UNAIDS STRATEGY DEVELOPMENT

UNAIDS STRATEGY REVIEW:
Focus Group Synthesis template

Country: Philippines

Organizer: UNAIDS Philippines

Date: 18 August 2020

UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Please use the template to organize your feedback from the session. Please keep responses succinct and as clear as possible to ensure our synthesis is a reflection of the focus groups hosted.

You can enter your report directly into a form on SurveyMonkey:
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Would you accept for UNAIDS to make your report publicly available: **Yes** / No

SECTION 1: Information about the focus group (to be completed by host of Focus Group)

Organization leading discussion: <u>UNAIDS Philippines Country Office</u>

Date of discussion: <u>18 August 2020</u>

Theme to be discussed: <u>Country-level implementation to achieve Fast Track Targets</u>

Participants (types of organizations participating):

<u>Members of the UN Joint Team on AIDS (JTA)</u>
- ☐ UNDP
- ☐ UNFPA
- ☐ UNICEF
- ☐ UNODC
- ☐ WHO
- ☐ UNAIDS Secretariat

Country, regional or global focus: <u>Country Focus</u>

Introducing the theme

Please enter the main characteristics of the theme being explored in 5 sentences (please share the presentation if possible by email)

In the context of the individual mandates of the JTA members, the FGD participants looked at the extent to which the UNAIDS Strategy has been implemented in the Philippines, and the gaps, challenges and opportunities to scale up and accelerate the country's response to HIV towards ending AIDS by 2030. The discussion was against the backdrop of COVID-19 that threatens to negate current gains of the national AIDS programme, and which requires rethinking of how AIDS Programming need to operate under the "new normal".

See attachments:
1. *Presentation on Country Progress vis-à-vis 10 fast track targets*
2. *Individual journals of JTA*

SECTION 2: People-centered response to HIV – key emerging messages

Please enter the main messages coming out, up to 5 points maximum per section

REACHING THE PERSON

How do we see the current situation?	- Gap between awareness and knowledge, knowledge and practice. There are huge knowledge gaps in the general population and key populations where basic myths and misconceptions about HIV transmission and prevention still prevail. Young people do not receive comprehensive sexuality education. Young key populations are targeted for HIV prevention when they already practice risk behaviours. - Lots of good data indicating gaps across the whole cascade but not enough attention to granular data for informed action. What is the data telling us? What are the gaps? - While reasonable attention has been given to the most affected population (men who have sex with men and trans women) based on epidemiologic data, who are we missing? We should include the young, partners of men who have sex with men and people who inject drugs, including women whose numbers are growing steadily. Establishment-based sex workers are easily reached but freelance sex workers and those operating online are a challenge. We also need to proactively generate data on people who use drugs (including in the context of chemsex) and people in places of detention – epidemiology, country-context vulnerabilities, etc. -- for evidence-based advocacy and decision-making. Unfortunately, UNODC's proposal to conduct IHBSS in jails in the National Capital Region was not implemented, even knowing that 80% of the jail population are drug related cases and that sexual and drug activities are happening inside the jails. - We also need to start investing in Category B & C cities, noting that some previously Category B Cities are now under Category A. This means a number of areas are seeing increase in HIV cases because their efforts to implement and scale up their HIV response are not supported. - The COVID-19 pandemic has derailed program implementation, thus decreasing coverage of key populations in all aspects of the care cascade. Social and economic inequalities have been magnified by the COVID-19 situation. Young key populations, people who inject drugs and poor people living with HIV were most affected in accessing HIV services and financial assistance. For instance, those with access to private transportation and who can afford to pay for courier services for ARV refill were less affected by the quarantine and service interruptions compared with those who had to rely on public transportation which were suspended during the quarantine. Threat of HIV and COVID-19 co-infection brought another layer of fear and anxiety among people living with HIV; a few reported violations, e.g., disclosures of status when crossing boarders to access ARV.

What concerns us?	• Slow scale-up of innovations including differentiated interventions, combination prevention, PrEP, HIV self-testing, partner notification, differentiated care, multi-month dispensing resulting to low access to prevention services, especially condoms, and gaps between tested and know results, and between diagnosed and enrolled to treatment. • COVID-19 has impacted significantly on the provision and uptake of services, exacerbating the risks especially among young people. Recent data shows significant decrease in testing coverage and treatment enrolment within the period of the COVID-19 quarantine (starting 16 March 2020 and still ongoing at varying degrees of restrictions across the country). People living with HIV and frontline service providers suffering psychosocial issues due to lack of mental health services and social protection, both before the pandemic and exacerbated during the pandemic.
What gives us hope?	• Young key populations below 18 can now access testing and counseling services due to the Philippine HIV and AIDS Policy Act of 2018. • National programme is now intent on implementing combination prevention strategies • Promising community response, with CBO/CSOs becoming more holistic and innovative in providing services. Increasingly empowered community of people living with HIV demanding for sustained services, conducting community monitoring and reporting of ARV stocks, and involved in TWG and in multi-stakeholder discussions on a wide range of issues such as programme reviews, development of strategic plans and GFATM grant development. Youth engagement, not just among formally-established youth organizations, but also among groups with information structures. • Digital technology as tool for creative and resilient strategies to continue providing services in the time of the COVID-19 pandemic and beyond. Although many initiatives are focused on middle class men, some can be adapted and new measures are also being developed to respond to the needs of other segments of the population. We need to be conscious, however, of the digital divide and the importance of making sure that those reached online are linked effectively to offline services.
What constrains our ability to achieve our goals?	• Limited and slow scale-up of good interventions, thereby limiting access to *quality* services. Limited service access points for key populations. • Lack of social protection, and slow, inefficient and patchy implementation of PhilHealth (national health insurance) reimbursements • Condom use, not popular even as a family planning method, has to be made more popular and acceptable; if we can procure condoms that the key populations want to use then there might be some improvement regarding its use.

THE STRUCTURES THAT RESPOND TO HIV	
How do we see the current situation?	• Strong engagement of civil society in service delivery. Strong partnerships between and among CSOs, people living with HIV and JTA. • Slow implementation of long-recommended WHO policies due to complicated bureaucracy. Also, variable local government involvement and commitment impact on the scope and quality of services delivered on the ground. • Lack proper and coordinated mechanisms when it comes to making HIV services available in closed settings, including non-prison settings such as Drug Treatment and Rehabilitation Centers (DTRC) and detention facilities (including juvenile justice centers). Engagement with other partners show that HIV services for people who use drugs are not readily available. • The COVID-19 pandemic greatly affected accessibility to services. Less testing and diagnosis were conducted. Delivery of ARV supplies from central warehouse to regional warehouses and eventually to local facilities were delayed, Health facilities' operations were affected because some HIV service providers were repurposed for COVID-19.
What concerns us?	• Uneven implementation of policies and guidelines, e.g., PhilHealth's Outpatient HIV and AIDS Treatment Package. Slow implementation of recommended WHO policies. Complicated bureaucratic procedures, e.g. PhilHealth, regulatory approvals, procurement and supply management. • Patchy implementation of good practices. National government needs to hasten its efforts to scale up or adapt innovations of civil society or local government units (LGUs). The HIV innovations by LGUs and/or CSO in non-GF sites are not documented or not on the national government's radar. Weak capacity of public and even community service providers to provide age-responsive services beyond HIV counseling and testing. Conduct of events-based interventions and other high-cost low impact activities that do not promote sustainable availability of services. • Gains of the programme -- in terms of moving closer to reach our targets, political commitments, etc.-- may be negated by the impact of COVID-19. If before COVID-19 we needed to double our efforts to reach our targets, now we may need to triple our efforts. For instance, we have already been discussing online outreach pre-COVID-19. But given the catching up we need to do following low programme performance due to COVID-19, we need to immediately scale up our interventions even as we're still trying to figure out "the new normal". In short, we may no longer have the luxury of "testing" our innovations.
What gives us hope?	• The Philippine HIV and AIDS Policy Act of 2018, especially as it has laid down a human rights framework for the country response. Notably, the law allows young key populations (15-below 18) to access HIV counseling and testing without parents' consent. • Progress on implementation of rHIVda, TLD transition, MMD, ARV

	delivery initiatives
	• Partnerships:
	   ➤ Well-functioning coordination mechanism, open communication between and among government, development partners and CSO.
	   ➤ Civil society will always rise to the occasion. New and innovative initiatives by civil society and LGUs during the COVID-19 quarantine minimized interruptions to treatment. We have been able to test certain service delivery modalities that may be instituted even post-COVID-19
	   ➤ Technical support and other functions performed by development partners - Innovations/WHO recommendations integrated in the new Health Sector Plan for HIV; UN JTA advocacy, coordination, partnership building and convening functions; GFATM funding; PEPFAR as the latest player in the country
	   ➤ Fast track commitments of LGUs. LGUs and partners appreciate the value of multi sectoral approach to HIV response for young key populations; notable progress among those who work with other sectors, including the private sector and peoples' organization and youth networks.
	• Strong Epidemiology Bureau. Functional community monitoring, albeit still informal for the most part and not yet integrated in government monitoring and reporting systems at national and local levels.

