⁴⁷.

The epidemic in the Philippines is primarily concentrated among MSM and PWID, depending on location and sub-populations⁴⁸. The estimated HIV prevalence among the general population in 2013 was 0.051%. According to the 2013 IHBS, the HIV prevalence was 2.93% among MSM (21 sites), 48.24% among male PWID (2 sites), 30.39% among female PWID (Cebu City), 0.07% among RFSW (10 sites), and 1.03% among FFSW (9 sites)⁴⁹. HIV transmission via MSM has become the predominant mode of transmission since 2007 and is the driving force of the epidemic in the country⁵⁰.

The “War on Drugs” has had a significant impact not just on lives lost from extra-judicial killings but has also made harm reduction and HIV health promotion interventions more challenging. 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 populations⁵¹.

II. HIV Financing: Domestic vs. International

For the period 2011 to 2013, the country spent about PHP 1.3 billion for HIV/AIDS. This is an annual average of PHP 453 million. Total spending from international and public sources is increasing (PHP 346 million in 2011; PHP 401 million in 2012; and PHP 412 million in 2013).



HIV/AIDS spending from international sources has been steadily decreasing since 2013 (see table below). In 2015 spending from international donors represented only 35% of total HIV/AIDS spending, with the Global Fund being the biggest contributor. Since 2004, the Global Fund has allocated more than USD 44 million to support the HIV response in the Philippines.

Other sources of financing include multilateral agencies (UN agencies, Asian Development Bank, World Bank), and USAID. Other government agencies that contributed include the Department of Social Welfare and Development, Department of Education, selected local government units (Quezon City, Makati City)⁵³.

Source	2011		2012		2013		2014		2015	
	USD	%	USD	%	USD	%	USD	%	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)

47. World Bank (2017). Essential Information Philippines

48. Philippine National AIDS Council (2014). Global AIDS response progress reporting. Country progress report of Philippines

49. Department of Health of Philippines (2013) National Epidemiology Center, 2013 Integrated HIV behavioural and serologic surveillance

50. Philippines National AIDS Council, Philippine Estimates of the Most At-Risk Population and People living with HIV. 2011 Philippines MARP and PLHIV estimates 2011, Philippine National AIDS Council: Manila.

51. Human Rights Watch (2017). “License To Kill”. <https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killings-dutertes-war-drugs>

52. Gotsadze, T (2017). The Philippines HIV/AIDS Programme Transition from Donor Support – Transition Preparedness Assessment

53. GARPR (2014). Country Progress Report – Philippines PNAC

Philippines

Spending Category (excluding private)	2011	2012	2013
Prevention	153,054,158	242,071,135	165,672,105
Care and treatment	42,107,334	68,111,215	77,488,595
OVC	0	0	0
Programme Management and Administrative Strengthening	122,329,314	76,763,661	140,549,256
Incentives for Human Resources	4,409,181	617,400	2,237,572
Social Protection and Social Services	2,604,877	2,250,000	2,350,000
Enabling Environment	19,928,145	9,113,680	12,182,774
Research	2,020,031	1,686,022	11,348,142
Total	346,453,040	400,613,113	411,828,444

Table: HIV Expenditure by category (Peso), 2014⁵⁴

III. Key Populations Epidemiology vs. HIV Expenditure

Starting from 2009, the predominant mode of transmission shifted from heterosexuals to MSM, and it has continually increased since then. From January 2011 to October 2016, 85% (26,019) of new infections through sexual contact were among MSM⁵⁵. HIV prevalence for transgender people is also disaggregated for 2015, standing at 1.7%⁵⁶.

Type	KAP	2011	2012	2013	2014	2015
Prevalence	PWID*	13.6	13.6	46.1	44.9	29.0
	SW**	0.3	0.3	1.8	0.6	0.6
	MSM**	1.7	1.7	3.3	3.3	4.9

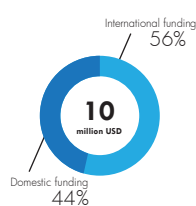
* Source: 2015 IHBS for Male PWID: Cebu, Mandaue. 2015 IHBS for Female PWID: Cebu

** Source: <http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx>

Figure: HIV prevalence among MSM, PWID and sex workers in sentinel sites, 2007 – 2015⁵⁷

Reported cases are centred in three highly urbanised areas: Greater Metro Manila Area (which includes the provinces adjacent to Metro Manila - Rizal, Cavite, Laguna and Bulacan), Metro Cebu, and Davao City. These three areas plus Angeles City and Davao City are the highest priority areas for HIV intervention control⁵⁸.

