Baseline Assessment – Philippines

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV Services

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The Global Fund

Disclaimer

Toward the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics*, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working draft for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in this paper do not necessarily reflect the views of the Global Fund.

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List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CBO	Community Based Organization
CDC	Centers for Disease Control
DoH	Department of Health
DILG	Department of Interior & Local Government
DoJ	Department of Justice
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
IPT	Isoniazid Preventive Therapy
IRR	Implementation Rules and Regulations
KP	Key Population
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LTFU	Loss to follow-up
MDR-TB	Multidrug-resistant tuberculosis
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission
NASCP	National AIDS & STI Control Programme
NGO	Non-governmental Organization
NSP	Needle and Syringe Programme
OST	Opioid Substitution Therapy
PCCM	Philippines Country Coordinating Mechanism
PBSP	Philippine Business for Social Progress (TB GF Principal Recipient Philippines)
PDEA	Philippines Drug Enforcement Agency
PCR	Polymerase Chain Reaction
PhilSTEP	Philippine Strategic Tuberculosis Elimination Plan
PHO	Provincial Health Office
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure Prophylaxis
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SHC	Social Hygiene Clinic
STI	Sexually Transmissible Infections
SW	Sex Worker(s)
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	The United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VL	Viral load
WHO	World Health Organization
XDR TB	Extensively Drug Resistant Tuberculosis
YKP	Young Key Populations

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Executive Summary

Introduction

Since the adoption of its Strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

This Executive Summary sets out the findings of the baseline assessment conducted in the Philippines as part of operationalizing Strategic Objective 3, which commits the Global Fund to Fight AIDS, TB and Malaria to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services*".[1]

Though the Global Fund provides support to all recipient countries to scale up programs to remove human rights-related barriers to health services, it is providing intensive support to 20 countries to enable them to put in place comprehensive programs aimed at reducing these barriers.[2] Based on criteria involving needs, opportunities, capacities and partnerships in country, the Philippines and nineteen other countries were selected for intensive support.

This baseline assessment is the first component of the package of support the Philippines will receive and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV and TB services. Towards this end, this assessment: (a) establishes a baseline concerning the present situation in the Philippines with regard to barriers to HIV and TB services and existing programs to remove them, (b) describes what comprehensive programs aimed at reducing these barriers would look like, and their costs, and (c) suggests opportunities regarding possible next steps in putting comprehensive programs in place.

In November-December 2017 and January 2018, data was collected for this baseline assessment through a desk review and in-country research, which comprised a total of 32 Key Informant Interviews and Focus Groups made up of 202 key population members. These were held in Manila City, Zamboanga and Cebu. Further research to determine historic costs and projected costs of programs to reduce barriers was conducted in January and February 2018.

This Executive Summary summarizes the baseline findings in the Philippines with regard to populations affected by service access barriers, the nature of the barriers, and the existing programs to reduce these barriers. The findings are separated into HIV and TB findings, as these were the two program areas selected for this baseline. Recommendations and costs for a comprehensive program to reduce barriers to HIV and TB services are also presented, along with priorities for immediate action.

[1] The Global Fund Strategy 2017-2022: Investing to End Epidemics. GF/B35/02

[2] Ibid, Key Performance Indicator 9.

Baseline HIV findings

Key and vulnerable populations

Key populations include gay and other men who have sex with men; transgender women; female, male and transgender sex workers; people who inject drugs and prisoners. More than 95% of the people identified with HIV in the Philippines are male (primarily men having sex with men), or transgender women. For the men diagnosed since 2012, the primary mode of transmission has been sex with other men (56%). Although the number of women with HIV is quite low in comparison with men and transgender women, it has been increasing steadily. Younger people are disproportionately affected, with 29% of the people with HIV identified since 2012 aged 15-24 years and 52% aged 25-35 years. A total of 88 children have been identified with HIV since 2012 as a result of parent-to-child transmission. HIV prevalence in men having sex with men over the age of 25 was 4.41%, and in men aged 18-24 – 2.47%. HIV prevalence in sex workers was 1.8% in 2013, with those younger than 25 facing a higher burden (2.1% compared to 1.4% in those above 25). Other vulnerable populations include young people, particularly those living in poverty.

Barriers to HIV services

The most significant human rights-related barriers identified by key and vulnerable populations and the people who work with them were the following:

1. **Shame, internal stigma, fear and denial** by people from key populations about the reality of HIV, their risk and the consequences of being diagnosed with HIV
2. **Insufficient information and false beliefs** about the benefits that knowing their HIV status and accessing HIV treatments would bring to their long-term health and of the support and services available if they were diagnosed with HIV
3. **Service delivery problems** including location, timing, confidentiality, quality and discriminatory treatment
4. **Fear of violence and loss of freedom** if identified as coming from a key population – particular issues for people who used drugs
5. **Financial burden** associated with travel to treatment centers, loss of income, costs of nutrition and opportunistic infection diagnosis and treatment

The ways that these barriers impact on the key and vulnerable populations are set out in detail in the findings section of this report.

Programs to address barriers to HIV services – from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in the Philippines to remove barriers to services and provides a summary of the proposed elements a comprehensive program[3], based on the seven program areas set out in the Global Fund *HIV, Human Rights and Gender Equality Technical Brief*.[4]

[3] Programs to remove human rights-related barriers to services are defined to be *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV and TB services.

[4] Technical *Brief HIV, Human Rights and Gender Equality,* Global Fund to Fight AIDS, TB and Malaria (April 2017)

The seven program areas are:

PA 1: Programs to reduce HIV-related stigma and discrimination
PA 2: Programs to train health care workers on human rights and ethics related to HIV
PA 3: Programs to sensitize lawmakers and law enforcement agents
PA 4: Programs to provide legal literacy ("know your rights")
PA 5: Programs to provide HIV-related legal services
PA 6: Programs to monitor and reform laws, regulations and policies related to HIV
PA 7: Programs to reduce discrimination against women and girls in the context of HIV

PA 1: Stigma and discrimination reduction for key populations

Existing programs: A number of activities have been conducted in recent years to address broad stigma and discrimination faced by PLHIV and key populations. These are generally embedded in broader HIV programs. They include HIV Joint Evaluation Exercise and Planning (JEEP) workshops that confirmed earlier findings of experience of stigma faced by men who have sex with men and transgender individuals, harassment by barangay officials of outreach teams working with people who inject drugs, and confidentiality issues. The Reaching Out to Most-at-risk Populations or ROMP project carried out a number of initiatives designed to provide greater access to HIV services for stigmatized and discriminated key populations, including outreach and accompanied referral to testing and treatment clinics.

Save the Children Philippines, the Global Fund PR for the *Strengthening HIV/AIDS Prevention, Community Linkages and Response in the Philippines* project implements awareness-raising campaigns to reduce stigma using social media and celebrities to disseminate messages. The Cebu-based transgender organization, COLORS, in partnership with the Cebu City DOH, implements a peer outreach model in the transgender community to encourage acceptance and demand for HIV/AIDS services including HIV counselling and testing. Repos Angels offered LGBT-friendly HIV screening and testing outreach services and awareness seminars in Cebu city.

Elements of a comprehensive program in this area: Reduced self-stigma among people from key populations and stigma within families and communities will leading to increased motivation to access HIV testing services and treatment care and support of people living with HIV. Activities proposed in this area include the development of plain-language information materials and capacity building of outreach peers carried out to particularly address attitudes and beliefs among some key population members about the benefits of HIV testing and treatment and health seeking behaviour in general. Increasing the availability of information and support in this area is likely to assist in addressing issues regarding sense of future, positive health options and attachment to community.

A forum of religious leaders working through their networks to support families affected by HIV will be supported to increase compassionate care in community and mobilize the social care services they administer. A policy framework and guidance materials will be developed to support the integration of sexual orientation and gender identity and expression (SOGIE) principles into the gender reform processes currently underway in several key government departments.

To address significant gaps between the number of people testing positive for HIV and the number successfully initiated on/staying on treatment, additional outreach workers will be attached to key populations programs with a specific brief to engage

with people with HIV. Test and treat targets take up significant time in the outreach workforce. These workers will also increase the capacity of the outreach teams to widen their support to include linkage to care and treatment.

Champions, particularly young leaders from within key populations, will be supported to increase their capacity to speak publicly and to engage in partnership with government and other stakeholders. To keep information about the nature and extent of HIV-related discrimination, the HIV Stigma Index Study will be repeated every two years. In addition, a national hotline to document and monitor HIV-related and key population-related discrimination and to assist people affected by discrimination to find assistance, advocacy and legal services will be established.

PA 2: Training of health care providers on human rights and medical ethics related to HIV

Existing programs: Most health worker training initiatives and curricula identified were focused on HIV 101 and infection control and not on rights and ethics in relation to key populations. The DOH NASPCP and the Research Institute of Tropical Medicine (RITM) collaborated with Love Yourself, Inc. to establish a satellite clinic in the Metro Manila area aimed at providing HIV services primarily for men who have sex with men and transgender communities. These clinics offer HIV testing, screening for TB, and research on PEP and PrEP and are co-located with a treatment center for immediate access.

Specific activities on HCW trainings on rights issues were implemented by the AIDS Society of the Philippines, Inc., a sub-recipient (SR) of the three-year GF HIV project that conducted half-day stigma reduction workshops in all of its sites across nine cities in the country. The project has also rolled out SOGIE manuals and held sessions on SOGIE during healthcare worker trainings.

Elements of the proposed comprehensive program in this area: Activities proposed in this area include an assessment of health care worker training initiatives, methodologies and needs to establish what has been done in the past. Based on this assessment, a strategy (combined with TB) for institutionalizing health worker HIV capacity development and for ensuring that all curricula include significant material on rights and ethics will be developed in relation to all key populations. This involves working with the Department of Health, the professional medical, nursing and allied health organizations, the higher education curriculum settings bodies, and KP community organizations to develop a comprehensive program for integrating attention to rights and ethics related to HIV (and TB) into pre- and in-service training programmes and into the compulsory Continuous Professional Development programs that health workers already participate in.

Standards for providing non-discriminatory care and a positive, welcoming environment for people with HIV and people from key populations will be developed and circulated. These will include innovative models of peer involvement.

PA 3: Sensitization of law-makers and law enforcement agents

Existing programs: The proposed new HIV law and SOGIE laws are examples of successful sensitization and lobbying in this area. These would not have been possible without informed law-makers. One key issue included in the amendment is a change to the age of consent for HIV testing from 18 years to 15 years, together with the use of proxy consent by health workers for those under 15 years. Evidence from pilot

activities in five districts is being collected by local government agencies and will be used for the development of a standard protocol on proxy consent.

The Center for Health Solutions and Innovations, Inc. (CHSI), through a grant from UNFPA, piloted and implemented the Integrated HIV-Family Planning-Gender-Based Violence project among registered sex workers in Angeles City. This two-year project was implemented with the owners and managers of entertainment establishments (who employ registered sex workers) along with government partners – City Health Office (CHO), Philippine National Police (PNP), Department of Social Welfare and Development, and local barangays. Following this, the PNP organized their own training on GBV as part of the Women and Children's Protection Desk program. The Commission on Human Rights (CHR) carried out human rights promotion workshops for barangay members, PNP and armed forces in several provinces. Harm reduction workshops for PNP, Philippines Drug Enforcement Agency (PDEA) and the Cebu City Jail were supported by a grant from the International HIV/AIDS Alliance.

There is funding under the current 3-year GF-funded Save the Children contract for the planning and facilitation of workshop aiming at improving the legal and policy environment for men who have sex with men, transgender communities targeting local government unit. Executives.

Elements of a comprehensive program in this area: Activities proposed in this area include support for a high-level dialogue among health, police other law enforcement agency leaders aimed at developing a and rolling out a strategic capacity development program for police and other law enforcement agencies that includes practical strategies to support the government's public health goals. Briefing materials twill be prepared and circulated through law enforcement agencies on the rationale for HIV and TB strategies, and specific targeted training for people at appropriate levels within these agencies.

The training materials will include content on the right to health and access to health services. These will be used in pre- and in-service capacity building, targeting various levels of law enforcement. Particular attention will be paid to the intersection between HIV policies and illicit drug policies and on finding practical ways for law enforcement agencies to contribute to positive outcomes in both areas.

PA 4: Legal literacy ("know your rights")

Existing programs: HIV-focused NGOs have consistently included attention to assisting people from key populations to gain access health and other services, though not always under a specific rights framework. The Commission on Human Rights has conducted some general population rights information roadshows/workshops at local level in some provinces. Special investigators and lawyers from the Commission on Human Rights (CHR) have been provided with a series of trainings on HIV-related legal standards and rights.
Save the Children supported Cebu Plus to conduct learning group sessions on legal rights for men who have sex with men, sex workers, people who inject drugs and PLHIV.

Elements of a comprehensive program in this area: Activities proposed include the development of a set of plain language 'know your rights' materials for key populations including PLHIV and a series of workshops and on-the-job coaching sessions conducted among community organizations conducting outreach activities

for integration into outreach practice. Legal literacy information and skills-building will also be included in the activities of PA5 below.

PA 5: HIV-related legal services

Existing programs: There does not currently exist an established, nationwide legal redress mechanism for rights violations faced by PLHIV and/or key populations. Pinoy Plus, based in Manila, is working to monitor and register cases of people living with HIV needing legal assistance through its PLHIV Response Center, although these cases are not necessarily referred to legal assistance, and the monitoring effort is not nationwide. Action for Health Initiatives, Inc. (ACHIEVE) provides legal assistance for cases of discrimination experienced by people living with HIV. In Cebu, efforts to provide legal services through 'legal caravans' or mobile legal clinics for people living with HIV and key populations have been carried out on an ad-hoc basis and with limited success. There is funding under the current Global Fund program through Save the Children to facilitate quarterly meetings with legal service providers in Luzon, Mindanao and Visayas. There is also some limited funding in the Global Fund allocation for a limited expansion of legal networks to regions, case documentation and legal assistance for complainants.

Elements of a comprehensive program in this area: Proposed activities include a review of models for improving access to legal services for key populations and people with HIV and/or TB. Successful models will be rolled out in ten high impact areas. Models such as the local-level funding of travelling legal clinics by the Commission for Human Rights (in Cebu) and the deployment of paralegals and volunteer lawyers through key populations NGOs to reach people who need legal assistance will be examined, and an appropriate organization identified to develop and begin the implementation of a strategy to improve legal service access.

Lawyers, paralegals and key population organizations will be engaged in the establishment of pilot community legal services attached to key population NGO clinics and other appropriate organizations in highest-burden areas to rapidly increase access to legal services. Eleven additional NGO clinics (based on the Love Yourself model) with integrated legal services will be established under the 2018/2020 Global Fund HIV allocation.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

Existing programs: Experiences with implementation of the current AIDS law have led to efforts by law-makers, PLHIV and key population groups, local governments and various government departments (i.e. Health, Social Welfare, Education Departments) to amend the law, which aims to increase access to HIV services and address rights-related issues. The new HIV law formally amends the age of consent for HIV testing to 15 years. UNICEF's efforts to pilot proxy consent in five cities has proven successful and the model is expected to be expanded to 38 sites under the new GF HIV grant implemented by the PR, Save the Children, and a standard proxy consent protocol would be used where needed for children under 15 years.

Other monitoring efforts have been around the impact of the employer-provided health insurance, PhilHealth, on PLHIV privacy and confidentiality.

Elements of a comprehensive program in this area: The new HIV Law came into effect in January 2019. It is proposed that this will be supported by the

development of briefing materials and facilitation of round table meetings to assist provinces to adopt ordinances and policies in line with them. Activities to support this process will include:

- Review and reform of the local ordinances that allow for the arrest of people with condoms or sterile syringes and needles in their possession and the development of policy materials and specific assistance at local level to address these reforms.
- Development and implementation of a dissemination strategy and materials to ensure national and local compliance with the new HIV Law and the propsoed Sexual Orientation and Gender Identity and Expression Equality (SOGIE) Law come into force.
- Facilitation of workshops and briefing sessions in provinces with provincial authorities and other stakeholders.

PA 7: Reducing discrimination against women in the context of HIV

Existing programs: Dedicated initiatives to reduce discrimination against women living with HIV more broadly were not identified during data collection.

Elements of a comprehensive program in this area: Many of the interventions proposed in other program areas will benefit women from key populations and vulnerable groups, as long as a conscientious effort is made to ensure they are targeted to women in all their diversity and that women are involved in their design and implementation. In addition, a set of interventions that specifically address the intersectional forms of discrimination and service barriers faced by women will be developed. These recommendations will be built on the mainstream gender assessments conducted in 2014.[5] To address particular issues from the female sex worker focus groups, a review of lessons learned from recent Women's Police Desk strategies that increased the level of positive engagement between police services and female sex workers in some provinces conducted and the lessons drawn from that work will be promoted across programs and provinces.

Operations research will be conducted to determine strategies to increase access to HIV prevention information and services and knowledge of HIV status among female partners of men who have sex with men. This will involve operations research to develop targeted strategies to reach women at higher risk and undiagnosed women with HIV. It will work through women's groups and women's networks as well as integrating messages about the risk to female partners in men who have sex with men and transgender people's programs.