What constrains our ability to achieve our goals?	• Weak programme leadership and capacity at the national level, especially in fast-tracking the response. Weak enforcement of national policies and guidelines, in line with WHO and other international standards, at the sub-national levels and facilities. Inadequate government funding for the national HIV programme, especially for prevention which relies heavily on GF funding. Weak capacity of public health facilities to reach hard-to-reach, higher-risk key populations, especially using online platforms. • HIV programme competes with other equally critical health programmes. Lack of integration with other diseases: MNCHN, TB, VH, STIs, NCDs (including drug dependence). Response are very sector specific and implemented in silos. We have yet to see a strengthened Adolescent Health and Development Programme and HIV programming in DOH trickle down to LGUs for implementation, pointing to the need to improve coordination between national government and LGUs. • Government procurement and supply management system is one of the major and long-standing barriers to scaling up and sustaining services despite numerous assessments and technical assistance provided by development partners. As TA providers, how have we followed through on the implementation of the recommendations offered by these assessments? • COVID-19 pandemic interrupted/slowed down provision of services across the HIV care cascade and affected/displaced deployment of funds and human resource.

	• Sometimes conflicting UN agency priorities (as defined in country programme documents negotiated with and approved by government counterparts) and HIV programme priorities in terms of target populations and sites (Category A cities).

CONTEXTUAL ENVIRONMENT	
How do we see the current situation?	• The overall human rights situation in the country under the current administration is alarming. Pervasive stigma and discrimination against LGBTQI people, people who use drugs and women. Key populations are not consulted especially people who inject drugs/people who use drugs, thus services do not adequately respond to their needs. • Low access to quality education, especially in light of COVID-19. Low access to sexual and reproductive health services. While UNFPA is working closely with DepEd for a Comprehensive Sexuality Education reform for K-12, its effects are not to be seen in the near future. CoViD crisis affected implementation - online training for teachers is not as effective as face-to-face. Many young people will not be able to enroll this school year. • There is a disconnect in understanding the link between the risk in drug use and HIV and other communicable diseases. Lack of foresight especially the risks associated with vulnerable populations, like those in prisons (e.g. when the COVID-19 hits the country). People always think that jails are safe. • LGUs have varying priorities and capacities (human, technical, financial) to deliver health services. Slow progress on the implementation of the Universal Health Care Act. Multi-sectoral engagement is limited beyond the health sector. • Funding allocations were repurposed for COVID-19 response
What concerns us?	• How will HIV be integrated in UHC, or in other social protection programmes such as the conditional cash transfer? • Legal restriction that requires parental consent for young people below 18 years old to be able to access sexual and reproductive health services • Limited human resource capacity to implement programmes at the national, regional and local levels, including challenges in cross-cutting components, e.g., procurement and supply management, laboratory and data management • There is a need to have more focus on other social, economic, and cultural factors surrounding HIV and health that will help improve general help-seeking behavior of Filipinos, in general, and Filipinos living with HIV in particular. • Limited multi-sectoral engagement (e.g. prisons). War on drugs severely restricts engagement of people who inject drugs/people who use drugs in service provision and uptake.

What gives us hope?	• Civil society, private sector step up where government falters • Potential to scale up prevention and testing under Universal Health Care Act. • The increasing appreciation of the role of human rights and well-being in health and development • Other organizations have found creative ways to reach young people. Guidance about minors with special needs (adolescents living with HIV, juveniles, etc.), have been issued by the Council for the Welfare of Children and Department of Interior and Local Government (DILG), as well as in a Joint Memorandum from the DILG and the Commission on Human Rights. • Online platforms are utilized for advocacy and referral for service delivery. Maximizing technology for social innovation requires working with other departments of the government and not only with DOH. • The COVID-19 caused Government authorities to realize that jails and prisons are breeding ground for infection and diseases which caught the attention of the Supreme Court to consider the early release of qualified people deprived of liberty, elderly, with chronic disease and with minor offences. Interim guidelines are also being developed by key Government agencies, including DOH to support the prevention and control of infections in jails and prisons. Discussion had started about making services available in DTRC, although there is still the need for advocacy allies in the area of drug treatment. Instead of investing on drug testing, we should invest on HIV testing and other related services.
What constrains our ability to achieve our goals?	• Need for stronger institutions and more inclusive societies to achieve a sustainable response in addressing the HIV epidemic • The health system (including service delivery, procurement and supply management, etc) has been constrained long before COVID-19. But the crisis within our health system has been further exposed by the pandemic. • Election every 3 years that necessitates constant advocacy, recommitments at local level, etc. • Conflicting priorities of partners and varying interpretation of the laws. Realignment of priorities due to COVID-19 (e.g., funding for economic recovery over health; exacerbation of human resource constraints, including program managers, health workers, etc.) • Pervasive stigma and discrimination and low priority to sexual and reproductive health

EMERGING PATTERNS:

☐ While it makes strategic sense to focus on specific key populations, this should not be to the exclusion of other vulnerable populations lest we are left reactive again to a problem we did not properly prepare for. In fact, there is precedence to this: in the mid to late 2000's the country's response was still primarily focused on sex workers at a time when there were indications of a growing epidemic among men who have sex with men. Now the country is the fastest growing epidemic in the world, primarily among men who have

sex with men. But current data also tells us that the infections are getting younger, and there is a steady increase in HIV cases among women.

☐ The country has good laws (Philippine HIV and AIDS Policy Act of 2018, Universal Health Care Act) but has always been challenged in their implementation. The country also has access to information on the latest science and international standards, quality technical support and has the capacity to generate its own strategic information for evidence-based decision-making but has been slow to scale-up high-impact interventions. Instead of being reactive, we need to go beyond programmatic support and assist the country in addressing its systemic and structural barriers, including governance and leadership, procurement, human resources, financing, etc.

☐ The COVID-19 pandemic magnified the critical contributions of civil society in ensuring the access of key populations and people living with HIV to services especially at a time when the health system is severely constrained. This included mobilizing its ranks and innovating service delivery mechanisms that can be adapted beyond COVID-19; in conducting rapid surveys and proactively monitoring and reporting what is happening in the field and helping analyze the complexity of issues faced by key populations and people living with HIV for immediate actions, among others.

☐ A functioning coordination mechanism between and among the Department of Health, UN, GF, USAID and CSOs long before COVID-19 allowed quick actions needed during the COVID-19 quarantine. In a number of instances, the UN's convening role has contributed substantially in moving forward various UN agenda in-country, e.g., combination prevention, different testing and treatment modalities, access of young people to testing, flagging issues of people deprived of liberty and people who use drugs, human rights and gender, etc. This role needs to be optimized further in pursuit of Agenda 2030.

☐ We need to use what we have learned from the exposure of health systems fragilities by COVID-19 to advocate for widespread systems strengthening, including but not limited to HIV. Lest we do that, we may see our programme gains negated and our efforts to scale-up impeded. At the same time, we need to acknowledge the anxieties of partners, especially the community of people living with HIV, because we don't know how long before we can get the COVID-19 situation under control (given current government response after 5 months of quarantine and still counting). By then what would be the extent of its impact on the economy, health systems, social systems, governance structures, etc.? How long before the country can recover? What will the "new normal" look like and what do we need to do (and how) in that context?

SECTION 3: RECOMMENDATIONS

Please enter the main messages coming out, up to 5 points maximum per section

What are the key recommendations back to UNAIDS in terms of the strategy specifically?	

CONTINUE
What is working that we must continue to do?
	• Push for evidence-based integrated HIV services to an expanded range of key populations (to include women partners of men who have sex with men, young key populations, people who use/inject drugs) and other vulnerable people (e.g. people deprived of liberty). Ensure timeliness of calibrating the response that is sensitive to the evolving trends in the epidemic. Support rapid scale-up and implementation of innovations that give people options – tailored combination prevention (condoms, PrEP), testing (community-based, self-screening), differentiated care (one-stop shops, community centers, telemedicine) across the HIV care cascade. Speed up and strengthen implementation of HIV self-testing and place more emphasis on index testing and sexual network testing. Scale-up use of online media platforms to reach key populations with information and services and ensure efficient linkage to prevention and treatment services. Accelerate implementation of comprehensive sexuality education. Frame and provide services as improved sexual health and well-being.
	• Advocate and support national leadership that ensures a genuine multisectoral and multidisciplinary HIV national response at all levels including and beyond the health sector. Intensify programme integration and taking HIV out of isolation:
	   ➢ Integration of health services: HIV, STI, hepatitis, EMTCT, SRHR, TB, NCDs, mental health, nutrition.
	   ➢ Engagement of sectors beyond health: law enforcement, labor, education, social welfare, humanitarian
	   ➢ HIV in the broader context of poverty, gender and human rights. Intensify Human Rights programmes to address stigma and discrimination, gender issues, punitive laws and practices, and advancing sexual rights and well-being as outlined in the Philippine HIV and AIDS Policy Act of 2018.
	• Advocate for increased domestic financing for HIV at the national and local levels.
	• Build on local technical expertise, address fragmented approach brought about by devolution of health services in the Local Government Code, and structural readjustments in investments, human resource, and coordination platforms and mechanisms
	• Enable civil society engagement/partnership in the response through capacity building and sustainable financing so that CBOs can really pursue what they can do so well. Further strengthen community based/led interventions and promote social contracting to further strengthen GO-CSO partnership, and sustain and scale-up services in a way that de-load the public health system, etc.