AIDS spending by financing source



AIDS spending by service category

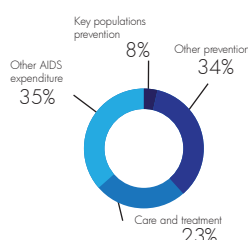


Figure: Share of AIDS spending by financing source and service category, 2013⁵⁹

Latest available data (2013) indicates 18%⁶⁰ of spending on key populations prevention (note data incongruity in UNAIDS country snapshot 2016 above). This is contrasted against the major share of the burden of HIV at 95% of new infections. Key population expenditure is also heavily financed by international donors, accounting for 100% of MSM and sex worker prevention investment. However, a highlight is the overwhelming domestic investment for PWID of 95%. This is based on latest available 2013 data which pre-dates the Duterte administration with its “War On Drugs” approach. It is imperative that up-to-date data be sourced to shed light on subsequent spending, which will most likely reveal a different reality.

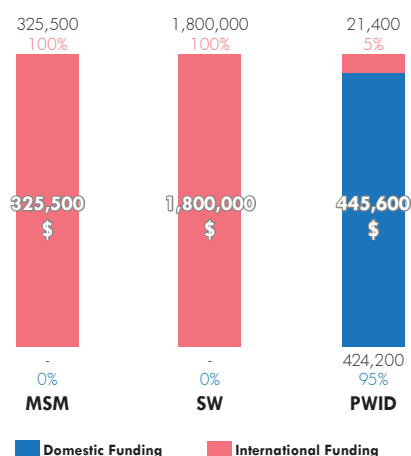
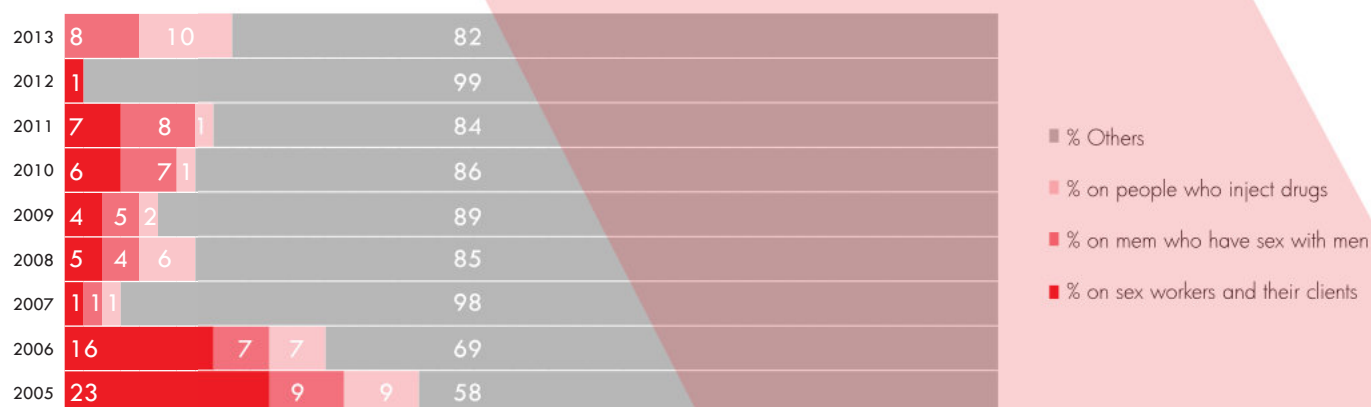


Figure: Share of Prevention Investments in Key Populations (Philippines, 2013), latest available data⁶¹

54. GARPR (2014). Country Progress Report – Philippines PNAC
55. Golsadze, T (2017). The Philippines HIV/AIDS Programme Transition from Donor Support – Transition Preparedness Assessment
56. UNAIDS DataHub (2016). Philippines Country Snapshot 2016
57. Golsadze, T (2017). The Philippines HIV/AIDS Programme Transition from Donor Support – Transition Preparedness Assessment
58. Golsadze, T (2017)
59. UNAIDS DataHub (2016). Philippines Country Snapshot 2016
60. UNAIDS Datahub (2017).
61. <http://www.aidsinfoonline.org/kpallas>