2016 HIV investments and proposed comprehensive program costs

The latest available data on overall HIV spending in the Philippines is from the National AIDS Spending Assessment 2011-2013. In 2013, total spending by all sources was US$10,320,880 with 56% from international sources with the Global Fund as the biggest contributor. Other international sources included UN agencies, the Asian Development Bank, the World Bank and USAID. Public spending made up 44% of total spending in 2013 with the majority from the Department of Health's National AIDS/STD Prevention and Control Program and the National Epidemiology Center for surveillance activities. Other government agencies that contributed spending for HIV and AIDS included: the Department of Social Welfare and Development (DSWD), the Department of Education (DepEd), the Department of

[5] Kiesel, R. and E. Rottach. 2014. The Fade-Away Effect: Findings from a Gender Assessment of Health Policies and Programs in the Philippines. Washington, DC: Futures Group, Health Policy Project.

Justice (DOJ), the Philippine Information Agency (PIA), the Occupational Safety and Health Center of the Department of Labor and Employment (DOLE-OSHC), and several local government units (Quezon City, Makati City, Cebu City, Caloocan City, Pasay City, and Davao City).
In 2016, a total of approximately US$185,000 was invested in the Philippines to reduce human rights-related barriers to HIV services.[6] Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	**2016 allocation**
Global Fund	$85,000
UN Organizations	$50,250
Alliance Regional	$10,000
Other	$10,000
Total	**$155,250**

This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Service Access Barriers Program Area	**2016**
PA 1: Stigma and discrimination reduction for key populations	$22,000
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$56,000
PA 3: Sensitization of law-makers and law enforcement agents	$26,000
PA 4: Legal literacy ("know your rights")	$0
PA 5: HIV-related legal services	$0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$46,250
PA 7: Reducing discrimination against women in the context of HIV	$5,000
Total	**$155,250**

The costing for the 5-year comprehensive program is set out in the following table:

HIV Service Access Barriers Program Area	**Total**
PA 1: Stigma and discrimination reduction for key populations	$1,391,594
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$591,057
PA 3: Sensitization of law-makers and law enforcement agents	$305,523
PA 4: Legal literacy ("know your rights")	$301,229
PA 5: HIV-related legal services	$973,745

[6] It should be noted that this is an estimate only as it was difficult to obtain detailed budget information in some areas as attention to access barriers was embedded in general HIV service delivery and not separately identified in budgets. More intensive budget finding was only carried out in the three identified target cities for the study.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$717,300
PA 7: Reducing discrimination against women in the context of HIV	$345,255
Total	**$4,625,704**

Details of yearly costs are set out in the main report below and detailed costing information is available in Annex 4.

Immediate priorities for HIV

Key recommended priorities for more immediate action are:

- Implement initiatives to reduce self-stigma that is preventing people from seeking testing for HIV, or if diagnosed with HIV, from accessing long-term treatment, care and support. This involves working to increase the level of confidence people from key populations have in health services and in treatment for HIV.
- Document and monitor HIV-related discrimination and provide immediate referral assistance for people experiencing discrimination.
- Develop and implement a policy framework, strategies and materials on Sexual Orientation and Gender Identity (SOGI).
- To build upon and catalyze legal service provision envisaged in the Global Fund grant, review models for improving access for people from HIV and/or TB key populations and people with HIV and/or TB to legal services to inform adaptation and roll out of successful models in high impact areas.
- Establish a policy dialogue with police services and develop and roll-out a strategic capacity development program for police and other law enforcement agencies.
- Review and reform the local ordinances that allow for the arrest of people with condoms or sterile syringes and needles in their possession.
- Develop and implement of a dissemination strategy and materials to ensure national and local compliance with the new HIV Law.

Integration of advocacy and legal services into HIV, STI and TB NGO clinics is already budgeted for and underway as part of the 2018/2020 Global Fund HIV allocation.

Baseline TB findings

Key and vulnerable populations

The Global Plan to End TB 2016 – 2020 refers to a set of key populations that are vulnerable, underserved or at risk of TB, often due to factors such as: increased exposure to TB because of here they live or work; limited access to quality TB services; and/or increased risk because of biological or behavioral factors that compromise immune function.[7] Key populations and populations vulnerable to TB vary from country to country and include but are not restricted to close contacts, prisoners, people living with HIV (vulnerable to co-infection), migrants, refugees and indigenous populations. People living in poverty in crowded conditions are also vulnerable, as are smokers and people with diabetes. All people who have TB or have survived TB also considered as a key population for TB.

[7] STOP TB Partnership, UNOPS. (2015). The Paradigm Shift. The Global Plan to End TB.

Barriers to TB services

The main barriers to TB service access can be categorized under three main areas:

1. Barriers that prevent people with symptoms and people from vulnerable and high-risk populations from presenting at health services for testing and treatment
2. Barriers that prevent people from maintaining and completing their treatment regime, or from returning to clinics to re-enrol in treatment if they have had a treatment interruption – this applies to both DS-TB and DR-TB
3. Issues for particular populations – people with DR-TB, children with TB and children at risk from family members with TB, people with HIV and TB, prisoners.

Programs to address barriers to TB services – from existing programs to comprehensive programs

Similar to HIV, it was not possible to identify specific initiatives directly aimed at addressing rights-related issues faced by people with and/or affected by TB in the Philippines. The national TB program and TB control in the country have traditionally followed a medical, formalized approach with community involvement limited to awareness-raising and referral. One of the key initiatives of the National TB Plan (NTP) over the years has been community TB care, community TB task Forces and Advocacy Communication and Social Mobilization (ACSM) which directly involved communities as educators, source of referrals and as treatment partners. This is reflected in the latest TB Manual of Procedures (MOP 5th), wherein community health teams (which includes Barangay Health Workers (BHW) organized to support health facilities) are organized.

This section highlights key activities to address rights-related barriers and sets out recommendations for a comprehensive program to reduce these barriers to TB services. Information is organized under the Program Areas set out in the Global Fund Technical Brief *Tuberculosis, Gender and Human Rights*.[8]

PA 1: Reducing stigma and discrimination
PA 2: Reducing gender-related barriers to TB services
PA 3: TB-related legal services
PA 4: Monitoring and reforming policies, regulations and laws that impede TB services
PA 5: Know your TB-related rights
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents
PA 7: Training of health care workers on human rights and ethics related to TB
PA 8: Ensuring confidentiality and privacy
PA 9: Mobilizing and empowering patient and community groups
PA 10: Programs in prisons and other closed settings

PA 1: Reducing stigma and discrimination

Existing programs: The national TB program employs the AIDERS strategy – Accelerating Implementation of DOTS Enhancements to Reach Special Sub-Groups – which aims to bring TB services to Geographically Isolated and Disadvantaged Areas (GIDA) in the country. AIDERS are trained healthcare workers who are deployed to GIDA and provide TB services.

[8] Technical Briefs *HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017);

The USAID-supported CHANGE project (2013-2018) supported three nationwide TV campaigns on TB that reached over 17 million target individuals per campaign, contributing to increasing demand for TB services.[9]

The Global Fund project conducted activities to reduce stigma around TB through organized interactions with people affected by HIV and TB, survivors of MDR-TB and people living with HIV, and staff from Programmatic Management of Drug-resistant TB (PMDT) facilities, HIV treatment hubs, satellite treatment hubs, Social Hygiene Clinics, provincial coordinators, Category A and B areas, high prevalence municipalities for HIV, low performing LGUs for TB, and private practitioners.

Elements of a comprehensive program in this area: Proposed activities include the
establishment of a national hotline to provide basic TB information and as a place for people to report service access/quality problems and stigma and discrimination linked to TB. The hotline would also refer people to redress mechanisms such as local complaints mechanisms and legal services. A TB stigma assessment, based on validated assessment tools, would be implemented twice in the time of the 5-year strategy. In line with the HIV activities above, a national coalition of religious leaders will be established to provide a reference group for the development of strategies and messages to integrate attention to TB and care for people affected by TB into their religious care programs and into their ministry and engagement with congregations and followers.

PA 2: Reducing gender-related barriers to TB services

Existing programs: No existing programs that specifically addressed gender and TB were identified, though this is a key performance target of the PhilSTEP: 90% of DOTS facilities are adapting gender sensitive, non-discriminatory and patient-centered services

Elements of a comprehensive program in this area: Women bear the burden of care (and loss of household income if men are on treatment and unable to work) – strategies to support women – particularly in assisting their male partners to complete treatment. USAID has recently conducted a TB gender assessment (the report is still in preparation). Funds are set aside here to take forward the priority recommendations of this assessment.

PA 2: TB-related legal services

Existing programs: Activities focused on providing TB-related legal services were not identified in this assessment. There were reports of people with TB accessing the Commission on Human Rights mobile legal clinics in some provinces, but little data is available on activity levels, cost or outcomes. The WHO Patients Charter for TB Care was introduced in the Philippines in mid 2000s. Ref Dissemination of the charter was part of the activities under the PPM (with PhilCAT) component of the Global Fund project. The charter was widely distributed thru the PPM network.

Elements of a comprehensive program in this area: Activities proposed include the strengthening the connection between TB patient and advocacy groups and legal services.
This involves facilitating round tables between services, then trainings provided by lawyers and paralegals for TB community group staff and volunteers. TB community groups with significant reach will be identified in several provinces and supported

[9] Information available at https://www.usaid.gov/philippines/health/change

with paralegal services. These groups will use the regionally-developed HIV Community Legal Centre model to establish part-time legal services in community legal groups (with referral to community legal centers for more complex assistance).

The Philippine Public Attorney's Office (PAO - public legal aid provider in all provinces) will be assisted to identify ways to bring greater attention to TB (and HIV) issues and remedies – could be a position in their national office with some funds for roundtables, workshops, development of relevant materials. HIV or general population mobile legal clinic services provided by the branches of the Commission on Human Rights (or other mobile legal clinic providers) will be assisted to integrate greater attention to TB issues and to provide support to people affected by TB.

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

Existing programs: The national TB program and related government agencies have developed a number of guiding documents and policies for the control of TB, TB/HIV and MDR-TB in various settings. However, efforts by the NTP to monitor implementation have revealed that in some areas, doctors are not diagnosing and treating according to international or national standards. Reports of MDR-TB patients being refused treatment at some health clinics imply a need to improve understanding of the guidelines. In addition, reports of employers refusing to hire candidates based on X-ray results which do not necessarily mean the candidate has TB indicate a need to educate employers about TB.

Elements of a comprehensive program in this area: Activities proposed include the establishment of community monitoring/feedback mechanism between TB groups and DoH/provincial health on standards of care and treatment. This will involve the establishment of a standardized mechanism for TB groups to feed directly from their constituents to provincial and national (and private providers) breaches of national standards or guidelines in relation to the diagnosis and treatment of people with TB, including discriminatory exclusion from services. Local problem solving will be prioritized, but implications for national guidance and intervention also identified.

A working group is proposed (in conjunction with HIV efforts) to clarify consent and treatment issues for minors and prepare materials to assist in more consistent implementation of minors' consent policies.

PA 5: Know your TB-related rights

Existing programs: Activities focused on educating communities about their TB-related rights were not identified. Rather, community organizations supported by PBSP, USAID and the DOH focus on general awareness-raising aimed at increasing case finding and referrals to health facilities for TB testing.

***Elements of a comprehensive program in this area*:** Activities proposed include the development and dissemination of plain-language gender-sensitive materials on human rights in the context of TB, quality of service standards, appropriate behavior by health-care workers, employers and others. Training materials, training and follow-up coaching for TB groups to increase understanding across communities about the Patients' Charter, health standards, patient rights and how to make complaints. Materials will contain information on PhilHealth and other benefit/financial coverage schemes.

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

Existing programs: Activities focused on sensitizing law-makers were not identified.

***Elements of a comprehensive program in this area*:** There are no costed activities proposed in this area. TB content will be integrated in the sensitization of law enforcement agents envisaged under the HIV component in HIV PA 3.

PA *Activity* 7: Training of health care workers on human rights and ethics related to TB

Existing programs: The GF-PBSP and USAID projects both include healthcare worker training components aimed at improved case-finding, support for people on TB treatment, compliance with national guidelines and improved quality of care. Support will be provided to ensure that training materials contain practical information on rights, standards for ethical behaviour and reinforcement for the connection between client-centered health care and treatment adherence.

***Elements of a comprehensive program in this area*:** Activities proposed include the development of a toolkit to better define and support patient-centered care, including rights to care, privacy and confidentiality. This activity refers back to TB focus group information about the reasons for ceasing treatment and being reluctant to return to clinics for re-commencement. Integration of attention to ethics and rights will be included in all TB training and coaching provided to health workers. This activity includes pre-service, in-service, continuous medical education, public and private sector training and will promote a follow-up on-the-job coaching method. There will be a focus on client-centered care and on MDR-TB to ensure a reduction in stigma and discrimination experienced by people with MDR-TB in general health services. In addition to integrating this into TB curricula in general health worker training and coaching, the toolkit developed in PA 7.1 above, a tool will be developed to assist clinics to examine systems that affect patient privacy, confidentiality and care quality.

PA 8: Ensuring confidentiality and privacy

Existing programs: Under the Global Fund RCC grant, PBSP initiated the creation of an Integrated TB Information System (ITIS), which "aims to establish a standardized recording and reporting framework that will be web-based and have the capability to update records in real time."[10] ITIS is now functional and is currently being piloted. Health care workers across all levels of the TB control system have been trained on its use. However, who has access to what data and issues of protecting confidentiality and privacy of patient records are pending issues in need of clarity and decision – and eventually policies, guidelines and further training of healthcare workers. The NTP is coordinating with the National Privacy Commission to ensure that policies (e.g. Mandatory Notification) are compliant with the Philippines Data Privacy Law.

***Elements of a comprehensive program in this area*:** It is proposed that systems that protect privacy for TB patients will be promoted, including the toolkit described in PA 7.

[10] Breaking New Ground: Sustaining TB Control and Ensuring Access to Comprehensive TB Care Project – Accomplishment Report 2010 to 2011. Philippine Business for Social Progress (PBSP).

PA 9: Mobilizing and empowering patient and community groups

Existing programs: Community groups have been a main partner of the national TB program and donor-supported TB projects. The PBSP-managed Global Fund project supported the creation of TB patient groups to provide existing TB patients with support and encouragement to stay the course with treatment. The project also supported community groups as important and consistent partners in awareness-raising activities, active case finding, advocacy and treatment management of TB patients.

***Elements of a comprehensive program in this area*:** Proposed activities in this area include the development of advocacy materials and skills-building for patient groups. This component will involve the development of advocacy materials for TB groups – assisting them to maintain a constructive engagement with provincial, city and local-level health systems. Models of TB peer involvement in multi-disciplinary teams for case-finding, adherence support will be explored and promoted. These will be adapted and trialed in TB clinics. This cadre will also be trained in community engagement to reduce stigma and increase community care and support.

PA 10: Programs in prisons and other closed settings

Existing programs: Prisoners have been identified as a particularly vulnerable population for TB. The Philippines also has one of the highest rates in the world of pretrial detention among people in state custody -- about 75%. A pilot project for the management of TB in the Quezon City Jail was implemented by the International Committee of the Red Cross (ICRC) in partnership with the Philippine Bureau of Jail Management and Penology (BJMP).[11] Under its Global Fund RCC grant, PBSP supported the establishment of a new drug-resistant TB treatment center in the Quezon City Jail. These efforts have been recognized as good models in the management of TB and DR-TB among prisoners in the Joint TB Program Review of 2016. Results from these pilots were used to inform the update of DOH policy on TB control in jails and prisons in 2015. This will involve the review of results to date and advocacy for a scale-up plan.

***Elements of a comprehensive program in this area*:** Activities proposed include advocacy for improvements of TB diagnosis and care in prisons (linked to HIV activities). This activity involves convening people working in TB and in prisons health to determine strategies to improve access to health for people with TB (and with HIV) in prisons, particularly in relation to the stigma associated with treatment and diagnosis and the lack of privacy that are causing people with TB and/or HIV to cease their treatment.

2016 investments and proposed comprehensive program costs - TB

The latest WHO TB Country Profile for the Philippines indicates that the national TB budget is US$104 million of which 19% is from domestic sources, 53% from international sources and the remaining 28% is unfunded. Contributions from international sources have increased steadily since 2013. The 2016 Joint Tuberculosis Program Review found that 60% of the NTP budget is for procurement with another 26% to support TB control in the various Regions of the country. The JPR also noted a heavy reliance on the Global Fund particularly around human resources, which raises flags for sustainability.

[11] Available at https://www.icrc.org/en/document/philippines-pilot-project-improves-tb-control-quezon-city-jail

It is estimated that a total of US $440,000 was allocated in the Philippines to reduce barriers to TB services. Major funders for reduction of human rights barriers to TB services in 2016 were as follows: [12]

Funding Source	**Amount**
USAID	$ 245,000
Global Fund	$ 195,000
Total	**USD 440,000**

The table below allocates that funding to Program Areas – though many programs do not fit neatly within one area.