	• Strengthen processes for establishing reliable strategic information to inform programming, targeting, financial and logistics allocation. Capacitate stakeholders on data-driven decision-making and course correction at the sub-national and local levels, especially in developing and costing programmes and services and exploring options for sustainable co-financing (mixed NGAs, LGUs, development partners).
STOP *What must we stop doing, that if we don't stop will ensure failure?*	*As a matter of principle:* • Stop <u>over</u>-reliance on GF to the point where it becomes a cop-out for the country from increasing its own investments in the programme. (We may potentially develop the same over-reliance on PEPFAR.) • Stop pilot-testing interventions which are already backed by science to be effective. Scale-up! • Stop allowing complex bureaucracy to impede action and progress, and which enables a fragmented response and working in silos, • Stop putting people in a box, neglecting other related key populations that are also at risk to HIV, like people who use drugs. • Be careful not to allow COVID-19 to interrupt action and progress.
START *What are we not doing that we have to start doing?*	*While these are not necessarily new (in fact, discussions in-country have already commenced), the following need to be <u>accelerated</u>:* • In the context of the Universal Health Care Act, to mainstream HIV care cascade at various levels of health care as well as ensure social protection for key populations including young people. Social enablers integrated in all aspects of services (prevention, testing, treatment) • Implementation of new initiatives: TLD, HIV-ST, MMD, decentralized testing and treatment • Increase inclusivity. Important to be key population-targeted but not at the exclusion of other at-risk and vulnerable populations, e.g., women and girls, people who use drugs. Be aware that people who inject drugs are not the only population in the spectrum of drug abuse that is affected by HIV. We were able to put the cause for people deprived of liberty in the agenda of the Global Fund. This is a good start but must be put forward in the country-wide action plan. • Sustainable human resource plan for HIV • Address HIV vulnerabilities by addressing intersectionality of HIV-related issues e.g., poverty
What is the one key recommendation you want to reiterate for strong consideration?	1. The 8 Key Result Areas and 10 Targets of the current strategy remain relevant. But while all these are at varying levels of implementation in the country, UNAIDS Cosponsors and Secretariat need to push further and harder the agenda around the other targets as it has done so far with targets 1 (90-90-90), 6 (combination prevention targeting key populations), 8 (human rights) and 9 (financing). This is imperative particularly to strengthen systemic and structural barriers and bottlenecks towards resilience and greater country ownership and accountability. (See "continue" and "start" above.)

	2. Add "community engagement" as a separate pillar or target. When placed upfront and not just integrated under other targets, this may catalyze the institutionalization of community-led interventions that are supported through domestic investments and not just external grants. Also institutionalizing private sector engagement and social contracting to sustain and scale-up services in a way that de-loads the public health system, etc. Just as important, this places premium on strengthening CSOs' role and capacity to demand quality and comprehensive services, and for inclusion and accountability. The latter is becoming more imperative as civil society spaces diminish. 3. Amplify under Key Result Area 8 the issue of resilience: ➤ Need to define a roadmap towards HIV programme resilience in times of pandemics and disasters. For instance, how do we deal with global stockouts of ARVs due to COVID-19? How will pandemics and disasters at global and/or national scale play out for the HIV programme in terms of funding landscape, etc.? ➤ Explore opportunities provided by UHC in addressing the impact of COVID-19 and strengthening the resilience of the health system against future pandemics.

Please share with us any references you think would be useful for the Strategy Development, such as examples of case studies that illustrate the challenges or recommendations you outlined in the discussion report.

Please also share a list of names and email addresses of participants who would wish to continue to be informed of the Strategy development process. Note names and contacts will not be shared publicly or with any third party.

You can send us additional documents via e-mail ***strategyteam@unaids.org***

Where we stand
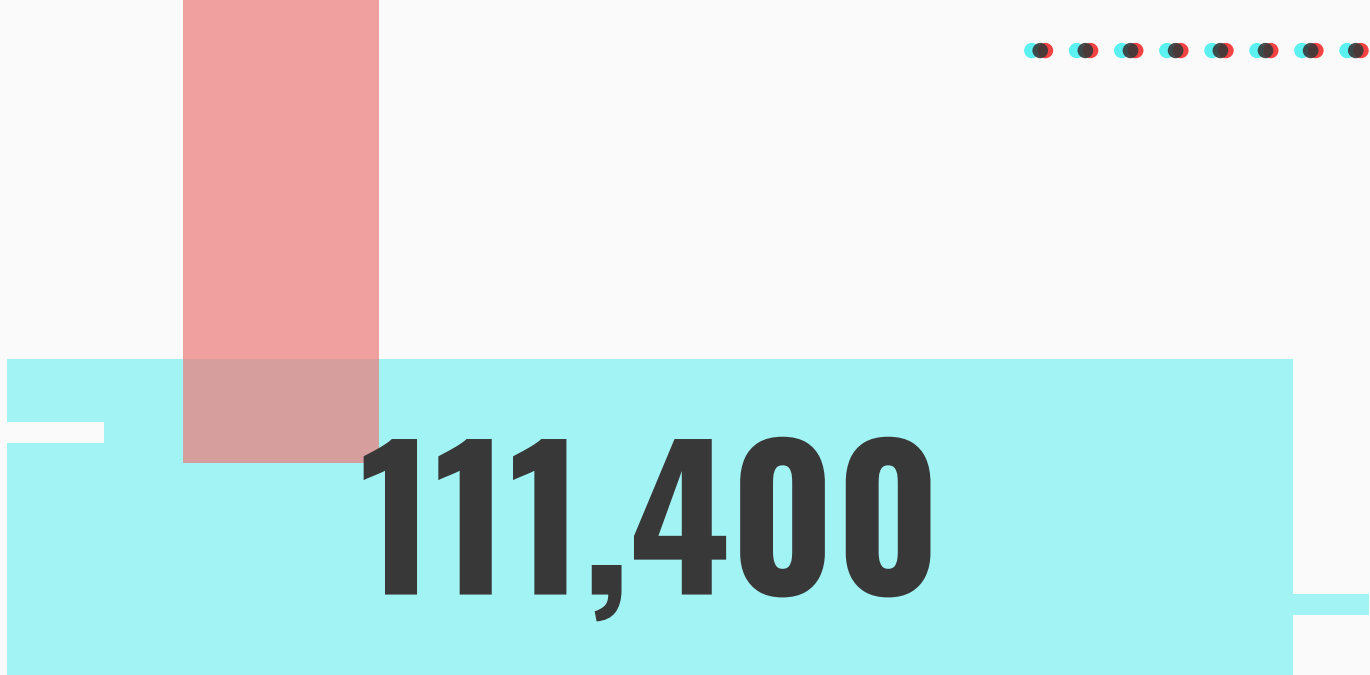
The Philippine's progress towards the 10 Fast Track Targets

111,400

Estimated number of people living with HIV in the Philippines in 2020

11,100

Estimated number of **new HIV infections** in the Philippines in **2016**

16,800

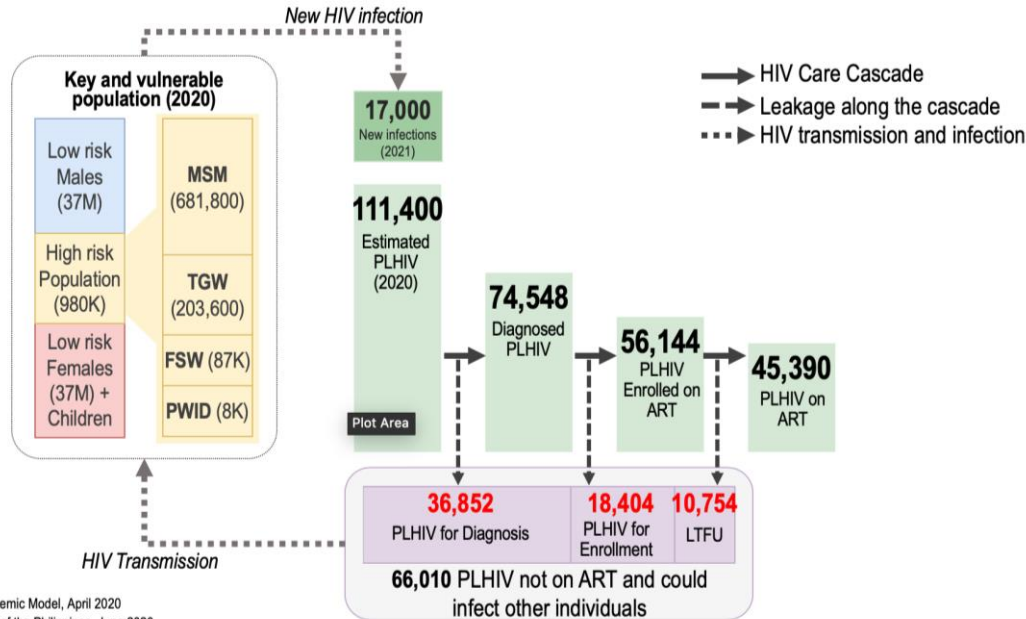Estimated number of **new HIV infections** in the Philippines in **2020**