Philippines



Proportion of total prevention programme spending on key populations at higher risk, 2005-2013⁶²

IV. HIV Financing Mechanisms

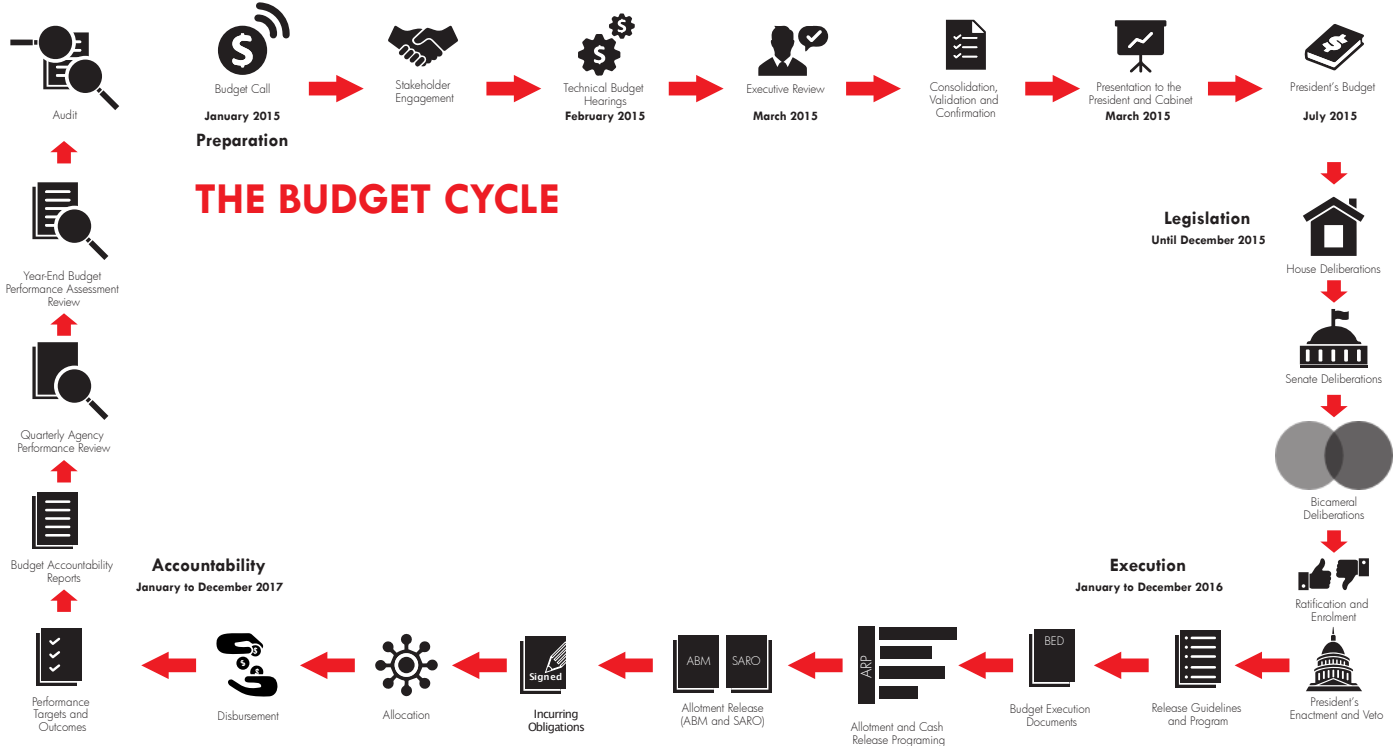
While the Department of Health accounts for a substantial proportion of the national government's health spending, there has been increased health spending in recent years by other national government agencies such as the Office of the President and the Philippine Charity Sweepstakes Office. Health expenditures by other national government agencies are sometimes implemented by the DOH but not usually covered by the medium-term planning carried out for the sector by the DOH, as this funding source is usually erratic, subject to fund availability and could be motivated by reasons other than national health goals. As this non-DOH national government spending becomes relatively larger, there is a greater need to coordinate these two expenditure streams so that overlaps and crowding out are minimised and gaps are properly identified and addressed⁶³

In the Philippines, the National Health Insurance Programme is the largest insurance programme in terms of coverage and benefit payments. The two main agencies that pool health care resources are the government and PhilHealth (the Philippine Health Insurance Corporation). The annual process of developing a DOH budget starts with the issuance of a budget call by the Department of Budget Management (DBM) in late February to the middle of March. The budget call sees national government agencies to start formulating their budgets for the coming year.