TB Service Access Barriers Program Area	**2016 allocation**
PA 1: Stigma and discrimination reduction	$95,000
PA 2: Reducing gender-related barriers to TB services	$0
PA 3: TB-related legal services	$10,000
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	$25,000
PA 5: Knowing your TB-related rights	$15,000
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	$50,000
PA 7: Training of health care providers on human rights and medical ethics related to TB	$120,000
PA 8: Ensuring confidentiality and privacy	$60,000
PA 9: Mobilizing and empowering patient and community groups	$50,000
PA 10: Programs in prisons and other closed settings	$15,000
Total	**$440,000**

Costs for the recommended interventions for the five-year comprehensive program set out are set out in the table below. Details of yearly budgets are set out in the main report below and costing information is available in Annex 4.

TB Service Access Barriers Program Area	**Total**
PA 1: Stigma and discrimination reduction	$949,218
PA 2: Reducing gender-related barriers to TB services	$500,000
PA 3: TB-related legal services	$1,654,772
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	$239,384
PA 5: Knowing your TB-related rights	$324,891
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	$0

[12] It is difficult to accurately estimate these figures as the barriers reduction content area is often embedded in a broader program – for example, the TB television campaign advertisements covered basic TB symptoms and services, so only a proportion of costs is included.

PA 7: Training of health care providers on human rights and medical ethics related to TB	$229,343
PA 8: Ensuring confidentiality and privacy	$10,468
PA 9: Mobilizing and empowering patient and community groups	$68,900
PA 10: Programs in prisons and other closed settings	$105,532
Total	**$4,082,528**

Immediate priorities for TB

Key recommended priorities for more immediate action are:

- Strengthening support groups for people living with TB and TB community groups (and co-operation and communication between groups) as a key mechanism for improving service access and quality, reducing stigma and discrimination and therefore improving access to services for people with TB or those with symptoms and as key service navigators.
- Addressing the indirect costs of TB treatment, including loss of family income and additional tests.
- Work within prisons to increase quality of TB services and confidentiality and privacy for people on TB medications.
- Improving re-entry points for people who stop their TB treatment – client-centered services that do not punish or shame people if they return after a break in treatment.
- Improving side-effect management and support for people on treatment.

Findings of the HIV baseline assessment

Introduction

This report sets out findings of the baseline assessment conducted in the Philippines to support the scaling up of programs to remove barriers to HIV and TB services. Since the adoption of its strategy, *Investing to End Epidemics,* 2017-2022, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service";* and, to *"scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities.*"[13] The Global Fund recognizes that programs to remove access barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases.

The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.
Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – "Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation". This KPI measures "the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries".[14] Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected the Philippines as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV and TB, is the first component of the package of support the country will receive.

The outcomes of this assessment in the Philippines were: (a) to establish a baseline of access barriers to HIV and TB services and existing programs to remove them; (b) to set out a costed comprehensive program aimed at reducing these barriers; and (c) to recommend next steps in putting this comprehensive program in place.

The programs recognized by UNAIDS, STOP TB and other technical partners as effective in removing access barriers to HIV and TB services are: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB. Three additional program areas are included for TB: ensuring confidentiality and privacy related to TB diagnosis; mobilizing and empowering TB patient and community groups especially to reduce TB-related stigma and discrimination; and establishing programs in

[13] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02
[14] 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

prisons and other closed settings.[15] A comprehensive program[16] is seen as one that contains interventions at scale under each of the program areas set out above (seven areas for HIV; ten areas for TB).
The findings of this baseline assessment will be used by countries, the Global Fund, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove barriers to HIV and TB services in the Philippines. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

Methodology

Conceptual framework

The conceptual framework for the baseline assessments (and Global Fund Strategic Objective 3) is the following: (a) Depending on the country and local contexts, there exist barriers to the full access to, uptake of and retention on HIV, TB and malaria services; (b) These barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV, TB and malaria; (c) There are program areas comprising several interventions and activities that are effective in removing these barriers; (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country, they will remove or at least significantly reduce these barriers; (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV, TB and the malaria; and, (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in the Philippines has identified:
a) Barriers to HIV and TB services
b) Key and vulnerable populations most affected by these barriers
c) Existing programs in place to address these barriers; and
d) A comprehensive set of programs to address these barriers most effectively.

Barriers to HIV and TB services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and, poverty and economic and social inequality.

Key populations have been defined as follows by the Global Fund:
a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the two diseases – due to a combination of biological, socioeconomic and structural factors;
b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or

[15] See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E. See also Technical *Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)
[16] Programs to remove human rights-related barriers to services are defined to be *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV and TB services.

criminalization – which increase vulnerability and risk and reduces access to essential services.[17]

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable than the general population to HIV and TB and their impact.[18]

The design, outcomes and costs of existing programs to reduce these barriers were analyzed and a set of initiatives have been proposed in order to make up a comprehensive program to address access barriers at scale.

Steps in the assessment process

a) **Literature review** - A comprehensive search to assess access barriers to HIV and TB services in the Philippines, key and vulnerable populations affected by these barriers and programs to address them was conducted using PubMed, Embase, and Web of Science to identify peer-reviewed literature.
b) **Preparation for in-country work –** Discussions were held with the Department of Health, UNAIDS, the PCCM Secretariat and other relevant stakeholders to identify appropriate sites for data collection. These were agreed upon as Manila City, Cebu and Zamboanga.
c) **In country work** - An inception meeting introduced the project to national stakeholders, explained the role of the baseline assessment and data collection procedures, and summarized the findings of the desk review. This was followed by key informant interviews and focus group discussions with members of key and affected populations in Manila City, Cebu and Zamboanga. A total of 32 key informant interviews were conducted and 202 key population members participated in focus group discussions and one-on-one interviews.
d) **Data collection -** Data was collected on the following areas:
    I. Barriers to HIV and TB services
    II. Key and vulnerable populations most affected by these barriers
    III. Programs carried out currently or in the past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers
    IV. Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
    V. Funding of all such programs (for 2016 calendar year); and
    VI. Costing of effective programs carried out currently or in the past.[19]
e) **Data analysis -** The in-country data were analyzed to explore agreement with or divergence from the literature review findings and to add data on barriers and affected populations missing from the literature review. This information, together with data on funding in 2016, was used to develop the baseline data summary. Data on existing effective projects and on stated needs were combined to suggest the comprehensive programs to reduce barriers to HIV and TB services in the Philippines. The comprehensive programs were costed using costing data from present and previously implemented projects.
f) **Finalization and next steps** – A summary of initial findings including suggestions for elements of a comprehensive program was presented to the

[17] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva
[18] Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017;95:159-161. doi: http://dx.doi.org/10.2471/BLT.16.179192
[19] Effectiveness is determined either by evaluation or by broad agreement among KIs that a program is/was effective.

PCCM in February 2018. A further iteration exploring access barriers to HIV services was provided to the Department of Health, CCM members and other stakeholders in early March to share preliminary key findings on barriers and recommended actions to address them, and to elicit feedback that have guided the finalization of the report. Additional data on the current programs, their scope and costs, was collected in March. Comments to the current version will be incorporated into the final working draft that will inform the multi-stakeholder consultation.

Costing methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who have financed any activities in the program areas for HIV and TB were asked to supply details of the amount of funding provided and the program areas for which funding was provided; and, if possible, to state the type of activities and reach or coverage of funded activities. This approach was largely successful in overall terms for HIV in that most donors were able to state what program areas the funds were directed to but did not provide details of the funded activities or their reach.

Second, specific implementers were approached, and information was gathered on costs involved in carrying out specific interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). Individual costing sheets for services provided by each of the organizations were prepared.

Third, a Prospective Costing of the comprehensive program was carried out. For each type of intervention, an intervention-level cost was assembled.

Limitations

The costing component of the baseline assessment was a rapid investment analysis, therefore it should not be viewed as a full-fledged resource need estimation. The retrospective costing has informed the estimation of intervention-level costs, hence the limited data collected through the baseline assessment inherently affected the prospective costing.

The baseline assessment encountered certain limitations in the costing component both as pertaining to HIV and TB programs aimed at removing human rights-related barriers:

- Certain key stakeholders were not able to take part in the data collection due to competing priorities. As a result, an important viewpoint on human rights barriers and on the effectiveness of current efforts to address them may be missing from the analysis. Stakeholders that could not participate also included a number of bilateral partners and, as a result, the description of current efforts to address and remove barriers may not include what these entities are currently funding or undertaking directly.

More specific limitations and challenges to the collection of financial data included:

- It appeared that a number or organizations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymized at the implementer level.
- Some organizations appeared to take the position that the benefit of completing the exercise was not worth the level of effort required, given other pressures on them.
- Most funders and intermediaries appeared to be unable to disaggregate their investments in combination prevention interventions to the level where funding for programmes addressing human rights barriers could be identified.
- Finally, as the analysis has noted there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

Adapting the methodology to the Philippines

The four agencies contracted to carry out the 20 national baseline assessments worked together with the Global Fund Community, Rights and Gender (CRG) Department to develop a standard methodology for the assessments. This included a desk review and an in-country assessment that involved a set of key informant interviews and focus group discussions with relevant stakeholders including people from the populations most affected by HIV, TB or malaria.

The assessment was scheduled to commence in the Philippines in November 2017. For each assessment, permission was first sought from the CCM. The following adjustments to the purpose, focus and methodology of the assessment were proposed by the PCCM to the Global Fund:

- That the focus of the assessment be focused on 'barriers to access to HIV and TB services' rather than 'human-rights-related barriers' and that all references to human rights be removed from the assessment materials and protocols
- That the focus be at 'health service operational level' rather than at policy and legal level
- That the focus group discussion and key informant interview schedules contain questions on access barriers and not on broader issues relating to rights

The Philippines CCM provided its approval for the baseline assessment with the following stipulations:

1. That the consultant's recommendations will be subject to discussion with the CCM
2. That recommendations will be cleared by the CCM to ensure alignment with the

Government's stance on Health and Human Rights
3. That the CCM shall thoroughly look into the results prior to any report publication

Baseline assessment findings: HIV

Overview of epidemiological context and key and vulnerable populations

Since 1984, a total of 50,725 people with HIV have been identified in the Philippines. Some 42,361 of these have been identified since January 2012. In 2017, an average of 31 new people were diagnosed with HIV every day, compared with an average of only 17 per day in 2014.[20]

More than 95% of the people identified with HIV were male (primarily men having sex with men), or transgender women. Although the number of cis-gender women with HIV is quite low in comparison with men and transgender women, it has been increasing steadily. Younger people are disproportionately affected, with 29% of the people with HIV identified since 2012 aged 15-24 years and 52% aged 25-35 years. A total of 88 children have been identified with HIV since 2012 as a result of parent-to-child transmission.

HIV is not evenly distributed geographically across the Philippines. 41% of people with HIV were diagnosed in the National Capital Region; 15% were diagnosed in Region 4A (Calabarzon); 9% in each of Region 7 (Central Visayas) and Region 3 (Central Luzon); and 6% in Region 11 (Davao Region).

For the men diagnosed since 2012, the primary mode of transmission has been sex with other men (56%). A further 33% of the men diagnosed reported having had sex with both men and women. Around 10% of men diagnosed with HIV reported sex with women only. Around 4% of men diagnosed reported needle sharing, and 99% of these men came from Region 7 (around Cebu). The 2015 IHBSS revealed an HIV prevalence of 7.9% among men and transgender women who have sex with men in ten sentinel sites.[21] HIV prevalence in sex workers was 1.8% in 2013, with those younger than 25 facing a higher burden (2.1% compared to 1.4% in those above 25).[22]

Adolescents have been identified at particular risk of HIV in the Philippines. The 2015 IBBS identified that most men and transgender women who have sex with men, female sex workers and people who inject drugs in the Philippines start these risk behaviours in early adolescence and that there is a two-to-three-year lag before they begin adopting any protective behaviours.[23] Alcohol and other drugs are a key factor in risk for young key populations (YKP) with 45% of young men and transgender women who have sex with men, 52% of young female sex workers and 35% of young people who inject drugs reporting having had sex while intoxicated.[24]

[20] HIV/AIDS and ART Registry of the Philippines, Philippines Department of Health, Epidemiology Bureau December 2017 available at http://www.doh.gov.ph/sites/default/files/statistics/EB_HIV_December_AIDSreg2017.pdf
[21] The State of the Philippine HIV Epidemic, Philippines Department of Health, Epidemiology Bureau, 2016.
[22] http://www.aidsdatahub.org/Country-Profiles/Philippines
[23] The Growing HIV Epidemic among Adolescents in the Philippines, Philippines Department of Health, 2015 http://www.doh.gov.ph/sites/default/files/publications/2015_YKP_Briefer.pdf
[24] HIV/AIDS and ART Registry of the Philippines December 2017

The 2015 Integrated HIV Behavioural and Serologic Surveillance survey among men and transgender women who had had sex with a man in the previous twelve months indicated relatively low levels of condom use among those who had had anal sex (27% condom use for 15-17-year-olds; 43% among 18-24-year-olds; 46% among 25 years and older). Some 53% of those who did not use a condom cited that 'not having a condom available' was their main reason, with a further 21% saying that it was because they 'did not like condoms'. Access levels to a Social Hygiene Clinic or peer educator were low – less than 30% across all service elements. Some 78% of the transgender women and men who had had sex with men had never been tested for HIV.[25] These results differ from those of a 2015 study of drivers and barriers to condom use, HIV testing and access to SHC services, which revealed higher rates of condom use at last anal sex (59%) and higher levels of HIV testing (69%).[26]

A total of 24,754 people with HIV were on ART at the end of 2017.[27] This represents around 50% of the diagnosed people with HIV in the Philippines. Younger men who have sex with men with HIV (aged 15-19 years) show the greatest disadvantage in relation to linkage to ART and care – with only an estimated 3% of the men who have sex with men with HIV aged 15-19 years on ART compared with 11% of men who have sex with men with HIV aged 20-24 years and 30% among those aged 25-29 years.[28]

Analyzing data in the HIV cascade framework provides a useful way to not only look at outcomes for particular service elements like access to HIV testing or enrolment in ART, but also to highlight significant gaps in access from one service element to another.[29] Table 1 sets out the results of the testing and treatment part of the cascade for various service settings in the Philippines from July 2014 to June 2016. This provides an opportunity to link the barriers information identified in the Baseline Assessment directly to gaps in the HIV prevention to care continuum and identifies the particular health outcomes across the continuum that each barrier threatens.

Table 1: HIV Care Cascade July 2014 – June 2016[30]

Site	Diagnosed with HIV	Linked to care	Started on ART	Currently on ART	Eligible for VL after 12 months on ART	VL test in last 12 months	Viral suppression in last 12 months
Social Hygiene Clinics	5,657	2,312 (41%)	2,229 (39%)	1,978 (35%)	979	164	150
Treatment Hubs	3,146	1,923 (61%)	1,845 (59%)	1,602 (51%)	843	155	137
Satellite Treatment Hubs	1,576	984 (54%)	966 (53%)	876 (47%)	449	145	136

[25] IHBSS 2015 Fact Sheets available at http://www.doh.gov.ph/sites/default/files/publications/serials_2015%20Integrated%20HIV%20Behavioral%20Serologic%20Surveillance%20Fact%20Sheets.pdf

[26] Qualitative Study on the Drivers and Barriers to Condom Use, HIV Testing, HIV Testing, and Access to Social Hygiene Clinic Services among Males who have Sex with Males (men who have sex with men), Philippines Department of Health, Epidemiology Bureau, 2015

[27] HIV/AIDS and ART Registry of the Philippines, Philippines Department of Health, Epidemiology Bureau December 2017

[28] Ibid

[29] HIV Cascade Framework https://www.fhi360.org/sites/default/files/media/documents/linkages-hiv-cascade-framework-oct15.pdf

[30] Data provided by Philippines Department of Health Epidemiology Bureau

Other governme nt facilities	1,220	509 (42%)	490 (41%)	417 (34%)	204	34	30
Other private facilities	6,818	3,712 (54%)	3,618 (53%)	3,172 (47%)	1,992	487	451
TB DOTS Facilities	52	18 (35%)	17 (33%)	12 23%)	6	4	3

Table 1 highlights significant problems in two key areas – 1) starting people diagnosed with HIV on ART and 2) maintaining them consistently on ART to achieve long-term viral suppression.