20,700

Estimated number of **new HIV infections** in the Philippines in **2030**

10 Fast Track Targets

1. 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads
2. Zero new HIV infections among children, and mothers are alive and well
3. 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV
4. *90% of women and men, especially young people and those in high prevalence settings, have access to HIV combination prevention and sexual and reproductive health services*
5. *27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men*
6. 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services
7. 90% of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV
8. 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings
9. Overall financial investments for the AIDS response in low - and middle-income countries reach at least US$ 30 billion, with continued increase from the public sources
10. 75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV sensitive social protection

Target 1. 90-90-90

National HIV Care Cascade (June 2020)

Source: Spectrum-AIDS Epidemic Model, April 2020
HIV, AIDS and ART Registry of the Philippines, June 2020

First 90: Awareness of status

- Provider-Initiated Counseling and Testing
- Outreach Testing
- Community-Based Screening
- HIV testing in the workplace
- Proxy consent for YKP
- rapid HIV diagnostic algorithm (rHIVda)

Key issues that need to be addressed are:

- Limited options and implementation of targeted testing among key population and their partners (including female partners)
  - Limited implementation and lack of guidelines for CBS
  - Lack of YKP specific testing strategy
  - Lack of testing strategy for hard to reach KP (i.e. social media, self testing, index testing)
- Barriers to testing
  - Stigmatization of testing not sufficiently addressed
  - Discrimination by health care workers
  - Breach of confidentiality in testing
- Poor quality of pre and post test counseling
- rHIVda is not fully implemented
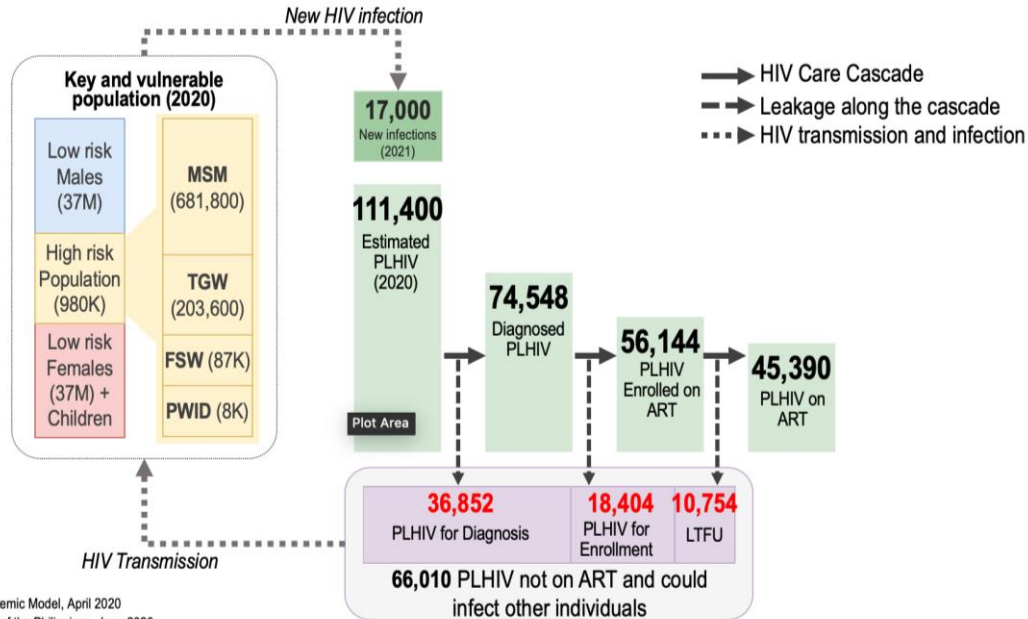 - Slow turnaround time for release of confirmatory test results

New strategies to be implemented
- *Social & sexual network testing*
- *Self-testing*

Target 1. 90-90-90

National HIV Care Cascade (June 2020)

Source: Spectrum-AIDS Epidemic Model, April 2020
HIV, AIDS and ART Registry of the Philippines, June 2020

Second 90: on ART

- Free ARV
- Treat all policy
- Expansion of treatment facilities (n=160)
- Establishment of one-stop shop & sundown clinics
- Case management

Key issues that need to be addressed are:

- Issues with ARV supply
- Inadequate resources at the facility-level
- Not all treatment hubs are one-stop shops
- Poor referral mechanisms
- No system to track referred clients
- Lack of differentiated approach in providing services
- Not all treatment facilities implement treat all
- Insufficient implementation of TB-HIV collaboration
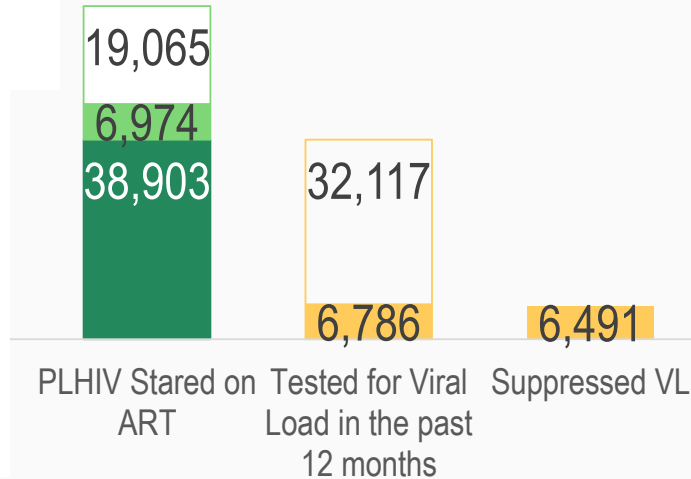
New strategies to be implemented
- *Real-time ART monitoring*
- *Transition to TLD*
- *Differentiated ART delivery*
- *Automated patient reminder system*
- *Distance consultation options through online or telemedicine*

Target 1. 90-90-90

National HIV Diagnosis and Treatment Cascade, June 2019

Legend:
- ☐ For Viral Load testing
- ■ Lost to follow up
- ☐ For enrollment
- ■ PLHIV on ART

PLHIV Started on ART:
- 19,065
- 6,974
- 38,903

Tested for Viral Load in the past 12 months:
- 32,117
- 6,786

Suppressed VL:
- 6,491

Third 90: VL suppression

- OHAT package for VL testing
- Use of Gene Xpert machines for VL testing

Key issues that need to be addressed are:

- Lack of viral load machines and CD4 machines in government treatment facilities
  - Challenges with the procurement of CD4 and Viral Load machines due to operational issues
  - Difficulty in utilization of Philhealth OHAT Package (organizational/facility level)
    - Absence of a clear and standardized guidelines on how to utilize OHAT
- Lack of promotion of "U = U" (undetectable viral load = untransmittable HIV) messaging

New strategies to implement:
- *Quality case management through case managers and support group*
- *Differentiated ART delivery*
- *Automated patient reminder system*
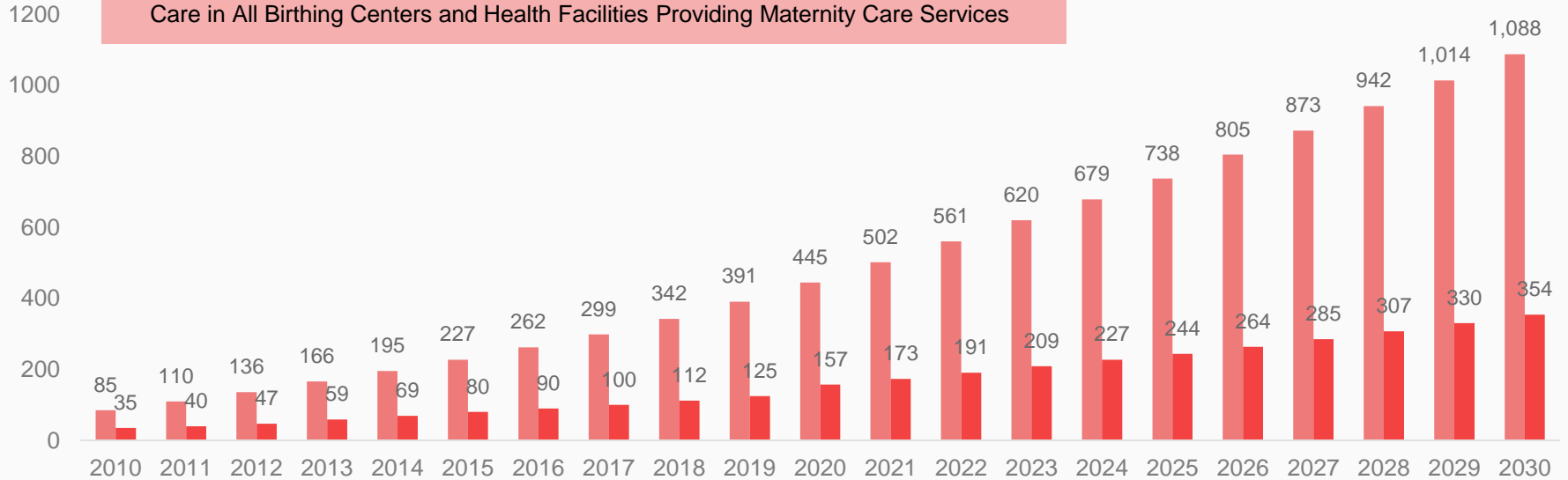- *Distance consultation options through online or telemedicine*