The budget ceilings issued by DBM are based on the available funds in treasury and projected government revenues for the planning year. Line agencies like the DOH then prepare annual budget proposals based on these set ceilings. The line agency proposals are consolidated into a national expenditure programme (NEP) that is submitted to Congress. Congress then converts the NEP into a general appropriations bill that is deliberated on and passed jointly by both houses of Congress. LGU health budgets are developed in a similar way to the DOH budget.

62. UNAIDS DataHub (2017)
63. TPA (2016)

V. National Budget Mechanisms



The Philippines' budget cycle begins with budget preparation. A budget call is issued in December of the previous year to aim for the completion of the president's budget for submission to Congress by July. The budget call contains budget parameters (including macroeconomic and fiscal targets and agency budget ceilings) as set beforehand by the Development Budget Coordination Committee (DBCC); and policy guidelines and procedures in the preparation and submission of agency budget proposals⁶⁴.

Congressional hearings are conducted to discuss the budget submitted by the president. Congress cannot insert new items in the budget but can increase or decrease the budget of agencies. Stakeholders can attend and participate in these public hearings. They can also lobby the legislature to influence spending priorities.

Until 2012, only the appropriation stage has the provision for citizen's participation in the entire budget process. Participation on taxation and revenue issues are limited to professional groups and participation in the budget process is only during the budget legislation phase. Some citizens group are now starting to monitor elements of government expenditure⁶⁵. In 2012,

the Department of Budget and Management issued the National Budget Circular No. 536 which provides the guidelines on partnership with civil society organisations and other stakeholders in the preparation of agency budget proposals. The circular aims to institutionalise participatory budgeting by allowing agencies to enter into a budget partnership agreement (BPA) with CSOs. The BPA is a formal agreement between the national government agency and the partner civil society organisation. It defines the roles, duties, responsibilities, schedules, expectations and limitations with regard to implementing the CSO's participation in budget preparation, execution, monitoring and evaluation of specific programmes, activities or projects of the partner agency. The circular also outlines the requirements for CSOs to enter into a BPA with a government agency⁶⁶.

The Department of Budget and Management seeks to increase citizen participation in the budget process by tasking government agencies to partner with civil society organisations and citizen-stakeholders in the preparation of the agency's budget proposals. Government agencies were mandated to conduct CSO consultations⁶⁷.

64. Budget ng Bayan (2012)
 65. Briones (2010)
 66. Department of Budget and Management (2012)
 67. Budget ng Bayan (2012)

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The aim of the bottom-up budgeting process is to promote inclusive growth and poverty reduction. It seeks to “increase citizens’ access to local service delivery through a demand-driven budget planning process and to strengthen government accountability in local public service provision”⁶⁸. Priority poverty reduction projects are identified at the city/municipal level through the bottom-up participatory planning and budgeting.

The bottom-up budgeting approach started in 2013. The Cabinet Cluster on Human Development and Poverty Reduction identified 300 to 400 of the poorest municipalities that were engaged in crafting community-level poverty reduction and empowerment plans. The Department of Agriculture, Department of Agrarian Reform, Department of Environment and Natural Resources, Department of Social Welfare and Development, Department of Education and the Department of Health include the community plans in their proposed budgets.

In its current decentralised setting, the Philippine health system has the Department of Health (DOH) serving as the governing agency on a national level, with both local government units (LGU) and the private sector providing services to communities and individuals. The DOH is mandated to provide national policy direction and develop national plans, technical standards and guidelines on health.

Under the Local Government Code of 1991, LGUs serve as stewards of the local health system and are required to formulate and enforce local policies and ordinances related to health, nutrition, sanitation and other health-related matters in accordance with national policies and standards. LGUs are also in charge of creating an environment conducive for establishing partnerships with all sectors at the local level. Provincial governments are mandated to provide secondary hospital care, while city and municipal administrations are charged with providing primary care, including maternal and child health, nutrition services, etc. Rural health units were created for every municipality in the country to improve access to health care.