The Philippines AIDS response has been guided by a series of medium-term plans – the latest – the 6th AIDS Medium Term Plan 2017 – 2022 – was released in December 2016.[31] The 6th MTP identifies the country's key populations (including young key populations) as men who have sex with men, transgender women, people who inject drugs and female sex workers (including trafficked women and girls who are forced to be involved in transactional sex). Vulnerable populations include migrant workers, people in closed settings, people with disabilities and female partners of people from key populations. It is important to note that 25% of men who have sex with men and 68% of men who inject drugs have female partners – leading to an increasing level of new HIV diagnoses among pregnant women.[32]

Overview of the policy, political and social context relevant to barriers to HIV services

Protective laws and policies

In 2017, the Senate of the 17th Congress of the Philippines considered an amendment (Senate Bill No. 1390) to the Philippines AIDS Prevention and Control Act of 1998 (Republic Act No.8504) that strengthens a number of areas important to a rights-based HIV response.[33] A version of the amendment was passed by the House of Representatives in December 2017 (House Bill 6617).[34] An amended Senate Bill (No 1390) was passed in May 2018 and the new Law was enacted in January 2019.[35] The Implementation Rules and Regulations (IRRs) are currently being prepared.

The Philippine National AIDS Council (PNAC), as the central advisory, planning and policy-making body for the comprehensive and integrated HIV response in the Philippines, has been supportive of the proposed revision of the current HIV law. Key features of the amendment that refer particularly to the removal of barriers to service access include:

[31] 6th AIDS Medium Term Plan 2017 – 2022: Synergizing the Philippine HIV & AIDS Response, Philippine National AIDS Council, December 2016 https://static1.squarespace.com/static/5a150aa08dd04195b66c58c7/t/5a98a65524a694fe7eba4de5/1519953517374/6th+AMTP+Final.pdf

[32] Ibid p21

[33] Seventeenth Congress of the Republic of the Philippines: Senate Bill No 1390 Strengthening the Philippine Comprehensive policy on HIV and AIDS Prevention, Treatment, Care and Support ad Establishing the Philippines National AIDS Council, March 2017, available at https://www.senate.gov.ph/lisdata/2559822066!.pdf

[34] http://www.gmanetwork.com/news/news/nation/635361/house-oks-bill-on-measures-to-prevent-hiv-spread-discrimination/story/

[35] http://www.gmanetwork.com/news/news/nation/635361/house-oks-bill-on-measures-to-prevent-hiv-spread-discrimination/story/

- Establishing policies and programs in accordance with evidence-based strategies and approaches that follow the principles of human rights, gender responsiveness and meaningful participation of affected populations
- Partnership with CSOs to work particularly among key populations and vulnerable communities
- Universal access to medically safe, legally affordable, effective and quality treatment
- The delivery of non-discriminatory HIV and AIDS services by government and private providers
- Redress mechanisms to ensure the protection of the civil, political, economic and social rights of PLHIV, including the promotion of local-level mediation and reconciliation mechanisms
- Age-appropriate HIV education
- Financial and policy support for peer education, support groups, outreach activities and community-based research among key populations and vulnerable groups
- HIV prevention and treatment in closed settings
- Lowering of the age of consent for HIV testing to 15 years from 18 years
- Eligibility for persons under 15 who are engaged in risk behaviour to access HIV testing with the assistance of a licensed social worker and introducing the concept of a 'mature minor'
- Standard setting for the provision of HIV testing, including free pre- and post-test counselling in government services
- Free HIV treatment for all indigent persons living with HIV
- Non-discriminatory access for PLHIV in employment, livelihood, micro-finance, self-help and co-operative programs
- PLHIV care and support including peer-led counselling and support, social protection, welfare assistance and case management
- An insurance package for PLHIV that covers inpatient and outpatient medical and diagnostic services including medication and treatment
- Strengthened confidentiality provisions
- Under section 30 of the new AIDS Law, read with the Family Code, non-disclosure of HIV status may be a cause for marriage annulment and that, the same section, read with the revised penal code, may result in the criminalization of non-disclosure
- Requirement to nominated agencies to prevent or deter acts of discrimination against PLHIV and to provide procedures for resolution of complaints or reports of acts of discrimination.

Many of these provisions provide a foundation for overcoming many of the issues raised in the focus group discussions that were part of the Baseline Assessment. Some introduce new issues, particularly in relation to some of the provisions that allow compulsory HIV testing and the potential criminalization of non-disclosure of HIV status, that will require strategies to that these provisions are applied by the judiciary in a rational manner, based on most up-to date scientific evidence, public health and human rights concerns. Obviously there will need to be extensive education about the new law across national, provincial and local agencies and services to ensure consistent application of these principles. There will also need to be extensive work with provincial governments to align local ordinances and policies and practices with this law.

Under the Philippines decentralization strategy, provinces can also set binding policy in relation to HIV. Faced by issues with consent for HIV testing for children, some provinces like Zamboanga have passed ordinances and memoranda of understanding with health services that set out consent provisions for minors, including the

lowering of the age of consent for HIV testing. In 2013 Quezon City Council approved an ordinance addressing HIV-related discrimination requiring local government and private employers to develop an official protocol for handling HIV in the workplace.[36] Many other LGUs and cities have passed ordinances related to anti-discrimination, gender-fairness. These are summarized in Table 2 below.

Table 2: City, province and barangay anti-discrimination and gender-fairness ordinances[37]

Agusan del Norte Province	Agusan del Norte Anti-Discrimination Ordinance	2014-07-21	Agusan Del Norte Province ADO
Angeles City, Pampanga	Anti-Discrimination Ordinance of Angeles City	2013	Angeles City ADO
Antipolo City	Anti-Discrimination in Employment Ordinance	2015-01-26	Antipolo City ADO
Bacolod City	Bacolod City Anti-Discrimination Ordinance	2013-04-23	Bacolod City ADO
Bagbag Brgy.	LGBT No Discrimination Ordinance of Barangay Bagbag	2009-06-01	Brgy Bagbag ADO
Baguio City	Anti-Discrimination Ordinance of the City of Baguio	2017-02-20	Baguio City ADO
Batangas City	The Batangas City Gender-Fair Ordinance	2016-07-18	Batangas City ADO
Batangas Province	An Ordinance Prohibiting Discrimination on Sexual Orientation, Gender Identity and Gender Expression for LGBT	2015-09-23	Batangas Province ADO
Butuan City	Butuan City Anti-Discrimination Ordinance	2016-06-13	Butuan City ADO
Candon City, Ilocos Sur	The Anti-Discrimination Ordinance of Candon City	2014-08-04	Candon City ADO
Cavite Province	Anti-Discrimination Ordinance of the Province of Cavite	2014-02-3	Cavite Province ADO
Cebu City	Cebu City Anti-Discrimination Ordinance	2012-10-17	Cebu City ADO
Dagupan City	Further Promoting Gender Equality in the City of Dagupan or Gender Equality Ordinance	2010-06-21	Dagupan City ADO
Davao City	Anti-Discrimination Ordinance of Davao City	2012-12-12	Davao City ADO
Dinagat Islands Province	Dinagat Islands Anti-Discrimination Ordinance	2016-11-20	Dinagat Islands Province ADO
General Santos City	General Santos City Anti-Discrimination Ordinance	2016-11-29	General Santos City ADO
Greater Lagro Brgy.	Barangay Greater Lagro Anti LGBT Discrimination Ordinance	2014-06-16	Brgy Greater Lagro ADO
Iloilo Province	Iloilo Province Anti-Discrimination Ordinance of 2016	2016-12-9	Iloilo Province ADO
Mandaue City	Anti-Discrimination Ordinance for People of Diverse Sexual Orientation, Gender Identity and Expression	2016-02-10	Mandaue City ADO
Pansol Brgy.	Antidiscrimination Ordinance of Barangay Pansol, Quezon City	2008-11-8	Brgy Pansol ADO
Puerto Princesa City	Lesbians, Gays, Bisexual and Transgenders (LGBT) Anti-Discrimination Act of Puerto Princesa City	2015-06-01	Puerto Princesa City ADO

[36] Legal Protections against HIV Human Rights Violations, 2013

[37] Accessed at Transgender Philippines 10 July 2018: http://www.transph.org/information/philippine-anti-discrimination-ordinances/

Quezon City	An Ordinance Prohibiting All Acts of Discrimination Directed Against Homosexuals in any Office in Quezon City, Whether in the Government or in the Private Sector, and Providing Penalties for Violation Thereof	2003-09-02	Old Quezon City ADO
Quezon City	The Quezon City Gender-Fair Ordinance	2014-09-29	New Quezon City ADO
San Julian, Eastern Samar Municipality	Anti-Discrimination Ordinance of San Julian Eastern Samar	2014-10-13	San Julian ADO
Vigan City	The Anti-Discrimination Ordinance of Vigan	2014-11-10	Vigan City ADO

The Civil Service Commission (CSC) also issued an announcement requiring all government agencies to submit a report to the Philippine National AIDS Council (PNAC) on their respective efforts to implement workplace policy and education programmes on HIV. This paved the way for the following policy announcements by major government agencies:

- The Department of Interior and Local Government (DILG) issued a memorandum encouraging all Local Government Units (LGUs) to implement HIV and AIDS education in communities and to create Local AIDS Councils that are mandated to ensure that a local response to HIV and AIDS is allotted with budget
- The Department of Labor and Employment issued an order that aims to strengthen the workplace response in implementing occupational safety and health policy and program of the establishment
- The Department of Education issued an order mandating the Health and Nutrition Centers to conduct the training workshops on HIV and AIDS education among teaching and non-teaching personnel

In addition to specific laws and policies, Article III of the Constitution of Philippines provides a Bill of Rights including equal protection under the law for all. The *Magna Carta for Disabled Persons*[38] and the *Magna Carta for Women*[39] also provide protections that can be applied to people living with HIV and to women.

The Philippines Public Attorney's Office (PAO) is a government institution that has a mandate "to provide the indigent litigants, the oppressed, marginalized, and underprivileged members of the society free access to courts, judicial and quasi-judicial agencies, by rendering legal services, counselling and assistance in consonance with the Constitutional mandate that 'free access to courts shall not be denied to any person by reason of poverty' in order to ensure the rule of law, truth and social justice as components of the country's sustainable development."[40] PAO services and standards are set out in a Citizens' Charter.[41] It should be noted that only persons under investigation for an alleged commission of an offense are eligible to the PAO's legal aid services.

The Supreme Court's *Rule on Community Legal Aid Services* particularly apply to cases of public interest that have societal impact, which may exclude individual cases of discrimination that require address. These gaps need to be properly assessed to

[38] http://www.ncda.gov.ph/disability-laws/republic-acts/republic-act-7277/
[39] http://pcw.gov.ph/law/republic-act-9710
[40] Available at http://www.pao.gov.ph/page.php?id=19
[41] Available at http://www.pao.gov.ph/UserFiles/Public_Attorney's_Office/file/PAO%20Revised%20Citizen's%20Charter%20201 70522%20v1_2.pdf

ensure that each person living with, affected by or at risk of HIV infection receives proper judicial redress when their rights are violated.

In 2017, the Supreme Court of the Philippines issued a *Rule on Community Legal Aid Services*[42] setting out the Constitutional requirement for lawyers to provide *pro bono* legal services to people who would otherwise not be able to afford or access them. The particular groups identified for pro bono services are: indigent parties, pauper litigants and other persons of limited means; individuals, groups, or organizations unable to obtain free legal assistance because of a conflict of interest on the part of government-provided legal assistance through the Public Attorney's Office; and, public interest cases that have a societal impact. A wide range of legal services are prescribed under the rules including: legal representation in civil and criminal proceedings; mediation, conflict resolution and other representation in administrative cases; assistance to know and achieve rights; and, assistance with employment disputes.

The role of the PAO and the undertakings about access to free legal aid for particular populations are important for people living with HIV and people from key populations who also fall into these groups that qualify for access.

Law and policy conflicts

There are some conflicts between national AIDS policy and national drug policy that have an impact on HIV service access. The Dangerous Drugs Act 2002 imposes a prison sentence and a fine for a person who, 'unless authorized by law, shall possess or have under his/her control any equipment, instrument, apparatus and other paraphernalia fit or intended for smoking, consuming, administering, injecting, ingesting, or introducing any dangerous drug into the body.'[43] Authorized medical practitioners are exempted.

Elements of the National Drug Policy appear to place people who use drugs (and the people who work amongst them) at high risk of legitimate or arbitrary arrest, and imprisonment, violence and death. It was not possible to obtain a comprehensive document that sets out powers, systems and operations under the policy, but some of these elements identified in the consultation include:

- A drug user 'watch list' of people who use drugs that is maintained by the police and that individuals from the general public, from services or barangay can nominate people to if they think they are using drugs
- Pressure on people placed on the list to register for weekly supervision by barangay officials in their place of residence, routine drug testing, and participation in rehabilitation activities
- Movement of people who do not come forward when they are on the 'watch list' on to 'hunt list' (euphemistically called *Tok hang* "Knock and request"). This places people at extreme danger of violent arrest or extra-judicial killing.
- Arrest of people with drug use track marks on their arms, then alleged placement of drugs on them by the arresting police to increase the severity of the charge and the penalty.[44]

In 2014, guidelines for *Operations Research on Community-Based Comprehensive Services for People Who Inject Drugs (PWID) in Barangay Kamagayan, Cebu City* were approved to specifically address the growing prevalence of HIV among people

[42] Available at http://sc.judiciary.gov.ph/pdf/web/viewer.html?file=/17-03-09-SC.pdf
[43] Philippine Republic Act No 9165 available at http://www.lawphil.net/statutes/repacts/ra2002/ra_9165_2002.html
[44] Key Informant Interviews/focus groups

who inject drugs. These guidelines allowed for limited distribution of needles and syringes to PWID under the banner of operations research. In 2015 these guidelines were challenged, and access to sterile needle and syringe access for people who inject drugs has become more difficult. Policies and practices that include registration and compulsory rehabilitation of people who use drugs also serve as access barriers for people who use drugs as it becomes more difficult for HIV prevention and care services to access them and they are less likely to present themselves to health and HIV education and prevention services. It should be noted that the law provides that those who are arrested for drug possession of under five grams of drugs are eligible to enter a plea bargain for the lesser offence of drug use, but are not always aware of this.

Sex work and profiting from sex work are illegal under the Revised Penal Code of the Philippines. Pimping and loitering without a lawful or justifiable purpose is illegal under vagrancy law.[45] Despite these national laws, some Local and city ordinances require HIV education and HIV and STI testing and treatment for sex workers operating in licensed entertainment venues.[46] Some provincial or city police services have women police officers who include liaison with entertainment venues and sex workers as a key part of their work, often as part of a broader anti-trafficking agenda.[47]

Barriers to access to HIV services

There have been several key studies in recent years that highlight the particular barriers that people from key populations and vulnerable groups face in accessing HIV prevention, treatment and care programmes and services. In this section, the data from these studies is cross-checked against the information gained through the key informant interviews and focus group discussions conducted during this Baseline Assessment.

The main barriers to service access were identified can be categorized under the following:

1. **Shame, internal stigma, fear and denial** among people from key populations about the reality of HIV, their risk and the consequences of being diagnosed with HIV.
2. **Insufficient information and false beliefs** about the benefits that knowing their HIV status and accessing HIV treatments would bring to their long-term health and about the support and services available if they were diagnosed with HIV
3. **Service delivery problems** including lack of protection of confidentiality, quality and discriminatory treatment. This includes location, delivery models, quality and timing of services; stigma, discrimination, disclosure of status and poor treatment by health workers and others.
4. **Fear of violence and loss of freedom** if identified as coming from a key population. Particular issues for people who inject or use drugs.
5. **Financial burden** associated with travel to treatment centers, loss of income, costs of nutrition and opportunistic infection diagnosis and treatment.

[45] Sex Work and the Law in Asia and the Pacific, UNAIDS, UNDP, UNFPA, 2012
[46] UNDP (2015). HIV and the Law in South-East Asia. Bangkok, UNDP, p22
[47] https://www.unfpa.org/news/training-helps-filipino-police-officer-uncover-human-trafficking-case

1. **Shame, internal stigma, fear and denial** by people from key populations about the reality of HIV, their risk and the consequences of being diagnosed with HIV

Shame, internal stigma and fear have been consistently identified as major barriers to HIV health-seeking among key populations in the Philippines.[48,49] This is often termed 'self-stigma' but in the Philippines, as in many countries, it represents a complex set of internal and external drivers and barriers that affect the ability of an individual to comprehend risk and take positive action.

Men who have sex with men respondents in the *Qualitative Barriers Study* and the *Missing in Action* study and in the focus groups for this Baseline Assessment identify shame as playing a big part in holding them back from HIV testing. They fear what a diagnosis of HIV would mean for them and their family, particularly since many feel that have already burdened their family by being gay. If not already identified as gay or as men who have sex with men within their family and community, they fear family and community rejection for this as well, as a diagnosis with HIV may lead to assumptions that the person belongs to a key population and may expose him to compounded stigma and discrimination on several grounds.

Some find it difficult to personalize HIV risk or the presence of HIV in their community. They believe that the people they have sex with are not people likely to have HIV, or that the people they have sex with will protect them from HIV. Many express little sense of hope or future – they are not sure why they should know their HIV status, they are afraid that no one would support them, that they would be further disadvantaged and that treatment and support would not be available to them. Drawing on a sense of hope or future is often the motivator used by peer outreach workers and health workers to engage with people from key populations about their health and to help them make healthy choices. When this is absent or undeveloped, it is difficult to engage with people about these choices.