Target 2. Zero new MTCT infections

■ Mothers needing PMTCT

■ Number of new child infections due to MTCT

- 2009 PMTCT Guidelines
- Inclusion of HIV-screening in the 2016 Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services

Year	Mothers needing PMTCT	New child infections due to MTCT
2010	85	35
2011	110	40
2012	136	47
2013	166	59
2014	195	69
2015	227	80
2016	262	90
2017	299	100
2018	342	112
2019	391	125
2020	445	157
2021	502	173
2022	561	191
2023	620	209
2024	679	227
2025	738	244
2026	805	264
2027	873	285
2028	942	307
2029	1,014	330
2030	1,088	354

Target 3. 90% of young people empowered with skills & knowledge and capability to protect themselves from HIV

29%

15-24yo MSM & TGW with correct knowledge on 5 basic HIV transmission & prevention concepts

36%

15-24yo MSM & TGW who used a condom with their last anal sex partners in the past 12 months

26%

15-24yo MSM & TGW who knows their HIV status in the past 12 months

20%

15-24yo young women have comprehensive knowledge of HIV*

55%

15-24yo young women who uses condoms every time they have sex & limits sex to one uninfected partner*

1%

15-24yo young women who knows their HIV status in the past 12 months*

Target 6. 90% of key populations have access to HIV combination prevention services

42%

MSM & TGW have access to condoms
(free or bought)

	MSM	TGW	FSW	PWID	YKP - MSM
Condom use	38%	39%	85%	15% Male 16% Female	36%
Comprehensive knowledge on HIV prevention and transmission	32%	33%	48%	33% Male 35% Female	29%

Notes:
- Data presented is from the 2018 IHBSS, except for PWID figures which are from the 2015 IHBSS in Cebu and Mandaue. No IHBSS was conducted for PWID in 2018.
- 2018 IHBSS among MSM and TGW was conducted in 13 sites including Angeles, Baguio, Cagayan De Oro, Cebu, Davao, General Santos, Iloilo, Zamboanga, Mandaue, Talisay, Quezon City, Pasay, Taguig.
  - Around 30% of the 4,098 respondents were female-identifying and were considered as TGW in the analysis, while 62% were young MSM and TGW between 15-24 years old
- FSW figures only represent registered female sex workers as the 2018 IHBSS among FSW was conducted among female sex workers who regularly visit SHCs in the 10 sentinel sites of IHBSS.
- Condom use among MSM, TGW and YKP-MSM is defined as condom use at last anal sex within the past 12 months; condom use with last client for FSW; condom use at last sex for PWID
- Comprehensive knowledge on HIV transmission and prevention includes correct knowledge on all 5 basic questions: a healthy looking person can have HIV, condoms use prevents HIV transmission, having a faithful uninfected partners reduces HIV transmission, HIV cannot be transmitted by mosquitoes and toilet bowls.

Programmatic response
- Outreach (HIV lectures & condom distribution)
- Condom access points

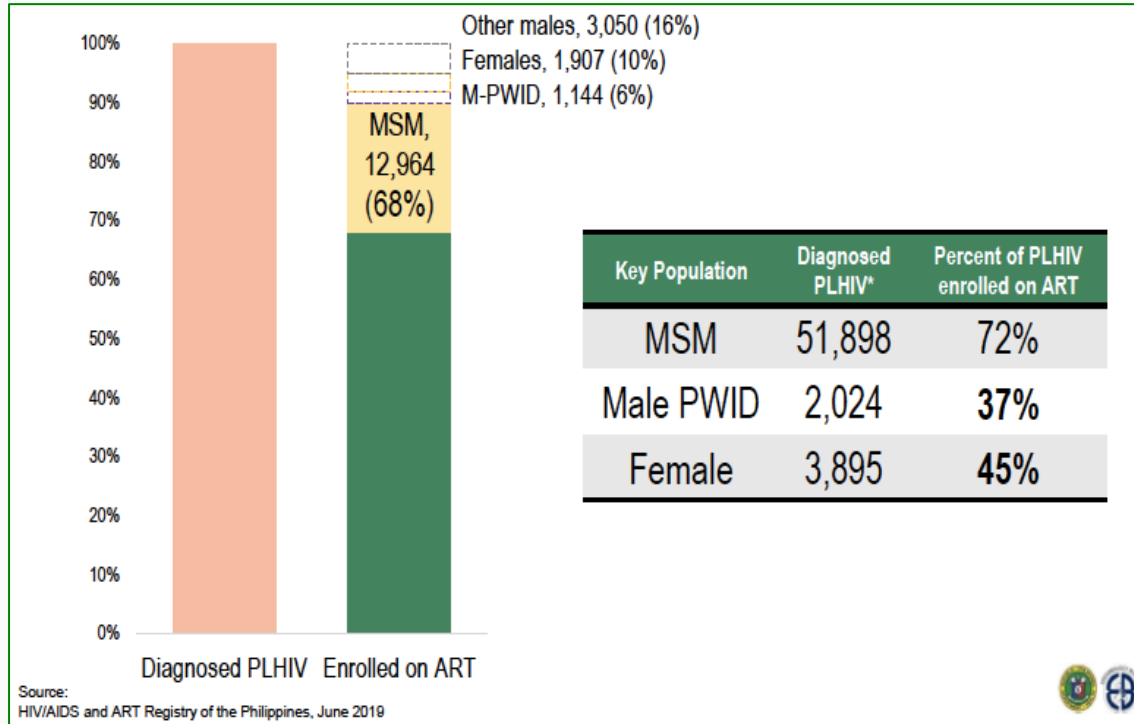**Key issues that need to be addressed are:**

- *Lack of an overall national prevention strategy*
  - Limited access to and unavailability of free condoms.
  - Lack of national condom promotion and distribution plan.
  - Lack of customized IEC material per key population.
  - Poor implementation of the developed essential package for YKP, TGW and PWID.
  - Lack of support in addressing legal barriers for PWID and YKP
  - Lack of KP-specific safe spaces
  - No policy/guidelines to introduce PrEP for prevention at a larger scale
  - Late adoption and weak implementation of "U=U" (undetectable VL = untransmittable HIV) messaging.

New strategies to implement
- *PrEP*
- *Retention of negative cohort*

Target 7. 90% of women and girls live free from gender inequality and gender-based violence

- **5%** of women aged 15-49yo experienced physical violence and **2%** experienced sexual violence in the past 12 months

- 5.5% of ever-married or partnered 15-49yo women experienced physical or sexual violence from a male intimate partner in the past 12 months

- *Gender equality issues in HIV service delivery*

Other males, 3,050 (16%)
Females, 1,907 (10%)
M-PWID, 1,144 (6%)
MSM, 12,964 (68%)

Key Population	Diagnosed PLHIV*	Percent of PLHIV enrolled on ART
MSM	51,898	72%
Male PWID	2,024	37%
Female	3,895	45%

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

Target 8. 90% of PLHIV and KP report no discrimination, especially in health, education and workplace settings

- Status is not reported in GAM
  - *Discriminatory attitude towards PLHIV*
  - *Avoidance of healthcare because of S&D*

Table 18. Percentage of respondents reporting stigma and discrimination when accessing HIV-specific health care

	Percent	N
Being advised not to have sex	14.7	150
Being talked badly or gossiped about	2.7	149
Verbally abused	2.0	149
Physical abuse	(0.7)	149
Avoiding physical contact	2.0	149
Telling other people about HIV status	(0.7)	147

Table 19. Percentage of respondents reporting stigma and discrimination when accessing non-HIV related health care

	Percent	N
Being denied of services because of HIV status	8.2	61
Being advised not to have sex	4.8	62
Being talked badly or gossiped about	11.5	61
Verbally abused	(3.3)	61
Physical abuse	(3.3)	61
Avoiding physical contact	(3.3)	60
Telling other people about HIV status	4.9	61