VI. Analysis

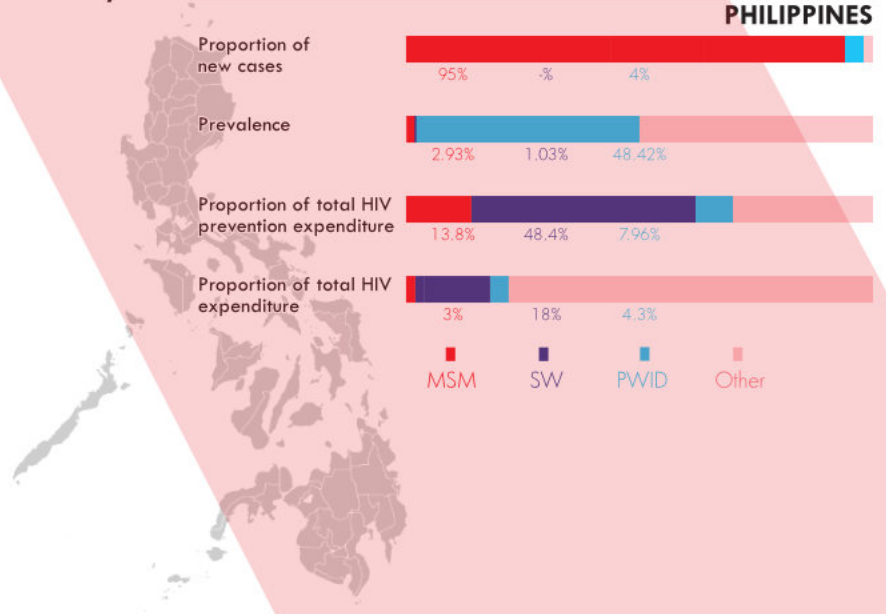


Figure: Mismatch between HIV expenditure and disease burden

While levels of investment in HIV are ultimately determined by many factors, evidence-based responses require a degree of proportionality between resources for programmes targeting key populations and the relative HIV burden in those populations. In the case of key populations, there is a considerable discrepancy, as with most countries. (See table above.) In particular, “the War on Drugs” significantly impacts drug users’ welfare in the country. The intensifying crackdown poses a serious risk of reversing gains made in HIV prevention among PWID.

68. National Anti-poverty Commission (2015)

Philippines

CSO Financing issues

Current needs are estimated at 50-60 million USD, markedly above actual HIV expenditure which is in the range of 20 million USD in 2016 (domestic and international). However, the new administration takes the growing epidemic seriously, with allocation of 21 million USD in 2017. Indicated within this is a substantial allocation to MSM-focused activities (6% were allocated to MSM in 2013, final amount has not been confirmed)⁶⁹.

The confidence for CSOs financing has suffered a blow, stemming from recent scandals of “ghost NGOs” set up by government officials to siphon public money into private purses. This drew skepticism on the system’s transparency and initiated a tightening of NGO regulations, with the government investigating new mechanisms with a stronger focus on financial control and accountability⁷⁰. No formal mechanisms have been implemented as yet, but a barrier raised in community consultations suggest accreditation of CSOs as a chief barrier, with upwards of a two-year processing time.

System Efficiency and Fund Absorption

A comparison of the allocation and actual spending of the “obligated funds” points to underutilised resources. There are two possible explanations for the inability of the DOH to maximise the spending of available resources. The first relates to weaknesses in the capacity of the central DOH, CHDs and LGUs to spend resources effectively. Another reason for low fund utilisation relates to weak incentives among managers to push spending⁷¹.

There is also a need to sustain and intensify current initiatives and mobilise resources for HIV prevention and control, especially from local government units (LGUs), and in areas where most infections are coming from. Commendable initiatives by LGUs (e.g. Quezon City) need to be replicated in other areas to ensure that interventions are in place for key populations.

69. UNAIDS Country Office (2016)

70. Francisco, K & Geronimo, J (2013). Why fake NGOs got away. <https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away>

71. WHO (2011) The Philippines Health System Review

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