Many also have fears that their HIV status, if positive, would not remain confidential, and that what would result from that would be loss of employment and opportunity and a rejection by community. For some this fear is not just fear of rejection by family and barangay, but rejection within gay community for being HIV-positive. They fear that the breach of confidentiality would come from either health services or from outreach workers or friends to whom they disclose their status. Some in focus groups pointed to breaches of confidentiality of people's HIV status on social media – people with HIV being 'outed' and shamed on social media platforms by other community members.

Many of these fears expressed by men who have sex with men in the *Qualitative Barriers* Study and the *Missing in Action* Study were also expressed by people from other key populations and vulnerable groups in this Baseline Assessment. Transgender people in focus groups said that they are already obvious in communities and blamed and shamed for the presence of HIV in community. They are often prevented by stigma and discrimination from completing their education, leaving them limited income-generation and vocational choices. They do not have

[48] Qualitative Study on the Drivers and Barriers to Condom Use, HIV Testing, HIV Testing, and Access to Social Hygiene Clinic Services among Males who have Sex with Males, Philippines Department of Health, Epidemiology Bureau, 2015

[49] Missing in Action: Loss of Clients from HIV Testing, Treatment, Care and Support Services: Case studies of Gay Men and other Men who have Sex with Men in Manila, UNDP, May 2017 available at http://www.ph.undp.org/content/philippines/en/home/library/hiv_aids/MissingInAction.html

access to clinics that take an interest in their overall health, they feel keenly the lack of proper recognition as a third gender or as women, and they report being stigmatized, treated badly and abused when they try to access clinic services. These findings are backed up by other studies and round tables that have been carried out in the Philippines.[50,51] Breaches in confidentiality are also reported as frequent. Transgender communities are small, and information is shared freely in person and through social media.

Female sex workers also expressed concerns that being tested and having it known that they had HIV would prevent them from working and cause problems (including exposing them to violence) with their clients and regular partners. They feared being fired from entertainment venues and having no source of income. PWID also expressed fears about retribution from police for being identified as living with HIV.

Prisoners with HIV reported stopping their HIV treatments because of shame and fear of discrimination and violence if they were seen queuing for or taking ART.

The last HIV Stigma Index was conducted in 2009-2010.[52] It detailed the nature of stigma and discrimination faced by people living with HIV in the Philippines, including exclusion for social, family and community activity, harassment, assault and insults, loss of employment and fear to complain or seek redress for loss of rights or discrimination. Some discrimination in health care was reported but the majority of respondents reported constructive engagement with health services.

2. **Insufficient information and false beliefs** about safer sex, the process of HIV testing and the benefits that knowing their HIV status and accessing HIV treatments would bring to their long-term health and of the support and services available if they were diagnosed with HIV

The *Qualitative Barriers* study highlighted a set of information gaps that was having an impact at several levels of the Prevention and Treatment Cascade and effectively blocking people from key populations from the information and services they need.[53] Men who have sex with men reported making subjective decisions about when to use condoms, based on a set of beliefs about what was more risky, what a person with HIV might look like or what a person 'in love' with them might do to protect them. The sharpening of focus of outreach around tight 'test and treat' targets – necessary because of the gap between the estimated number of people with HIV and the number who know their status – means that less information is being provided about how to make decisions about condom use. 'Use a condom every time' messages have been diluted in many places by the presence of effective ART, knowledge about PrEP and changing gay community norms about unprotected sex. This requires additional effort to assist people at risk to make safer decisions and to understand why these are necessary. Condom availability was also cited as a problem, particularly for young key populations members who were unaware of condom access through SHCs or reluctant or unsure about going into an SHC for condoms. These findings were backed up by the information provided in the focus group discussions.

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[50] Policy Brief: Transgender Health and HIV in the Philippines, WHO Western Pacific Region, 2016 available at http://iris.wpro.who.int/bitstream/handle/10665.1/13435/9789290617815-eng.pdf?ua=1

[51] Round Table Discussion on Legal Gender Recognition for Transgender People in the Philippines, UNDP 2015

[52] A Closer Look: The Stigma and Discrimination Experiences of People Living with HIV and AIDS in the Philippines, Pinot Plus, unofficial draft, 2015, available at http://www.stigmaindex.org/sites/default/files/reports/Philippines%20Peoplve%20Living%20with%20HIV%20Stigma%20Index%20Report%20cond%20%20fromOctober%202009%20to%20January%202010.pdf

[53] Qualitative Study on the Drivers and Barriers to Condom Use, HIV Testing, HIV Testing, and Access to Social Hygiene Clinic Services, Op Cit 2015

Focus group participants did not appear to understand that effective HIV treatment was free, readily available and likely to significantly extend their life-expectancy and quality of life if they had HIV. This lack of information (or false belief in the face of information) was directly connected to their decision not to be tested for HIV. This lack of understanding of the effectiveness of HIV treatments and the availability of treatment and support for HIV is echoed in the *Qualitative Barriers* and *Missing in Action* studies. There seems to be insufficient information available in media, language and formats that people from different sub-populations of key populations and vulnerable groups can access and understand, to explain that HIV treatments are accessible, relatively simple and effective. Even when people report that they have been accessed by outreach workers, or have been to SHCs, they report that the encounter was primarily about HIV and STI testing and that they did not receive information about HIV treatments and the consequences of not being treated if they had HIV.

There was feedback from focus groups (MSW, transgender women and female sex workers) that many felt that they did not have a support system that would be adequate to support them if they were diagnosed with HIV and did not know that there were support services available in community. Even if services existed, many felt that their poverty and marginalization would mean that they would not be able to access them.

3. **Service delivery problems including lack of protection of confidentiality, low-quality and discriminatory treatment.** Includes location, delivery models, quality and timing of services, stigma, discrimination, disclosure of status and poor treatment by health workers and others.

There were many reports in the focus groups and in the *Qualitative Barriers* and *Missing in Action* studies about difficulties key populations experienced with the location and timing of services. Some had heard reports of (or had direct experience of) judgmental treatment, particularly in SHCs. Others reported that they were able to access SHCs that were friendly towards men who have sex with men and transgender women. People complained about crowding, lack of privacy, lack of any time in the consultation to ask questions or discuss concerns and long waiting times at clinics. This deterred them from returning. Some attended private clinics instead, but complained of the cost and the lack of pre- or post-test counselling or information they received.

A study conducted in 2014 on men who have sex with men and transgender people's experiences of stigma and discrimination across four countries in Asia, including the Philippines, found significantly higher percentages of transgender people (compared to men who have sex with men) who reported being refused access to health care services, and faced physical and verbal maltreatment.[54] A recent evaluation of community-based HIV screening indicated that locating HIV screening within the barangay (with education of barangay leaders) and allowing access to this testing to people from general populations as well as key populations increased the comfort that people from key populations felt with the testing process and their willingness to participate. The additional advantage of educating community members was that

[54] Final Report: Analysis of ISEAN-HIVOS Program (IHP) Baseline Research on MSM and TG, Experiences of Stigma and Discrimination in Indonesia, Malaysia, Philippines and Timor-Leste. Islands of Southeast Asia Network on Male and Transgender Sexual Health (ISEAN) and the Humanist Institute for Co-operation with Developing Countries (Hivos). April 2015.

mothers felt comfortable to provide consent for testing of their men who have sex with men and transgender adolescents.[55]

Some people with HIV reported that some HIV treatment hubs insisted that they find a 'treatment partner' before enrolling them on ART, and that when they could not find one, they did not go back to enroll in ART. Such a requirement may exclude men who have sex with men and transgender people disproportionately. Foucs group participants reported that one hospital had a practice of examining people with HIV last in the queue, forcing people to take a full day off work each time they wanted to refill their ART prescription. Transgender women reported particular issues with health care workers shaming them, telling them to dress and behave more discreetly and moving them to the end of the queue.

Some prisoners who were men who have sex with men (or assumed to be men who have sex with men) reported being blamed for the existence of HIV and experiencing violence and intimidation from other inmates who assumed that they had HIV. Prisoners with HIV reported particular issues with the treatment services they were receiving. Several reported ceasing their ART shortly after commencing treatment as there was little privacy and they feared violence and discrimination when their status became known throughout the prison. The issues for prisoners with HIV were expressed as follows:

- Trained inmates generally dispensed the ART to other inmates. Inmates had to queue for these drugs at a particular time, thus identifying them to others as living with HIV.
- Overcrowding and poor infrastructure meant that inmates had to queue for other things – drinking water, washing water, food – and these queues were long. This meant some missed (or decided to miss) the ART queue.
- Significant overcrowding in prisons (following a sharp increase in drug-related arrests) meant that prisoners had no private space in which to store possessions in their cell, including their one-month's supply of ART. ART was dispensed in a particular plastic bottle easily identified by other inmates as 'AIDS drugs'.
- There was a general lack of privacy in prison, and they feared that people knowing their HIV status would lead to violence and harassment.
- There was little or no connection to outside HIV and health services once they were released, leading to gaps in treatment.

Some focus group participants reported having mostly punitive and judgmental relationships with SHCs – particularly around 'compulsory' STI testing and did not feel that they would be supported if living with HIV. Some sex workers reported being traumatized by police round-ups for compulsory testing, resulting in low levels of trust with health service personnel.

4. **Fear of violence and loss of freedom** if identified as coming from a key population

This was a particular issue for people who use or inject drugs, but also for some female sex workers, transgender women and men who have sex with men. Carrying condoms or sterile needles in some provinces was used as evidence of illegal activity. The law enforcement landscape in the Philippines is quite complex. In some settings, a range of law enforcement officials operate (some provincial, some from national agencies). They are policing different aspects of behaviour and operating with

[55] Community-based HIV Screening in the Philippines, Demonstration Project Process Evaluation, HIV & AIDS Support House Inc, 2017

different goals and practices. This makes it difficult for people from key populations to feel comfortable to access community-based or health care services. Some focus group participants feared that health care workers were under an obligation to report them to police if they presented at health services. Compulsory registration systems and compulsory rehabilitation for people who use drugs meant that people who use drugs were becoming more difficult to access by outreach workers or health officials. In some places, service access had contracted due to changes in ordinances or operational policies.

Key informants working with people who use drugs reported that false arrests are common in some cities. Police identify people who have drug use track marks on their arms and arrest them, sometimes planting drugs on them to increase the severity of charges. More arrests often occur on Fridays, as this delays court appearance until Monday, giving families time to over the weekend to assemble a bribe that can be paid to police to have the charges dropped. The bribe is generally around Pesos 20,000 (US$375).

The court system in many jurisdictions is completely clogged with cases due to the arrest quotas that exist. This means that a person can be charged and be on bail (or on remand in custody) for several years without trial or conviction. Some outreach workers reported having spent eight months on remand, and now on bail for more than four years with annual appearance to court. This traps people in the justice system for years without any clear sense of future.

The crack-down on drugs has also disturbed established drug availability patterns. Parts of some cities were tolerated as 'safe zones' for drug transactions (with corresponding protection money paid to police), but that system has largely been dismantled and drug selling is much more furtive and scattered across the city. This makes it difficult for outreach services to access drug users and assist them.

Barangays are required to sign up to be drug free – that involves finding and registering all people who use drugs in their barangay and placing them in rehabilitation, sporting and surveillance programs. People on the list are required to report weekly to the Barangay Drug Assistance Committee to demonstrate that they are not using and that they are participating in rehabilitation activities. Some people registered in one barangay move their residence registration to another to avoid this system.

Sex workers reported arrest for vagrancy, confiscation of condoms and use of these as evidence for arrest, theft of belongings and sexual assault by police. This increased their level of trauma and their cycle of debt (sometimes resulting in them having to have unsafe sex with clients to make up the money paid in fines and bribes).

5. **Financial burden** associated with travel to treatment centers, loss of income, cost of care, nutrition and opportunistic infection diagnosis and treatment

Despite ART being provided free of charge, many PLHIV reported that the cost of transport, side effects control, nutrition, care and opportunistic infection diagnosis and treatment were particular problems for them and affected their access to services. Whilst the Outpatient HIV/AIDS Treatment Package Provided by the Philippine Health Insurance Corporation provides people with HIV with some coverage for costs, some people with HIV are not aware or, or covered by the scheme and some treatment hubs and other services are not processing claims from the

scheme.[56,57] There are reports of inconsistency in coverage between provinces and between treatment hubs, of difficulties in relation to treatment initiation work-up tests and opportunistic infection diagnosis and treatment.[58]

Programs to address access barriers to HIV services – proposed elements of a comprehensive program

Overall, the Philippines produces a wealth of data on the status of HIV in the country. This includes progress to reach goals and targets, data on which parts of the country face higher prevalence rates, which populations are most affected, and recommendations to address the problems. However, documentation on exactly what has been done (i.e. who, what, when, where, how much) and information on results and outcomes are somewhat limited, making it difficult to identify exactly where the gaps are that need to be addressed. Documentation on efforts specifically designed to tackle rights-related barriers across the country has been even more challenging to find as these types of barriers have not been a focus of many organizations conducting HIV work or are simply not available or obtainable within the timeframe to conduct the baseline assessment. Therefore, while there were some gaps in the summaries of recent or existing activities to address rights-related barriers in the sections below, the data presented provides a general summary of large donor-supported programs as well as findings from the baseline assessment in Manila, Cebu and Zamboanga.

This section highlights key activities to address access barriers and sets out recommendations for a comprehensive program to reduce these barriers to HIV services. Information is organized under the Global Fund's seven Program Areas for HIV, Human Rights and Gender Equality.[59]

PA 1: Programs to reduce HIV-related stigma and discrimination
PA 2: Programs to train health care workers on human rights and ethics related to HIV
PA 3: Programs to sensitize lawmakers and law enforcement agents
PA 4: Programs to provide legal literacy ("know your rights")
PA 5: Programs to provide HIV-related legal services
PA 6: Programs to monitor and reform laws, regulations and policies related to HIV
PA 7: Programs to reduce discrimination against women and girls in the context of HIV

PA 1: Stigma and discrimination reduction for key populations

Existing/recent programming and outcomes to date:
A number of activities have been conducted in recent years to address broad stigma and discrimination faced by PLHIV and key populations, though these are generally embedded in broader HIV programs. They include the following:

- HIV Joint Evaluation Exercise and Planning (JEEP) workshops supported by the DOH were conducted among KAP and PLHIV from sites in Luzon, the Visayas and Mindanao, to assess progress towards national goals and targets, share best practices and strategies for ensuring a more rights-based, culturally- and gender-

[56] OHAT: https://www.philhealth.gov.ph/circulars/2015/circ011-2015.pdf
[57] Reyes-Lao, I, An Assessment of the Outpatient HIV/AIDS Treatment Package Provided by the Philippine Health Insurance Corporation, Philippine Institute for Development Studies, 2013
[58] http://outragemag.com/philhealth-clarifies-ohat-coverage/
[59] Technical Briefs *HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017);

sensitive response. These JEEPS confirmed earlier findings of fear of stigma faced by men who have sex with men and transgender individuals, harassment by barangay officials towards PWID outreach teams, and confidentiality issues.

- Addressing stigma and discrimination has also been a component of USAID's three-year (2012-2015) HIV prevention project implemented by FHI 360 entitled Reaching Out to Most-at-risk Populations or ROMP. Implemented in four cities in the country, ROMP used innovative approaches to provide HIV prevention services to men who have sex with men and PWID. While the project did not specifically focus on addressing rights issues, activities were designed to provide greater access to HIV services for stigmatized and discriminated key populations.
- From 2015-2017, Save the Children served as GF PR for the *Strengthening HIV/AIDS Prevention, Community Linkages and Response in the Philippines* project. The project conducted awareness-raising campaigns to reduce stigma using social media and celebrities to disseminate messages.
- The Cebu-based transgender organization, COLORS, in partnership with the Cebu City DOH, continued its Femina Trans Initiative, which implements a peer outreach model to encourage acceptance and demand for HIV/AIDS services including HIV counselling and testing among the transgender community.
- Repos Angels offered LGBT-friendly HIV screening and testing outreach services and awareness seminars in Cebu city. On a broader level, every year it organizes a public, *Gaksa Ko Bhe*, aimed at promoting equality and zero discrimination on the basis of SOGI, ethnicity and religion.

PA 1 RECOMMENDATIONS

The following recommendations are made to move towards comprehensive programming in stigma and discrimination reduction for key populations and vulnerable groups:

PA1.1: Reduced self-stigma among people from key populations and stigma within families and communities, leading to increased motivation to access HIV testing services and treatment care and support of people living with HIV

This activity responds to a key finding of the Baseline Assessment and previous studies on the high prevalence of self-stigma based on HIV or key population status that leads to delays in initiating ARV treatment and compromises structures of support. The *Qualitative Barriers* study recommended campaigns on living positively with HIV and increased treatment literacy information. Information materials should include low-literacy booklets on effectiveness of HIV treatments and on living with HIV, low-literacy e-information for addition to information websites that are frequented by men who have sex with men and transgender people, development of materials that demonstrate family and community support for PLHIV (including statements from mother/fathers about their sons and daughters, testimonials from barangay leaders, religious leaders, video grabs). This is intended as an internal campaign to be conducted by community-based organizations for inclusion in their work with key populations.