Key issues to be addressed:
- Only recently started to address S&D issues at the level of the national program
- Implementation in previous years is limited to a few actors; no nation-wide implementation
- No systemic reporting of S&D indicators
- HIV policies (i.e. HIV in the workplace) are usually focused on clinical components, no S&D policies included

HSP 2020-2022 Strategies:
Reduction of stigma and discrimination
1. Improvement of the Legal Literacy and SOGIE Sensitization Training Programs
2. Improving access to legal services
3. Improving messages and campaigns

Enhancing Legal and Policy Environment
1. Collaboration with PNAC
2. Increase PHIC – OHAT utilization
3. Transitioning to individual-based interventions (UHC)

Strengthening Community Systems and Community Engagement
1. Optimizing utilization of the CBMR
2. Capacitating community and ensuring sustainability
3. Improving KP-specific essential packages and their implementation

Source: 2019 The Philippine PLHIV Stigma Index 2.0

- **Target 9.** **Increase overall financial investments for the AIDS response**

Php32,306,697,022

Total cost required by the Health Sector Plan for HIV for 2020-2022

However, the total commitment and *anticipated resources* is only Php12,550,000,000 (USD251 million) or 40% of the financing requirement. The total funding gap amounts to Php18,650,000 (USD 373M) or 60% of the total HSP funding need.

- *No updates on the National AIDS Spending Assessment (NASA) since 2016*

Target 10. 75% of PLHIV & KP who are in need benefit from HIV-sensitive social protection

Existing programs
- PhilHealth OHAT access & accreditation issues
- GF-enabler's fund
- Enabler support from other agencies (i.e. DSWD assistance)

Key issues
- PhilHealth OHAT access and accreditation issues
- Non-utilization or low utilization of OHAT
- Need to expand the benefit package beyond treatment services
- Difficulty in accessing enabler support from other agencies
- Lack of support for other treatment needs
- No systematic monitoring in place for social protection interventions

Key Observations:
Facilitating factors in the delivery of care cascade

Governance
- Availability of the national strategic plan for HIV as guidance document in implementation
- Availability of DOH Guidelines
- PHilHealth policy on OHAT
- ARV procurement
- Support from DOH regional offices (Regional HIV Coordinators)

Service delivery
- Trained, skilled, and dedicated health service providers

Monitoring and evaluation
- Availability of strategic information for program planning (DOH-EB)

Financing
- External funding from Global Fund
- LGU funding

Enabling environment
- Support of local chief executives
- Establishment of the local AIDS council
- Local ordinances regarding HIV
- Presence of CBO, PLHIV support groups, peer educators and case managers
- Technical support from development partners (UN agencies, bilateral)
- Multisectoral partnerships – DSWD, NGOs, professional groups

Key Observations: Barriers to the delivery and access of services

Financial	Health System	Bio-psychosocial	Legal and Policy-related
• Philhealth- OHAT standardization issues and utilization • Out of pocket expenses	• Inadequate/lack of permanent staff/Health care worker (HCW) • HCW stigma, confidentiality and privacy issues • Lack of systematic record keeping and archiving	• ARV side effects • Stigma and discrimination • Lack of support systems • Myths and misconceptions in HIV treatment • Co-infection • Mental health issues • Cultural barriers and religious beliefs	• Contradicting provision in national laws (RH, drug law) • Lack of solid program to protect human rights of KP

Source: 2019 National Joint HIV Program Review

THANKS!

REFERENCES:
- Department of Health – Epidemiology Bureau, NHSSS Unit
  HIV,AIDS & ART Registry of the Philippines as of June 2019
  2018 Integrated HIV Behavioral and Serologic Surveillance
  2019 AEM-Spectrum, April 2020 version

- 2017 National Demographic Survey
- 2020 Global AIDS Monitoring Country Report
- National Health Sector Plan for HIV 2020-2022 (Draft)
- National Joint HIV Program Review Philippines, 2019
- 2019 The Philippine People Living with HIV Stigma Index 2.0
- 2010 UNAIDS & WHO Neonatal and child male circumcision: a global review

SESSION 3:
Journaling Template

Country	Philippines
Agency	UNDP
Date	18 August 2020

SESSION 3: PEOPLE-CENTERED HIV RESPONSE

Instructions:
- Please review your organization's roles and responsibilities in the Philippine AIDS response (Reference: Division of Labor 2018)
- Based on the current Philippine AIDS situation and your roles and responsibilities, please reflect and respond to the guide questions and areas of focus below.
- Provide top 3 answers only

Definitions:
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Guide Questions	Areas of Focus		
	Reaching People in Need	Structures that Respond to HIV	Contextual Environment
How do we see the current situation?	Reasonable attention provided to main drivers of the HIV epidemic, e.g., men who have sex with men, in terms of prevention and treatment	Engaged civil society in service delivery	Promising integration of human rights issues and overall human well-being in HIV response
What concerns us?	Other segments of the population are needing better differentiated interventions (e.g., urban poor, people in rural communities, and women)	There needs to be improvement in scaling up or adopting efforts by the civil society or in local government units to the national level	There is a need to have more focus on other social, economic, and cultural factors surrounding HIV and health that will help improve general help-seeking behaviour of Filipinos, in general, and Filipinos living with HIV, in particular.
	Not sure if EB can provide analyses with socioeconomic lens? (Either on an individual level or barangay level, that can help determine how unequal access to services is across different socioeconomic classes)	Improvement in data management	
What gives us hope?	Although many initiatives are focused on middle class men, some can be adapted and new measures are also being developed to respond to the needs of other segments of the population	New and innovative initiatives from the civil society and by local government units	The increasing appreciation of the role of human rights and well-being in health and development
What constrains our ability to achieve our goals?	SDG 4 Low access to quality education, especially in light of COVID-19 SDG 5 Low access to sexual and reproductive health and reproductive rights Existing numerous forms of discrimination against women and LGBTQI people SDG 16 We need stronger institutions and more inclusive societies to achieve a sustainable response in addressing the HIV epidemic		

SESSION 4: KEY RECOMMENDATIONS
What are **your recommendations** back to UNAIDS in terms of the strategy?

Instructions: Going back to the country's AIDS situation, our identified areas of focus, the JTA'S roles and responsibilities, reflect on what needs to continue, stop or start in the current UNAIDS Strategy in the Philippines? Please limit to three responses.

Continue *What is working that we must continue to do?*	Start *What are we not doing that we have to start doing?*	Stop *What must we stop doing, that if we don't stop will ensure failure?*
Community-based and community-led interventions	Focusing more on other factors, such as gender and socioeconomic class, and consider their intersections, (so we can also focus on other marginalized groups)	Fragmented response
Wholistic approach to HIV	Scaling up effective interventions	
Supporting the national program and strengthening government and non-government institutions		

SESSION 5: ONE KEY MESSAGE

What is the **one key recommendation** you want to reiterate for strong consideration?

One Key Message Suggestions (One from each Co-sponsor)
Support government and non-government institutions, not only in responding to HIV, but also in addressing other issues (such as poverty, gender, human rights, and other health issues) that impact our HIV response

SESSION 3:
Journaling Template

Country	Philippines
Agency	UNFPA
Date	18 August 2020

SESSION 3: PEOPLE-CENTERED HIV RESPONSE

Instructions:
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Guide Questions	Areas of Focus		
	Reaching People in Need	Structures that Respond to HIV	Contextual Environment
How do we see the current situation?	Not enough attention given to women and girls	LGUs CSOs	Education system – CSE for long-term impact, but results will not be seen immediately. Also, COVID19 has resulted in lower enrollment rates, so CSE will have even less reach.
	Treatment gap (gap between knowing HIV status and starting on ARVs) needs to be addressed	Health facilities Support groups	
	Need stronger prevention efforts	National Programme + Gov't agencies LGUs CSOs	Other sectors need to step up – labor, education, etc.
What concerns us?	We reach key populations, but a KAP-gap still exists.	CSOs, particularly youth groups Support groups	
	We are reaching KPs too late. Protective behaviors/knowledge should be in place at start of sexual activity	LGU facilities – YFS, teen centers, etc. CSOs – LGS, etc.	Comprehensive Sexuality Education – but it will take some time before this will have an impact
	Condoms are not a popular prevention method, even as an FP method.	CSOs	Explore possibility of procuring condoms that people will want to use (just an idea on how to improve condom use)
What gives us hope?	New technologies and approaches	All partners	Need to work with new partners involved in new technologies
	Youth engagement, not just formally-established CSOs, but also youth groups which have a more informal structure	Youth groups	SK can play a greater role
	National programme now more supportive of primary prevention	National government	

What constrains our ability to achieve our goals?	Changes brought about by COVID	All partners	COVID affects the whole landscape
	Reconciling agency mandates and HIV priorities in terms of target populations and sites	Co-sponsors	

SESSION 4: KEY RECOMMENDATIONS
What are **your recommendations** back to UNAIDS in terms of the strategy?