This to be accompanied by specific work to improve the capacity of outreach workers and counsellors to communicate effectively and in a non-discriminatory manner with people from key populations about HIV treatments and living with HIV. It also includes a program of capacity development for NGO management to put in place strategies to ensure that support for living with HIV and positive attitudes towards PLHIV are part of the culture of their organizations, including resources such as posters, other printed materials, standards statements and policies and treatment

information sessions for staff, volunteers and clients, and support for PLHIV within the organization. It also includes support for PLHIV organizations to produce materials on living positively with HIV, including testimonials by PLHIV leaders and to participate in the capacity building of prevention NGOs.

Proposed sub-activities and responsibilities Partners: DoH, social communications agency, PLHIV & KP organizations	
Operational/cost elements	*Agency*
1. Development of concept and plain language materials (including low-cost video grabs and other e-materials) on effectiveness of ART, living positively with HIV, examples of support for PLHIV	National consultant/agency /CSOs or KP organizations
2. Training and onward coaching of staff, outreach workers and volunteers in HIV prevention and care organizations	KP organizations
3. Additional outreach workers for group discussions/e-contact	KP organizations
4. Group session costs in communities	KP organizations

PA 1.2: Support for development and implementation of strategies to increase compassion and acceptance of people living with HIV and people from key populations by community and religious leaders

This activity responds to the real fears expressed by people from key populations who are reluctant to test that they will not be supported, or that they are already marginalized. This involves identifying progressive religious leaders (Catholic, other Christian, Muslim) and supporting them to gather and develop strategies to increase compassion and acceptance among the leaders and members of their organizations. This could be carried out in combination with the similar activity recommended under the TB section.

Proposed sub-activities and responsibilities Partners: PNAC, KP and PLHIV organizations, religious leaders	
Operational/cost elements	*Agency*
1. Establishment and functioning of working group	PNAC
2. Materials/statement development on compassion and support for families and individuals affected by HIV	PNAC/Consultant/religious organization/PLHIV organization
3. Workshops and round tables at local level in target provinces	Provincial agency/provincial health/PLHIV organization/religious leaders

PA 1.3: Development and implementation of a policy framework, strategies and materials on sexual orientation, gender identity and expression (SOGIE)

This activity responds to broad stigma and discrimination experienced by men who have sex with men and transgender women. It includes attention to integrating SOGIE principles into the gender reform processes currently underway in several key government departments.
It provides resources for the development of policy papers, summaries of the evidence-base for a positive engagement with these key populations, and options for policy and legal reform. The action points in the “Global Fund Strategy in Relation to Sexual Orientation and Gender Identity” will form the basis of set of policy and

practice options papers for particular high-priority government departments, to be included in mainstream gender reforms.[60]

Proposed sub-activities and responsibilities Partners: PNAC, key government departments, MSM and TG organizations	
Operational/cost elements	*Agency*
1. Inter-agency working group	PNAC
2. Development of SOGI integration options papers and briefing materials	Consultant/ MSM and TG organizations
3. Workshops and round tables with government departments and other relevant agencies	PNAC/MSM and TG organizations

PA 1.4: Expansion of outreach activities to include specific attention to stigma and discrimination as barriers to access to services

This activity responds to significant gaps between the number of people testing positive for HIV and the number successfully initiated on/staying on treatment. Test and treat targets take up significant time in the outreach workforce. This allocation allows for more service navigators who can provide assistance (simplified case management) for newly-diagnosed people with HIV and who can identify and quickly resolve local stigma and discrimination issues, particularly at health service level, by developing constructive relationships with SHCs and other services, becoming part of the multi-disciplinary teams and assisting people with HIV to stay connected to services and treatment. A model for simplified case management to reduce stigma will be used to guide this work, focusing on sustained connection between PLHIV and treatment and care agencies.

Proposed sub-activities and responsibilities Partners: DoH, KP organizations, Global Fund PRs, other donor programs	
Operational/cost elements	*Agency*
1. Development of a client navigation, complaints reduction and resolution and simplified HIV case management model and training materials for KP outreach and clinic partnership	Consultants/CSO/academics
2. Additional outreach workers (ORW) per implementing unit focussed in integrating complaints handling and simplified case management	KP organizations
3. Training and onward coaching for ORW in simplified case management	KP organizations

PA 1.5: Capacity development for champions from within key populations and people living with HIV in public speaking and constructive partnership with government – with a focus on young key populations

Key populations participation in policy and program design is well established in the Philippines. To make this participation as effective as possible, and in particular to ensure that program design takes account of the barriers that people from key populations experience to service access, the quality of the contribution of champions from within key populations is particularly important. Given the disproportionate impact of HIV on young people, it would be wise to ensure that young leaders from within key populations are provided with capacity building (training and then coaching over time so that their skills develop) to take their place and be a strong voice for the needs of their community.

[60] Available at https://www.theglobalfund.org/media/1257/core_sexualorientationandgenderidentities_strategy_en.pdf

Proposed sub-activities and responsibilities Partners: Communication/advocacy agency/KP organizations	
Operational/cost elements	*Agency*
1. Training and on-the-job coaching model curriculum development	Communication/ advocacy agency
2. Training and coaching of KP leaders	Communication/ advocacy agency /KP organizations

PA 1.6: Stigma Index studies

The last Stigma Index study was performed in 2010. A modified version of the study based on the Stigma Index 2.0 methodology and questionnaire will be repeated in years one and four of the strategy.

Proposed sub-activities and responsibilities Partners: PLHIV organization, consultant, appropriate technical support agency (university/consultancy group)	
Operational/cost elements	*Agency*
1. Design, recruitment of field workers, analysis of data, report preparation and dissemination	PLHIV organization/consultant
2. Field costs	PLHIV organization

PA 1.6: Establishment of a free hotline for the documentation and monitoring of HIV-related and key population-related discrimination and to provide a referral and information service for people affected by HIV-related discrimination

This 24-hour free hotline will assist to provide better information on the nature and extent of HIV-related discrimination that can be fed back into service design and into advocacy, and will counsel and refer people to legal and other services.

Proposed sub-activities and responsibilities Partners: PLHIV organization, consultant, legal services, policy makers	
Operational/cost elements	*Agency*
1. Establishment, recruitment of staff, training	PLHIV/KP organization/consultant
2. Documentation of HIV-related discrimination, referral and information, partnerships with legal services	PLHIV/KP organization, community legal services

PA 2: Training of health care providers on human rights and medical ethics related to HIV

Existing/recent programming and outcomes to date:
Currently there is no formalized mechanism to monitor cases of discrimination faced by key populations in accessing HIV services. Anecdotal evidence exists and has, in part, led to the development of specific services that meet the needs of key populations. For example, Social Hygiene Clinics serve as a go-to place for HIV and STI testing for sex workers. The DOH NACP and the Research Institute of Tropical Medicine (RITM) collaborated with Love Yourself, Inc. to establish a satellite clinic in the metro Manila area aimed at providing HIV services primarily for men who have sex with men and transgender communities. These clinics offer HIV testing, screening for TB, and research on PEP and PrEP and are co-located with a treatment center for immediate access.

The clinics are regarded as a successful model for key population-friendly services that can be replicated to other parts of the country. Specific activities on HCW

trainings on rights issues were implemented by the AIDS Society of the Philippines, Inc., a sub-recipient (SR) of the three-year GF HIV project that conducted half-day stigma reduction workshops in all of its sites across nine cities in the country. The project has also rolled out SOGI manuals and held sessions on SOGI during healthcare worker trainings.

PA 2 RECOMMENDATIONS

The following recommendations are made to move towards comprehensive programming in training for health care providers on human rights and medical ethics related to HIV:

PA 2.1: Develop a strategy for institutionalizing health worker (HCW) HIV capacity development (combined with TB), especially to ensure continued training on non-stigmatizing care

Many trainings on HIV (with curricula including attention to service quality and stigma and discrimination) have been held but unfortunately positive outcomes for single trainings are generally not sustained, health worker turnover is high and the health system is under considerable pressure. This initiative involves working with the Department of Health, the professional medical, nursing and allied health organizations and the higher education curriculum settings bodies to develop a comprehensive program for integrating attention to HIV (and TB) into pre- and in-service training programmes and into the compulsory continuous professional education programs in which existing health workers already participate. This includes funding for key population organizations to participate as trainers/coaches.

The training curriculum will include attention to standard setting and monitoring processes and complaints and redress mechanisms so that health care workers understand how their behaviour will be monitored. This responds to the statements in focus group discussions that people from key populations do not know how to make complaints about the service they receive and do not have confidence that if they did complain, the services would improve. It also responds to the fear that some men who have sex with men have expressed that they will not go to health services because they do not think they will be treated well or that their confidentiality will be maintained.

Proposed sub-activities and responsibilities Partners: DoH, universities, professional medical and nursing and allied health associations, provincial health, KP organizations, PLHIV organizations	
Operational/cost elements	*Agency*
1. Mapping and analysis of HCW HIV (and TB) training efforts to-date	DoH, National consultant
2. Development of a comprehensive HCW capacity development strategy – including pre-and in-service training, continuous professional education (CPE)	Consultant, DoH, DILG, universities, KP & PLHIV organizations
3. Module development and testing for pre-service, in-service and CPE	Consultant, KP & PLHIV organizations
4. Rollout of strategic capacity development	DoH, provincial health, KP & PLHIV organizations

PA 2.2: Develop and promote key population friendly standards for health services

This activity responds to the concerns expressed by key populations members that the quality and acceptability of health services they access vary significantly.

Standards for providing non-discriminatory care and a positive, welcoming environment for people with HIV and people from key populations will be developed and circulated. These will include innovative models of peer involvement.

Proposed sub-activities and responsibilities Partners: KP/PLHIV organizations, DoH	
Operational/cost elements	*Agency*
1. Analysis of quality improvement, friendly service, KP/clinic partnership models	KP/PLHIV organizations, consultant
2. Development of standards and methods for quality improvement and monitoring	DoH, provincial health authorities, private providers, KP/PLHIV organizations
3. Development of guidance/promotional materials	DoH, KP/PLHIV organizations
4. Training and support in clinics	KP/PLHIV organizations

PA 3: Sensitization of law-makers and law enforcement agents

Existing/recent programming and outcomes to date:
The proposed amendment to the HIV and AIDS law would not be possible without informed law-makers. One key issue included in the amendment is a change to the age of consent for HIV testing from 18 years to 15 years. Currently, the DOH along with the Departments of Education (DOE) and Social Welfare and Development (DSWD) support proxy consent for HIV testing among minors (i.e. waiving parental consent). For several years, UNICEF, with the support of Save the Children and other organizations working with youth and key populations, has been advocating for changes to the age of consent for HIV testing. These efforts resulted in support from five Local Government Units (LGUs) to pass local ordinances allowing proxy consent to be piloted. Evidence from these pilot activities is being collected by local government agencies and will be used for the development of a standard protocol.

The Center for Health Solutions and Innovations, Inc. (CHSI) through a grant from UNFPA piloted and implemented the Integrated HIV-FP-GBV project among registered sex workers in Angeles City. This two-year project (2015-2016) was implemented with the owners and managers of entertainment establishments (who employ registered sex workers) along with government partners – City Health Office (CHO), Philippine National Police (PNP), Department of Social Welfare and Development, and local barangays. The project involved information sessions with entertainment workers on sexual and reproductive health, their rights and sessions with local police and community leaders to brief them on the health programs in place in entertainment venues. Subsequently, the PNP organized their own training on GBV as part of the Women and Children's Protection Desk program. The program establishes a separate desk attached to every police station where women can go to report problems, complaints and issues.

Other activities include:
- Commission on Human Rights (CHR) human rights promotion workshops for barangay members, PNP and armed forces
- Harm reduction workshops for PNP, Philippines Drug Enforcement Agency (PDEA) and the Cebu City Jail supported by a grant from the International HIV/AIDS Alliance

PA 3 RECOMMENDATIONS

PA 3.1: Policy dialogue with police services and development and roll-out of a strategic capacity development program for police and other law enforcement agencies

This is a complex environment, and police and other law enforcement agencies are under considerable pressure to meet objectives in other policy areas like the illicit drugs policy and social order policies. In the light of this, there is a need to enter into a policy dialogue with police and other law enforcement agencies on areas of mutual interest and on concrete strategies that can improve outcomes across all government policy areas.

This will involve providing funds for high-level dialogue, preparation of materials to circulate through law enforcement agencies on the rationale for HIV and TB strategies, and specific targeted training for people at appropriate levels within law enforcement agencies.

There were concerns expressed in the key informant interviews that previous trainings had targeted people within the law enforcement system who did not have to power to bring about change and that high levels of turnover within police and other law enforcement agencies meant that training had to be continuously repeated. The dialogue will identify areas where policy change, the issuing of police circulars to improve compliance with policies and the law and training and coaching can support positive police behaviour to support public health goals.

The training materials will include content on the right to health and access to health services and will be used in pre- and in-service capacity building, targeting various levels of law enforcement.

Proposed sub-activities and responsibilities Partners: DoH, DoJ, DIPG, provincial authorities	
Operational/cost elements	*Agency*
1. Policy dialogue to identify areas of mutual interest and improved cooperation, policy challenges, examples of good practice	PNAC, DoH, DoJ, provincial authorities
2. Mapping and analysis of police and law enforcement training efforts to-date	National consultant
3. Curriculum review and training strategy development	PNAC, DoH, DoJ, provincial authorities
4. Targeted training in specific areas	DoH, DoJ
5. Exchange visits to police services in other parts of the region	DoJ, provincial authorities

PA 4: Legal literacy ("know your rights")

Existing/recent programming and outcomes to date:

Not much specific programming has been in place under this PA, though NGOs have focused attention on assisting people in their constituencies to gain service access and pursue issues and problems as they arise. The Commission on Human Rights has conducted some general population rights information roadshows/workshops at local level in some provinces. Only a few activities were identified during data collection:

- Special investigators and lawyers from the Commission on Human Rights (CHR) were provided with a series of trainings on HIV-related legal standards/rights.
- Save the Children supported Cebu Plus to conduct learning group sessions on legal rights for men who have sex with men, registered sex workers, people who inject drugs, and people living with HIV. For example, people who inject

drugs were provided with information on their rights if they were arrested, what the proper legal process is and where they can go for help.

PA 4 RECOMMENDATIONS

The following recommendations are made to move towards comprehensive programming in legal literacy:

PA 4.1: Development of plain language 'know your rights' materials and roll-out of workshops among the community organizations conducting outreach activities for integration into outreach practice

This activity responds to concerns raised in focus groups and through previous studies that many people from key populations are not familiar with their right to access to services and to respectful treatment. It involves developing materials to integrate into peer outreach worker training and training for staff, volunteers and beneficiaries of KP organizations.

Proposed sub-activities and responsibilities Partners: KP organizations, legal/advocacy groups	
Operational/cost elements	*Agency*
1. Development of materials on 'know your rights' (KYR)	KP organizations, legal/advocacy groups
2. Know your rights workshops and coaching in outreach organizations	KP organizations, legal/advocacy groups

PA 5: HIV-related legal services

Existing/recent programming and outcomes to date:
There does not currently exist an established, nationwide legal redress mechanism for rights violations faced by PLHIV and/or people from key populations. Cases of rights violations have been noted in various reports. In February 2018, Human Rights Watch reported on discrimination against workers with HIV in the Philippines,[61] and the national Commission on Human Rights (CHR) put out a statement in December 2017 on the PDEA's disclosure of a drug suspect's HIV status [62]noting that PDEA violated the suspect's privacy.

Pinoy Plus based in Manila is doing some work to monitor and register cases of PLHIV needing legal assistance through its PLHIV Response Center, although these cases are not necessarily referred to legal assistance and the monitoring effort is not nationwide. Action for Health Initiatives, Inc. (ACHIEVE) provides some legal assistance for cases of discrimination of PLHIV, but the regularity and scale of these efforts are unclear. In Cebu, efforts to provide legal services through 'legal caravans' or mobile legal clinics for PLHIV and people from key populations have been carried out on an ad-hoc basis and with limited success.

It was noted in interviews that while there are some efforts to monitor rights violations by the organizations noted above, PLHIV and people from key populations

[61] Philippines: Discrimination Against Workers with HIV, Amid Epidemic, Weak Government Response to Unlawful Firings, Harassment Feb 2018, Available at https://www.hrw.org/news/2018/02/09/philippines-discrimination-against-workers-hiv

[62] Commission on Human Rights, Philippines, Statement of the Commission on Human Rights on PDEA's public disclosure of a drug suspect's HIV status available at http://chr.gov.ph/statement-of-the-commission-on-human-rights-on-pdeas-public-disclosure-of-a-drug-suspects-hiv-status/

do more sharing amongst themselves via social media (ie.g. Facebook). However, the majority of these cases do not typically move to a legal case and remain mere stories within the PLHIV communities and key populations. It was acknowledged, however, that there are lawyers who are willing to help with rights-related cases, but that would require that the individual announce publicly his/her HIV status, which many are reluctant to do. In the absence of similar or precedent legal cases to guide lawyers, establishing a solid case would also be challenging in some circumstances.

PA 5 RECOMMENDATIONS

The following recommendations are made to move towards comprehensive programming in monitoring and reforming policies and laws relating to HIV.

PA 5.1: Integrate HIV legal and advocacy services into community-based HIV, STI and TB clinics and conduct process evaluation as this model is rolled out

Several formal and informal initiatives have been in place to improve access for people from key populations to legal services. These have included local-level funding of travelling legal clinics by the Commission for Human Rights (in Cebu) and the deployment of paralegals and volunteer lawyers through key populations NGOs to reach people who need legal assistance. These models will be examined, along with any others that can be identified, and an appropriate organization identified to develop and begin the implementation of a strategy to improve legal service access.

Based on successful Community Legal Centre and paralegal access models in other settings,[63] lawyers, paralegals and key population organizations will be engaged in the establishment of pilot community legal services attached to key populations NGOs or other appropriate organizations in highest burden areas to rapidly increase access to legal services.

This activity is already programmed into the 2018/2020 Global Fund HIV allocation. Twelve CBO clinics (Love Yourself in Manila plus 11 more in regions) will be supported in high prevalence areas. Each clinic will be provided with Judiciary Liaison Officers (paralegals) who will assist people from key population and people living with HIV to prepare and lodge complaints and report and gain redress for instances of discrimination. These officers will also play a proactive role in assisting the clinics to pursue an advocacy and quality-strengthening agenda with local services. A Legal Services Delivery Network is also to be established.

This also includes an allocation to a PWID CBO in Cebu for legal and advocacy services. The judicial system in Cebu is heavily congested by arrests for drug use. There are many people with HIV on remand in the system, awaiting trial. This situation can go on for years. PWID CBOs and the social Hygiene Clinic are in touch with PLHIV in the system, but the ART delivery and clinic care systems in the prison are under extreme stress. This allocation will assist to move PLHIV through the system as a matter of priority, to be released on bail or compassionate release. This is also required in Metro Manila, where PWUD arrest numbers are high, but it was not possible due to sensitivities and security reasons to scope out potential solutions in Metro Manila in this assessment.

Proposed sub-activities and responsibilities

[63] Toolkit: Scaling up HIV-related Legal Services, UNAIDS, UNDP, IDLO, 2009

Partners: DoJ, Philippine National Council on Population Health (SR), KP and PLHIV organizations, lawyers groups, public, private and NGO legal services, Commission on Human Rights	
Operational/cost elements	*Agency*
1. Implement a range legal service access models (using lawyers and paralegals) in selected 'high-impact' sites (range of models – attached to KP NGO clinics, attached to PLHIV NGOs, KP service integrated into general legal services	Philippine National Council on Population Health (SR), KP and PLHIV organizations, lawyers groups
2. Sub-activity 5.1.2 Conduct process and outcome evaluation to assist in further roll-out	Philippine National Council on Population Health (SR), KP and PLHIV organizations, lawyers groups
3. *Sub-activity 5.1.3 Provide advocacy and legal services for PLHIV on remand in Cebu to advance their cases*	PWID CBO Cebu

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

Existing/recent programming and outcomes to date:
Experiences with implementation of the current HIV and AIDS law have led to efforts by law-makers, PLHIV and key population groups, local governments and various government departments (i.e. Health, SWD, Education) to amend the law, which aims to increase access to HIV services and address rights-related issues. These efforts have been on-going for many years with various bills introduced in Congress. As discussed in PA 3, UNICEF with the support of Save the Children and others has been working specifically to address legal barriers to HIV testing among minors. The DOH, DOE and DSWD as well as a number of local governments have supported "proxy consent" for HIV testing among those as young as 15 years. The new law, if passed, will formally amend the age of consent to 15 years. UNICEF's efforts to pilot proxy consent in five cities has proven successful and the model is expected to be expanded to 38 sites under the new GF HIV grant implemented by the PR, Save the Children.

Other monitoring efforts have been around the impact of the employer-provided health insurance, PhilHealth, on PLHIV privacy and confidentiality. For PLHIV to benefit from the Outpatient HIV/AIDS Treatment (OHAT) package offered by PhilHealth, the employer is required to sign off on benefits essentially putting the PLHIV in a position of being forced to reveal his/her status – a clear violation of norms of privacy and confidentiality. The result has sometimes led to reports of PLHIV being fired or forced to resign. For fear of losing employment, PLHIV have, in some instances, turned to private doctors and pay for services out-of-pocket, therefore creating a financial burden to protect privacy and confidentiality of one's HIV status.

Monitoring of condom access has resulted in a realization that the current designation of the condom as a reproductive device under the reproductive health law creates a barrier to access. While condoms are free at the Social Hygiene Clinic, access to condoms in drug stores is restricted to the prescription counter. In many pharmacies this means the person has to ask for the condoms rather than just pick them up off the shelf. A change in designation of the condom from a reproductive device to a general health device could increase access to condoms as an over-the counter product.

In September 2017, the House of Representatives unanimously passed the LGBTQ Anti-Discrimination bill, also known as the SOGIE Equality Act. The bill imposes fines and even imprisonment for acts of discrimination against LGBTQ around access to health services, employment, gender profiling, and privacy among others. While the Senate has yet to pass its version of the bill, at the local government level, local ordinances on anti-discrimination have already been passed in a number of areas. However, LGBTQ groups have found that while the passage of these legal and policy instruments to reduce discrimination have been positive, guidelines need to be developed to operationalize them.

PA 6 RECOMMENDATIONS

The following recommendations are made to move towards comprehensive programming in monitoring and reforming policies and laws relating to HIV.

PA 6.1: Review and reform of the local ordinances that allow for the arrest of people with condoms or sterile syringes and needles in their possession

Arrest of people carrying large numbers of condoms or carrying sterile needles and syringes works against the public health goals of providing people with the means of protection as close to the site of risk as possible. This activity will involve the development of policy materials and specific assistance at local level to address these reforms.

Proposed sub-activities and responsibilities Partners: DoH, provincial health, provincial law enforcement, KP organizations	
Operational/cost elements	*Agency*
1. Round table meetings to discuss options for policy and practice review and reform	DoH, provincial health, provincial law enforcement
2. Development of policy briefing and advocacy paper	Local consultant

PA 6.2: Development and implementation of a dissemination strategy and materials to ensure national and local compliance with the new HIV Law

This activity responds to significant concerns expressed in key informant interviews about problems experienced under the current HIV law and opportunities to bring about practice reform once the new HIV law is passed. It will involve development of plain language materials to promote the positive changes under the law, including, as a priority, specific changes to age of consent for HIV testing to ensure that more young people between 15 and 18 years can access HIV testing. In the event that there are delays in the passing of the law, or changes to key clauses, an interim plan for clarifying consent issues for young key population members will be developed and implemented.

Proposed sub-activities and responsibilities Partners: PNAC, DoH, DoJ, DILG, KP and PLHIV organizations	
Operational/cost elements	*Agency*
1. Establishment of a multi-sector Working Group	PNAC, DoH, DILG, other government departments, KP organizations
2. Preparation of plain language briefing materials on key changes under the new law - consent, new program elements, education	Consultant, DoH and other departments, KP and PLHIV organizations

*linked to HCW and police training initiatives above	
3. Workshops and briefing sessions in provinces with provincial authorities and stakeholders	DoH, DILG, provincial authorities

PA 6.3 Review of the Outpatients HIV/AIDS Treatment (OHAT) Scheme to further reduce the financial burden on people with HIV by reforming insurance schemes and costs and promoting greater access to benefits and lower cost.

This activity is in response to complaints by people with HIV that some costs of clinical monitoring and care are not covered under the Scheme provided by the Philippine Health Insurance Corporation (PhilHealth), including costs of work-up test for ART initiation and costs of opportunistic infection (OI) diagnosis and treatment. Addressing this will involve a review of the OHAT scheme, particularly with a view to reducing costs of OI diagnosis and treatment and education of people with HIV about their rights under OHAT. It will also involve development and implementation of strategies to ensure consist application of OHAT across all treatment centers and promotion of the rights of people with HIV under OHAT.

Proposed sub-activities and responsibilities Partners: DoH, PLHIV organizations, PhilHealth	
Operational/cost elements	*Agency*
1. Review OHAT scheme and additional costs that PLHIV experience in treatment initiation work-up tests and OI diagnosis and treatment	Consultant
2. Develop strategies for cost reduction to improve access to ART and OI diagnosis and treatment	DoH, PLHIV groups

PA 6.4 Reform HIV treatment procedures and services in prisons (combined with TB) to ensure confidentiality, informed consent as sole basis for service provision, and uninterrupted access to health services.

This activity responds to specific and concerning HIV treatment practices in prisons that are causing people with HIV to cease treatment to avoid identification as a person with HIV and the harassment and potential violence that might result from that. HIV treatment models and practices will be studied across a range of closed settings in high-burden provinces, and resources will be provided for the Department of health to work closely with the Department of Justice, the Department of Interior and local government and provincial governments on reforms of HIV and TB healthcare in prisons.

Proposed sub-activities and responsibilities Partners: DoH, DoJ, provincial health and corrections authorities	
Operational/cost elements	*Agency*
1. Review ART and HIV clinical management in closed settings	Consultant
2. Establish an interagency working group to oversee system changes to ensure stigma reduction, privacy and increased adherence to ART and improved HIV clinical management *link to TB	DoJ, DoH, provincial corrections authorities, PLHIV groups

PA 7: Reducing discrimination against women in the context of HIV

Although the vast majority of people diagnosed with HIV since 2012 have been men or transgender women, more than 30% of the men diagnosed reported having had

regular sex with women. This may point to an under-diagnosed population of female partners of men who have sex with men.

Existing/recent programming and outcomes to date:
Dedicated initiatives to reduce discrimination against women with HIV more broadly were not identified during data collection. Social Hygiene Clinics currently serve registered sex workers, mostly female, with HIV and STI screening and testing.

PA 7 RECOMMENDATIONS

Many of the interventions proposed in other program areas will benefit women from key populations and vulnerable groups. In addition, a set of interventions that specifically address the discrimination and service barriers faced by women need to be developed. These recommendations should build on the mainstream gender assessments conducted in 2014.[64] To address particular issues from the female sex worker focus groups:

PA 7.1: Review lessons learned from recent Women's Police Desk strategies that increased the level of positive engagement between police services and female sex workers in some provinces

Women police officers were trained and deployed in some cities to engage positively with female sex workers, sex worker peer organizations and entertainment establishments. Focus group participants reported that this led to better entry points for sex worker reporting of gender-based violence and harassment. This activity includes a review of that experience and recommendations for its replication or expansion.

Proposed sub-activities and responsibilities Partners: PNAC, DoJ, provincial law enforcement, KP organizations	
Operational/cost elements	*Agency*
1. Review of Women's Police Desk initiatives and development of lessons learned/model document	Consultant
2. Development of strategies (including standards) to improve access to police services for female sex workers and other KP members experiencing gender-based violence	DoJ, DoH, provincial law enforcement, KP organizations

PA 7.2: Operations research to determine strategies to address increased HIV prevention and knowledge of HIV status among female partners of men who have sex with men.

This will involve operations research to develop targeted strategies to reach women at higher risk and undiagnosed women with HIV. It will work through women's groups and women's networks as well as integrating messages about the risk to female partners in men who have sex with men and transgender people's programs.

Proposed sub-activities and responsibilities Partners: PNAC, DoH, KP organizations, women's organizations	
Operational/cost elements	*Agency*
1. Design of research study to identify appropriate prevention and targeted HCT strategies	Consultant

[64] Kiesel, R. and E. Rottach. 2014. The Fade-Away Effect: Findings from a Gender Assessment of Health Policies and Programs in the Philippines. Washington, DC: Futures Group, Health Policy Project.

2. Development of action plan to advocate for increased attention to women at higher risk	DoJ, DoH, provincial law enforcement, KP organizations

2016 HIV investments and proposed comprehensive program costs

The latest available data on overall HIV spending in the Philippines is from the National AIDS Spending Assessment 2011-2013. In 2013, total spending by all sources was US$10,320,880 with 56% from international sources with the Global Fund as the biggest contributor. Other international sources included UN agencies, the Asian Development Bank, the World Bank and USAID. Public spending made up 44% of total spending in 2013 with the majority from the Department of Health's National AIDS/STD Prevention and Control Program and the National Epidemiology Center for surveillance activities. Other government agencies that contributed spending for HIV and AIDS included: the Department of Social Welfare and Development (DSWD), the Department of Education (DepEd), the Department of Justice (DOJ), the Philippine Information Agency (PIA), the Occupational Safety and Health Center of the Department of Labor and Employment (DOLE-OSHC), and several local government units (Quezon City, Makati City, Cebu City, Caloocan City, Pasay City, and Davao City).

In 2016, a total of approximately US$185,000 was invested in the Philippines to reduce access barriers to HIV services.[65]

Major funders and allocated amounts for reduction of access barriers to HIV services in 2016 were as follows:

Funding source	**2016 allocation**
Global Fund	$85,000
UN Organizations	$50,250
Alliance Regional	$10,000
Other Foundations	$10,000
Total	**$155,250**

This gave the following split of funding across program areas to remove access barriers to services:

HIV Service Access Barriers Program Area	**2016**
PA 1: Stigma and discrimination reduction for key populations	$22,000
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$56,000
PA 3: Sensitization of law-makers and law enforcement agents	$26,000
PA 4: Legal literacy ("know your rights")	$0
PA 5: HIV-related legal services	$0

[65] It should be noted that this is an estimate only as it was difficult to obtain detailed budget information in some areas as attention to access barriers was embedded in general HIV service delivery and not separately identified in budgets. More intensive budget finding was only carried out in the three identified target cities for the study

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$46,250
PA 7: Reducing discrimination against women in the context of HIV	$5,000
Total	**$155,250**

The costing for the 5-year comprehensive program is set out in the following table:

HIV Service Access Barriers Program Area	**Total**
PA 1: Stigma and discrimination reduction for key populations	$1,391,594
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$591,057
PA 3: Sensitization of law-makers and law enforcement agents	$305,523
PA 4: Legal literacy ("know your rights")	$301,229
PA 5: HIV-related legal services	$973,745
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$717,300
PA 7: Reducing discrimination against women in the context of HIV	$345,255
Total	**$4,625,704**

Details of yearly costs are set out below and detailed costing information is available in Annex 4.