Instructions: Going back to the country's AIDS situation, our identified areas of focus, the JTA'S roles and responsibilities, reflect on what needs to continue, stop or start in the current UNAIDS Strategy in the Philippines? Please limit to three responses.

Continue *What is working that we must continue to do?*	Start *What are we not doing that we have to start doing?*	Stop *What must we stop doing, that if we don't stop will ensure failure?*
CSO partnerships, particularly youth engagement	More focus on prevention	Working in silos, fragmented efforts
Integration of HIV across secors	Give attention to Other KPs	
	Humanitarian response	

SESSION 5: ONE KEY MESSAGE

What is the **one key recommendation** you want to reiterate for strong consideration?

One Key Message Suggestions (One from each Co-sponsor)
Ensure that women and girls, and young people have access to HIV and SRH services.

SESSION 3:
Journaling Template

Country	Philippines
Agency	UNICEF
Date	18 August 2020

SESSION 3: PEOPLE-CENTERED HIV RESPONSE

Instructions:
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- Based on the current Philippine AIDS situation and your roles and responsibilities, please reflect and respond to the guide questions and areas of focus below.
- Provide top 3 answers only

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Guide Questions	Areas of Focus		
	Reaching People in Need	Structures that Respond to HIV	Contextual Environment
How do we see the current situation?	YKPs are way behind target based on Nash's presentation	YKPs are provided access to testing and counseling services (as per the law)	The law allows YKP (15-below 18) to access HIV counseling and testing without parents' consent.
What concerns us?	This pandemic is exacerbating the risks as young people are not allowed to go out (but we are also aware that some of them still practice/ engage in high risk behaviors). This also prompt protection issues experienced at home where KPs are lockdown with potential perpetrators who will introduce them to risk activities.	But only few have capacity to deal with YKPs beyond counseling and testing for HIV	Not all LGUs have good interpretation of the law. Plus, the COVID19 pandemic resulted to restriction of movements. Minors can not go out should they need to get tested.
What gives us hope?	There are promising multi sectoral response but limited. Telemedicine reaching YKPs and providing referral support	Other LGUs and partners appreciate the value of multi sectoral approach to HIV response for YKP; notable progress among those who work with other sectors, including private sectors and peoples organization and youth networks.	Other organizations have found creative ways to reach young people. Guidance about minors with special needs (ALHIV, juveniles, etc), have been issued by CWC and DILG. Online platforms are utilized for advocacy and referral for service delivery. Maximizing technology for social innovation requires working with other department of the government and not only with DOH.
What constrains our ability to achieve our goals?	Priorities and buy in of the partners especially government. Majority of the Program are funds are only coming from GF. Everywhere, there are innovations	Response are very sector specific, in silo. We have yet to see a strengthened AHDP and HIV programming in DOH, trickle down to LGUs for implementation (down to	Priorities of the partners and interpretation of the laws

	led by government on HIV but there are not documents or not on the programme implementers radar, but these are actually entry points.	barangay), pointing out the need improving relationship between the NGAs and the LGUs and addressing outstanding bottlenecks.	

SESSION 4: KEY RECOMMENDATIONS
What are **your recommendations** back to UNAIDS in terms of the strategy?

Instructions: Going back to the country's AIDS situation, our identified areas of focus, the JTA'S roles and responsibilities, reflect on what needs to continue, stop or start in the current UNAIDS Strategy in the Philippines? Please limit to three responses.

Continue _What is working that we must continue to do?_	Start _What are we not doing that we have to start doing?_	Stop _What must we stop doing, that if we don't stop will ensure failure?_
Putting pressure on govt and other partners to put priority where the need is		Working in silos, sector specific response

SESSION 5: ONE KEY MESSAGE

What is the **one key recommendation** you want to reiterate for strong consideration?

One Key Message Suggestions (One from each Co-sponsor)
Ensure that social welfare and protection is included in HIV programming for YKP esp when providing TA to partners like LGUs

JOINT TEAM ON AIDS (JTA) FOCUS GROUP DISCUSSION (FGD)
ON UNAIDS STRATEGY DEVELOPMENT

SESSION 3:
Journaling Template

Country	Philippines
Agency	UNODC
Date	18 August 2020

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SESSION 3: PEOPLE-CENTERED HIV RESPONSE

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Instructions:
- Please review your organization's roles and responsibilities in the Philippine AIDS response (Reference: Division of Labor 2018)
- Based on the current Philippine AIDS situation and your roles and responsibilities, please reflect and respond to the guide questions and areas of focus below.
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Guide Questions	Areas of Focus		
	Reaching People in Need	Structures that Respond to HIV	Contextual Environment
How do we see the current situation?	Using the lens of UNODC, we see that a lot of the PWUDs population are being left behind in the HIV response. We are only so much focused on PWIDs. However, many PWUDs are more likely to engage in risky sexual behaviour which puts them at risk to acquire HIV.	We still lack mechanism when it comes to providing, or making HIV services available in other closed settings, such as Drug Treatment and Rehbilitation Centers, Detention facilities (balay silangan, balay pagbabago under PDEA, Children in conflict with the law centers under DSWD)	-Stigma is high among people who use drugs -Disconnect in understanding the link between the risk in drug use and HIV and other communicable diseases -lack of coordination/working in Siloe -lack of foresight especially the risks associated with vulnerable populations, like those in prisons (e.g. when the COVID-19 hits the country) -We tend to stick to business as ususal, like when we were proposing for an IHBSS in NCR in jails. We know that 80% of the jail population are drug related cases and that sexual activity are happening inside the jails, that there are so many factors that puts people suscepible to HIV
What concerns us?	We are putting people in a box COVID-19 sabotages a lot of the efforts		-The lack of proper coordinated mechanism -Activity based interventions (one time, big time activities) that does not promote availability of services. Clients are always at the mercy of the LGUs/service providers
What gives us hope?	-The JTA team -The openness to optimizing the combination of prevention response	We are able to open discussion about availability of services in DTRC. Althoguh, we still need more people to advocate in the area of drug treatment. Instead of investing on drug testing, should invest on HIV testing and other related services on HIV	
What constrains our ability to achieve our goals?	-Issues on procurement (complicated processes and requirements)		-defensive attitude when something is proposed

SESSION 4: KEY RECOMMENDATIONS
What are **your recommendations** back to UNAIDS in terms of the strategy?

Instructions: Going back to the country's AIDS situation, our identified areas of focus, the JTA'S roles and responsibilities, reflect on what needs to continue, stop or start in the current UNAIDS Strategy in the Philippines? Please limit to three responses.

Continue *What is working that we must continue to do?*	Start *What are we not doing that we have to start doing?*	Stop *What must we stop doing, that if we don't stop will ensure failure?*
We were able to put the cause for PDLs in the agenda of the Global Fund. This is a good start. But, this must be put forward in the countyrwide action plan.	Enhance combination prevention initiatives among LE groups, such as supporting development of HIV workplace policies and programmes. Many LE organizations are interested on this and they know that they are mandated by law. But, they are having difficulty looking for people or agencies to help them. PNAC and/or DOH must also reach-out and extend their assistance.	Putting people in a box, neglecting other related key populations that are also at risk to HIV, like PWUDs. Let's stop thinking that only PWID is the population in the spectrum of drug abuse that is affected by HIV.

SESSION 5: ONE KEY MESSAGE

What is the **one key recommendation** you want to reiterate for strong consideration? I understad that agencies have their own priorities and therefore even within one agency, it's different

One Key Message Suggestions (One from each Co-sponsor)
UNODC will continue to uphold the UN values. Most of the time, PDLs are the most marginalized and stigmatized group of people in a society. Yes, maybe many of them have committed henious crimes, but there are those who have been falsely accused and/or have committed minor offences, but are serving non-proportionate sentencing. In other terms, over kill. There were many who have not been heard in the court, yet they seem to have been sentenced already because of their long period of stay in jails. Worst were those who have been found not to be guilty after serving time in prison. UNODC will continue to provide support at the policy and operational level to push for the rights that these PDLs deserve. We will push for the Mandela Rules and the Bangkok Rules.

SESSION 3:
Journaling Template

Country	Philippines
Agency	WHO
Date	18 August 2020

SESSION 3: PEOPLE-CENTERED HIV RESPONSE

Instructions:
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Guide Questions	Areas of Focus		
	Reaching People in Need	Structures that Respond to HIV	Contextual Environment
How do we see the current situation?	Focus on key populations (MSM, TG), but not enough on young people, prisons, women	Good involvement of multiple stakeholders: JTA, CSOs, PLHIV	Significantly impacted by COVID-19 pandemic. Data shows this.
	Focus on high burden areas but may need more attention to Cat B & C cities	Variable LGU involvement and commitment	Slow progress on UHC
	Lots of good data indicating gaps across the whole cascade and not enough attention to granular data for action		
What concerns us?	The impact of COVID-19 on service provision and uptake	Slow implementation of recommended WHO policies	Limited multi-sectoral engagement (e.g. prisons)
	Patchy implementation of good practices	Complicated bureaucratic procedures, e.g. PhilHealth, regulatory approvals	War on drugs severely restricts engagement of PWID/PWUD in service provision and uptake
	Limited focus on EMTCT, paediatric patients, advanced HIV	Challenges with cross-cutting components, including PSM, lab and SI	Limited HR capacity in national programme, regional and municipal levels also
What gives us hope?	Flexibility and innovations implemented by CSO partners to ensure access to ART/PrEP	Progress on implementation of rHIVda, TLD transition, MMD, ARV delivery initiatives	Republic Act 11166: consent laws for adolescents. UHC law.
	Capitalizing on online interventions including telemedicine, online reach	GFATM funding, PEPFAR involvement, UN JTA	Innovations/WHO recommendations are being included in new HSP
What constrains our ability to achieve our goals?	Limited and slow scale-up of good interventions	Lack of integration with other diseases: TB, VH, STIs	High-level prioritization of and commitment to HIV and related infections
	Fragmented implementation		Ongoing stigma and discrimination and low priority to sexually transmitted infections
			Reprioritization to COVID-19 leading to exacerbation of HR constraints

Instructions: Going back to the country's AIDS situation, our identified areas of focus, the JTA'S roles and responsibilities, reflect on what needs to continue, stop or start in the current UNAIDS Strategy in the Philippines? Please limit to three responses.

Continue	Start	Stop
What is working that we must continue to do?	*What are we not doing that we have to start doing?*	*What must we stop doing, that if we don't stop will ensure failure?*
Differentiated service delivery with focus on community engagement and empowerment	Speed up and strengthen implementation of HIV-ST and place more emphasis on index testing and sexual network testing	Allowing complex bureaucracy to impede action and progress. High-level advocacy for change.
Implementation of new initiatives: TLD, PrEP, HIV-ST, MMD, decentralized testing and treatment	Optimize opportunities for integration of services: HIV, STI, hepatitis, EMTCT, SRHR, TB, NCDs, mental health, holistic service provision. More one-stop shops	Be careful not to allow COVID-19 to interrupt action and progress
	Frame and provide services as improved sexual health and well-being. Increase inclusivity, everyone deserves good sexual health. It is a human right.	

What is the **one key recommendation** you want to reiterate for strong consideration?

One Key Message Suggestions
(One from each Co-sponsor)
Inclusion of HIV and other related services in UHC to ensure that all people in need receive quality, person-centred care without incurring financial hardship

JOINT TEAM ON AIDS (JTA) FOCUS GROUP DISCUSSION (FGD)
ON UNAIDS STRATEGY DEVELOPMENT

SESSION 3:
Journaling Template

Country	Philippines
Agency	UNAIDS
Date	18 August 2020

SESSION 3: PEOPLE-CENTERED HIV RESPONSE

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- **Reaching People in Need** - Focusing on marginalized groups and maintaining access for those that were reached with prevention and treatment.
- **The structures that respond to HIV** - In a nutshell, this is the AIDS response; The structures and organisations that directly implement the AIDS Strategy. This includes but is not limited to the Joint Programme, Global Fund, PEPFAR, and most importantly, the national partners implementing the National AIDS Plan.
- **Contextual environment** - The external context, beyond HIV, that can have an impact either because the response to HIV fits within a larger issue (e.g., SDG3 and Agenda 2030, Universal health coverage) or because of emerging issues that will impact services, funds, or priorities (e.g., COVID-19 pandemic, natural disasters or humanitarian crises). Some of the issues could be driving forces in the world that we can engage and influence for a more effective AIDS response, and some we have no control over, but which have significant impact on our work.

Guide Questions	Areas of Focus		
	Reaching People in Need	Structures that Respond to HIV	Contextual Environment
How do we see the current situation?	Coverage decreased	interruptions, slowing down of programme activities	Our lives have been hijacked by covid-19!
	Social and economic inequalities magnified under covid. Ex, those with access to private transportation and can afford to pay for courier services for ARV refill were less affected by the quarantine compared with those who had to rely on public transportation, etc.	Operations of facilities affected, HIV service providers repurposed for Covid	LGUs -- varying priorities, capacities (human, technical, financial) to deliver health services
	Most vulnerable KP ie YKP, PWID are most affected in accessing HIV services	Quarantine - no immediate guidelines on provision of services, especially prevention and testing	Most of funding allocations repurposed to COVID response
What concerns us?	Increase infections, poor enrolment, LTFU	Gains of the programme -- in terms of moving closer to reach our targets, political commitments, etc -- may be negated by the impact of Covid. If before covid we needed to double our efforts to reach our targets, now we may need to triple our efforts.	It is hard to see past the current covid situation because we don't know how long before we can get the situation under control, and by then what would be the extent of its impact on the economy, health systems, social systems, governance structures, etc. How long before we can recover? What will the "new normal" look like?
	Innovations ie self testing, partner notification, differentiated care, combination prevention are slow to scale up	Although we have already been discussing online outreach pre-covid, but given the catching up we need to do, we need to immediately scale up our interventions even as we're still trying to figure out "the new normal". In short, we may no longer have the luxury of "testing" our innovations.	How will HIV be integrated in UHC?

	PLHIVs suffering psychosocial issues due to lack of mental health integration and social protection	Uneven implementation of policies and guidelines	OHAT implementation still varies across health facilities
What gives us hope?	PLHIV community (while far from perfect) empowered enough to not only demand for sustained services, but will also demand they be part of the solution. Community monitoring and reporting of ARV stocks, open communication between community and DOH, etc.	Well-functioning coordination mechanism, open communication between and among government, development partners and CSO	Civil society, private sector steps up where government fails
	CBO/CSOs becoming more holistic in providing services	We've been able to test certain service delivery modalities that may may be instituted even post-covid	UHC - potential to scale up prevention and testing
		Civil society (support groups) will always rise to the occasion	Fast track commitments of LGUs
		Strong EB; functional community monitoring, albeit still informal for the most part	RA 11166
What constrains our ability to achieve our goals?	Lack of social protection	Weak programme leadership at the national level	The health system (including service delivery, PSM, etc) has been constrained long before Covid-19. But the crisis within our health system unraveled with the pandemic.
	Few public health facilities engage in online platform in reaching KP	HIV programme competes with other equally critical health programmes	Realignment of priorities (e.g., funding for economic recovery over health; human resource, including program managers, health workers, etc.)
		HIV programmes and services beyond the health sector	Election every 3 yrs that necessitates constant advocacy, recommitments at local level, etc.

Instructions: Going back to the country's AIDS situation, our identified areas of focus, the JTA'S roles and responsibilities, reflect on what needs to continue, stop or start in the current UNAIDS Strategy in the Philippines? Please limit to three responses.

Continue *What is working that we must continue to do?*	Start *What are we not doing that we have to start doing?*	Stop *What must we stop doing, that if we don't stop will ensure failure?*
Innovations that give people options -- prevention (PrEP), testing (CBS, self-screening), differentiated care (one-stop shops, community centers), information and services (outreach, telemedicine)	Social enablers - integrated in all aspects of services (prevention, testing, treatment)	Stop pilot-testing. There is enough evidence for what works. Scale-up, scale-up,scale-up
Civil society engagement in the response, community-led interventions;	Social contracting to further strengthen GO-CSO partnership, sustain and scale-up services in a way that deloads the public health system, etc.	Stop over-reliance on GF and PEPFAR
Strategic information - regular generation of data, capacitating stakeholders to analyse data for evidence-based decision-making (capacitating the regional and facilities in analysing data for timely recalibration of utilization of information)	Integration of HIV in UHC	Stop repeating assessments, start following through and implementing recommendations -- procurement and supply management system!!!
Integration of programmes and services	HIV programmes and services beyond the health sector - labor, education, social protection	Important to be KP-targeted but not at the exclusion of other populations, e.g, women
Scale up programs to address stigma and discrimination	Sustainable human resource plan for HIV	

SESSION 5: ONE KEY MESSAGE

What is the **one key recommendation** you want to reiterate for strong consideration?

One Key Message Suggestions (One from each Co-sponsor)
What does it mean when experts say the world will never go back to how we were before Covid-19, and that this will not be the last pandemic? How will that play out for the programme in terms of funding landscape, etc.? Need to define the "new normal" and a roadmap towards HIV programme resilience in times of pandemics and disasters, e.g., resilience from global stockouts of ARVs, service delivery mechanisms that minimize service interruptions, etc. We need to intensify pushing the agenda of programme integration and taking HIV out of isolation, especially in the context of UHC. We need to demand more results and accountability in relation to commitments on domestic funding in order to continuously and self-reliantly provide HIV services amidst uncertain times. We know what works. Scale-up evidence-based strategies. Invest in high impact interventions. We need to practice data-driven decision-making at the sub-national and local level.