HIV Access Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Y
PA 1: Stigma and discrimination reduction for key populations	$585,027	$362,837	$138,664	$166,403	$1
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$270,006	$124,353	$65,566	$65,566	$
PA 3: Sensitization of law-makers and law enforcement agents	$149,064	$78,230	$0	$78,230	
PA 4: Legal literacy ("know your rights")	$62,931	$59,574	$59,574	$59,574	$
PA 5: HIV-related legal services	$184,383	$223,149	$223,149	$171,532	$1
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$250,338	$156,364	$172,828	$104,364	$
PA 7: Reducing discrimination against women in the context of HIV	$95,638	$62,404	$62,404	$62,404	$
Total	**$1,597,387**	**$1,066,911**	**$732,185**	**$708,073**	**$5**

Baseline assessment findings: TB

Overview of epidemiological context and key and vulnerable populations

The Philippines is among the countries with the highest TB incidence in the 30 high TB burden countries.[66] The Philippines 2016 National TB Prevalence Study (NTPS) estimates that the number of people with pulmonary TB is around 760,000. For all forms of TB, the estimate is around 1 million people in 2016 (1 in 15 of the prevalent cases globally) and 570,000 incident cases. Broader social and economic influences on the TB epidemic include undernourishment, with a prevalence of 14% in 2015 and no improvement since 2008; a large proportion of the population living below the national poverty line (25% in 2012); and low coverage of health insurance and social protection (4% in the poorest quintile in 2013), resulting in financial barriers to accessing health services and high levels of out-of-pocket expenditures on health care (34% in 2014).[67] From 2006 to 2015, the incidence of poverty has declined only slightly (21% to 16.5%), the number of families living in poverty has remained fairly steady at around 3.8 million, and the Human Development Index has improved only slightly (from 0.63 to 0.68).[68]

The 2016 survey estimates the pulmonary TB (PTB) prevalence rate in the adult population at 1,159 per 100,000 population, significantly higher than the 2015 estimate, but this can largely be explained by improvements in estimation methodology and the systematic use of Xpert MTB/RIF for all positively screened persons.[69] The Philippines has made significant progress in addressing TB – meeting the Millennium Development Goal targets in 2012, cutting TB mortality and prevalence in half compared to a 1990 baseline. TB remains, though, the eighth leading cause of death in the country.[70]

The WHO 2016 Tuberculosis Profile estimates TB incidence at 573,000 new cases that year, with a male-to-female ratio among adults of 2.7:1. Treatment coverage (number notified/estimated incidence) is estimated at 58% for 2016. The treatment success rate for new and relapsed DS-TB cases in 2015 is estimated at 91%, though this is thought to be based on an under-estimated TB incidence rate and over-diagnosed TB cases.[71] This estimate is at odds with data from the 2016 TB Prevalence Survey, in which 17% of those previously treated for TB reported problems with adherence to treatment.[72] MDR-TB rates are high – estimated in 2016 at 2.6% among newly-diagnosed cases and 29% among previously treated cases.[73]

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[66] World TB Report 2017 (WHO) http://apps.who.int/iris/bitstream/handle/10665/259366/9789241565516-eng.pdf?sequence=1
[67] Idem
[68] National Tuberculosis Prevalence Survey 2016, op. cit.
[69] National Tuberculosis Prevalence Survey, Department of Health, Foundation for the Advancement of Clinical Epidemiology, Philippine Council for Health Research and Development, 2017
[70] Joint Tuberculosis Program Review, Philippines 2016, Department of Health, Philippines, 2016
[71] 2017 - 2022 Philippine Strategic TB Elimination Plan: Phase 1 (PhilSTEP1) available at http://www.philcat.org/PDFFiles/PhilSTEP1_PhilCAT_2017.pdf
[72] National Tuberculosis Prevalence Survey, 2016, op. cit., p. 122
[73] WHO Philippines Tuberculosis Profile 2016 available at https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=PH&LAN=EN&outtype=pdf

For TB prevention, an estimated 49% of newly-diagnosed PLHIV enrolled in care were being treated with isoniazid, and 5% of children aged under five years in households of confirmed TB cases were receiving preventive treatment.[74]

In relation to demand for health services by people with TB symptoms, there has been little improvement since 2007 – 43.4% of people with TB symptoms self-medicated in 2007 compared with 40.1% in 2016. The proportion taking no action despite symptoms was higher in the 2016 survey (41% compared to 25% in the 2007 survey). A higher proportion of individuals with symptoms in the 2007 study than in the 2016 study consulted a health worker (32% compared with 19%).[75] A qualitative study of reasons for self-medicating and not seeking healthcare among people living in poverty in highly urbanized areas cites seeing a cough as normal and having work-related time constraints as the main reasons.[76]

The previous NTP identified the following vulnerable populations: (a) rural/urban poor, (b) indigenous population, (c) those living in congested settings, (d) those in disaster-affected areas and (e) people with diabetes. People at higher risk also include people with HIV, smokers and children living in households with an adult with TB.

Overview of the policy, political and social context relevant to barriers to TB services

The national response to TB in the Philippines has been guided by a series of national strategies managed by the Department of Health (DOH). DOH Regional Offices manage TB at regional level through Regional NTP Teams. Provincial Health and City Health Offices are responsible at provincial and city levels. The current National TB Strategy, the *2017-2022 Philippine Strategic TB Elimination Plan* (PhilSTEP1), sets the following impact targets to be achieved by 2022: reducing TB deaths by 50% to 7,000 per year; reducing the TB incidence rate (no figure stated); reducing to zero the number of households experiencing catastrophic costs due to TB (from an estimated 35% of affected households in 2017); and increasing patient satisfaction with DOTS facilities to 90%.[77]

PhilSTEP1 continues the **ACHIEVE** Strategy set out in the previous NTP: **A**ctivate communities and patient groups; **C**ollaborate to reduce out-of-pocket expenses and expand social protection programs; **H**armonize efforts on human resources; **I**nnovate TB information generation and utilization; Enforce standards on TB care and prevention; **V**alue clients and patients through integrated patient-centered TB services; and **E**ngage local government units on multi-sectoral implementation of TB elimination plans.[78] PhilSTEP1 contains the following activities under the heading '*value clients and patients through provision of integrated client-centered services*: 1) Develop models for TB services with a focus on gender, human rights and patient-centeredness; and 2) Support DOTS facilities to provide TB services that are patient-centered, gender sensitive and human-rights promoting.'[79]

The specific objectives of the 2017 – 2022 NTP are to:

[74] Ibid.
[75] Ibid.
[76] Reyes, K. and Amores, J.C. *Barriers to Early TB Diagnosis among the Poor in Highly Urbanized Areas in the Philippines*, Philippines Institute for Development Studies, 2014
[77] 2017 –2022 Philippine Strategic TB Elimination Plan: Phase 1 (PhilSTEP1) op. cit.
[78] Ibid.
[79] Ibid.

1. Improve the utilization of TB care and prevention services by patients and communities
2. Reduce catastrophic cost of TB-affected households accessing DOTS facilities to zero
3. Ensure adequate and competent human resources for TB elimination efforts
4. Improve the use of TB data for effective TB elimination efforts
5. Guarantee that all TB diagnostic and DOTS facilities are complying with NTP standards and with adequate quality NTP products
6. Increase to at least 90% of DOTS facilities that are providing integrated patient centered TB care and prevention services
7. Enhance the capacities of all LGUs to implement localized TB elimination plan in coordination with different sectors.[80]

One of the four principles of the new NTP (PhilSTEP1) is the 'Protection and promotion of human rights, ethics and equity'.[81] PhilSTEP1 endorses the concept of integrated patient-centered care. Illustrative outcomes under NTP-endorsed USAID support for patient-centered TB care in the Philippines include:

- Vulnerable populations and target groups seek TB diagnosis and treatment
- Messages and approaches to detect, diagnosis and treat TB are evidence-based and tailored to take gender and other needs into consideration
- Community encourages target populations to adopt priority health-seeking norms and behaviours (i.e. cough hygiene and early identification of people with persistent cough)
- Local organizations, patient groups and private providers provide patient and gender-sensitive TB prevention, advocacy and support services to TB patients to improve treatment adherence
- TB patients and family members receive education and social assistance
- Stigma and discrimination against TB reduced
- Treatment interruptions and loss to follow-up reduced.[82]

The National TB Program is supported by an allocation of government funds combined with significant external funding from the Global Fund, USAID, the Japanese Ministry of Foreign Affairs, the Korean Foundation for Healthcare, the International Committee of the Red Cross and other groups. The Global Fund has been supporting the national TB program for more than ten years. The current Principal Recipient is the Philippine Business for Social Progress (PBSP).

Protective laws and policies

In April 2016 the Congress of the Philippines passed a new TB Law – the *Republic Act 10767 Establishing a Comprehensive Philippine Plan of Action to Eliminate Tuberculosis and A Public Health Problem and Appropriating Funds Therefor*[83]- under which TB is made a notifiable disease, Regional Centers are strengthened, TB education is to be provided in schools, and PhilHealth Insurance packages are to be expanded to include new, relapsed and return-to-treatment patients and an extension of treatment coverage.

The Implementing *Rules and Regulations* developed by the Department of Health following the passing of the new law set out in more detail the processes and

[80] Available at http://www.ntp.doh.gov.ph/
[81] 2017 –2022 Philippine Strategic TB Elimination Plan: Phase 1 (PhilSTEP1) op. cit.
[82] Request for Application (RFA) No. 492-17-00001, USAID Philippines, 2016, available at https://s3-us-west-2.amazonaws.com/instrumentl/grantsgov/296251.pdf
[83] Available at http://www.officialgazette.gov.ph/downloads/2016/04apr/20160426-RA-10767-BSA.pdf

timelines for implementing elements of the legislation.[84] The following are of particular relevance to this assessment:

- Conducting a baseline Training Needs Assessment (TNA) of health care providers, program staff, representatives of key affected populations and community volunteers
- Modifying existing training programs and building new ones, including the use of online learning platforms
- Integrating TB prevention, diagnosis, treatment, care and elimination in the curricula of health professional education institutions (HEI)
- Support to model centers to generate evidence, lessons and experience
- Empowering and engaging TB key affected populations (KAP) in program planning, implementation and service delivery, monitoring and advocacy
- Strengthening of the PhilHealth coverage package.

There are other more general laws and policies in the Philippines that protect people affected by TB. These include Article III of the Constitution of Philippines that provides a Bill of Rights including equal protection under the law for all. The *Magna Carta for Disabled Persons*[85] and the *Magna Carta for Women*[86] also provide protections that can be applied to people living with TB and to women.

The Philippines Public Attorney's Office (PAO) is a government institution that has a mandate "to provide the indigent litigants, the oppressed, marginalized, and underprivileged members of the society free access to courts, judicial and quasi-judicial agencies, by rendering legal services, counselling and assistance in consonance with the Constitutional mandate that 'free access to courts shall not be denied to any person by reason of poverty' in order to ensure the rule of law, truth and social justice as components of the country's sustainable development."[87] PAO services and standards are set out in a Citizens' Charter.[88]

In 2017, the Supreme Court of the Philippines issued a *Rule on Community Legal Aid Services*[89] setting out the Constitutional requirement for lawyers to provide *pro bono* legal services to people who would otherwise not be able to afford or access them. The particular groups identified for pro bono services are: indigent parties, pauper litigants and other persons of limited means; individuals, groups, or organizations unable to obtain free legal assistance because of a conflict of interest on the part of government-provided legal assistance through the Public Attorney's Office; and, public interest cases that have a societal impact. A wide range of legal services are prescribed under the rules including: legal representation in civil and criminal proceedings; mediation, conflict resolution and other representation in administrative cases; assistance to know and achieve rights; and, assistance with employment disputes.
The role of the PAO and the undertakings about access to free legal aid for particular populations are important for people living with TB and people from vulnerable populations who also fall into these groups that qualify for access.

Potential law and policy conflicts

[84] Implementing Rules and Regulations of Republic Act No. 10767 available at http://www.philcat.org/images/irr.pdf
[85] Available at http://www.ncda.gov.ph/disability-laws/republic-acts/republic-act-7277/
[86] Available at http://pcw.gov.ph/law/republic-act-9710
[87] Available at http://www.pao.gov.ph/page.php?id=19
[88] Available at http://www.pao.gov.ph/UserFiles/Public_Attorney's_Office/file/PAO%20Revised%20Citizen's%20Charter%20201 70522%20v1_2.pdf
[89] Available at http://sc.judiciary.gov.ph/pdf/web/viewer.html?file=/17-03-09-SC.pdf

Policies and practices that include registration and compulsory rehabilitation of people who use drugs serve as access barriers for people affected by TB from these populations as it becomes difficult for services to reach them and they are less likely to present themselves to health services. People who use drugs often live in crowded unhealthy environments that facilitate TB transmission.

Barriers to access to TB services

This section summarizes the information gained through the key informant interviews and focus group discussions conducted during this Baseline Assessment along with data from recent reviews and studies that indicate barriers to access to TB services. Services include preventive, diagnostic, local community support, financial support and treatment and care.

The main barriers to TB service access can be categorized under three main areas:

1. Barriers that prevent people with symptoms and people from vulnerable and high-risk populations from presenting at health services for testing and treatment
2. Barriers that prevent people from maintaining and completing their treatment regime, or from returning to clinics to re-enrol in treatment if they have had a treatment interruption – this applies to both DS-TB and DR-TB
3. Issues for particular populations – people with MDR-TB, children with TB and children at risk from family members with TB, people with HIV and TB, prisoners.

1. *Barriers that prevent people with symptoms and people from vulnerable and high-risk populations from presenting at health services for testing and treatment*

There is ample evidence in the Philippines that many people with TB symptoms do not understand the severity of the symptoms or the consequences of not seeking testing and appropriate treatment.

This was borne out in the key informant interviews, with health clinic managers reporting a high number of late presentations with advanced TB symptoms. Health seeking behaviour is shaped by many factors – lack of information, myths and beliefs about where diseases come from and how they can be treated; limited confidence in the health system; feelings of marginalization from community and community serves; fear of rejection, stigma, shaming or punishment by family and community; financial constraints – inability to afford transport to clinics, or the costs that are associated with illness an treatment, and of loss of income whilst on treatment; gender factors such as men's beliefs and practices in relation to seeking health care and pressure felt by women to put the health needs of children and other family members before their own. All of these factors appear to be at play in contributing to the under-diagnosis and under-treatment of TB in the Philippines.[90,91]

The issue of fear of disclosure of TB status is an important one for people with TB. Focus group participants reported travelling to clinics outside their barangay for testing to ensure that their results would be confidential, incurring unnecessary transport costs, with some not returning for results or for treatment. They were

[90] Ibid.

[91] Kiesel, R. and E. Rottach. 2014. The Fade-Away Effect: Findings from a Gender Assessment of Health Policies and Programs in the Philippines. Washington, DC: Futures Group, Health Policy Project.

aware of how information about TB travels in their community, and of the stigma that other individuals and families had experienced in their community. They knew of people losing their jobs, either temporarily due to treatment demands or permanently due to illness or discrimination.

2. *Barriers that prevent people from maintaining and completing their treatment regimen, or from returning to clinics to re-enrol in treatment if they have had a treatment interruption – this applies to both DS-TB and DR-TB*

There are significant barriers that prevented people from maintaining treatment, or from returning to clinics to re-enrol in treatment if they have had a treatment interruption. These apply to both DS-TB and DR-TB, but with different intensity in some cases. These include:

- Fear of stigma, discrimination, rejection, isolation

People in focus groups who were currently on or had dropped out of TB treatment reported their own experience or stories they had heard of people being rejected, isolated, shamed and discriminated against because of their known or perceived TB status. Some reported being rejected from their family either permanently or temporarily, being isolated within community, or being isolated within prisons into cells with fewer privileges. Families reported being the talk of their community and feeling 'dirty' and isolated.

- Lack of support for side effects

Many of the focus group members who had stopped their TB treatment (both DS-TB and DR-TB) reported that insufficient assistance and concern from healthcare workers about how to manage their side effects was their primary reason for stopping treatment. They felt that the time given to them in consultations did not allow for any real discussion of what they were experiencing. Queues were long, healthcare workers were often absent, late or too busy to spend time with them and they felt generally rushed. They felt that their concerns about side effects were dismissed – 'they won't last long', 'everyone has them' – and they were not provided with solutions or remedies.

This was combined with poor information about the ramifications of stopping treatment. Many reported that they had been told to complete treatment, but did not really understand why, or what might happen if they stopped, except that they would 'be in trouble with the healthcare worker.' Many did not understand the connection between stopping treatment for DS-TB and the development of DR-TB. Many with DR-TB did not understand the severe consequences of under-treated DR-TB. Most had not seen, or could not remember reading IEC materials to help explain TB treatment or side effect management.

- Attitudes of health care workers

Many of the focus group attendees who had ceased treatment before completing it reported that the main reason for not returning to treatment after their treatment interruption was that they feared the response they would receive from the healthcare worker when they returned. They feared being shamed in public and blamed for not completing and did not think that they were welcome back. Some reported being shouted at and being shamed about their coughing. Others reported borrowing money for transport to clinic only to find that the healthcare workers were late, or did not come, or did not have medications for them. Some reported that they travelled long distances at extra cost to avoid their local health center as they knew

that it had problems and they feared that local staff would discuss their diagnosis in the community.

These findings accord with the findings of (relatively few compared with HIV) studies and commentaries that examine the stigma associated with TB and the relationship between TB patients and clinics.[92,93,94]

Program reviews have identified examples of TB Patient Charters and Treatment Contracts with people with TB that set out rights and responsibilities of patients and health services.[95] The use of AIDERS (Accelerating Implementation of DOTS Enhancements to Reach Special populations) in geographically isolated and disadvantaged areas has improved the connection between health clinics and people at risk, people on TB treatment and people who have ceased treatment before completing. Pressure on health clinic staff leaves them little time to travel into community, and AIDERS have been able to fill this gap.[96]

There have been complaints from individuals and by MDR-TB support groups about discrimination in general health services experienced by people with MDR-TB. One complaint concerned the death of a woman who had been treated for MDR-TB and who presented in labor to an NCD clinic, was shamed and refused birthing care, and was also refused ambulance assistance to travel to another hospital.[97]

- Clinic operating hours and general systems

There were many complaints about the quality, convenience and general functioning of public clinics. These included inconvenient opening times (particularly for people in employment, and more particularly for people in informal occupations who had little control over their working hours and had to present early each morning to secure work); long queues, often waiting for staff to arrive or for clinic to start; pressure to pay 'extra charges' even though they believed that treatment was free, lack of privacy, particularly at registration desks and in waiting rooms, segregation (and hence identification) of people with TB in 'special' waiting areas, lack of time to ask questions or discuss issues and general unfriendly or inconsiderate practices. Many of focus groups participants with TB who had ceased treatment cited these as key reasons for stopping their treatment.

- The cost of protecting privacy

Financial burden is a significant issue affecting the success of TB treatment. Whilst the new NTP aims to ensure that by 2022, 80% of people with TB who are under the National Household Targeting System (NHTS) for Poverty Alleviation are accessing social protection programs and that no people are experiencing of catastrophic costs, the current WHO TB Profile estimates that 35% of people with TB will have faced catastrophic total costs in 2017.[98]

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[92] Aguilar, F.V., *Targeting Tuberculars: Social Stigma and Public Health Campaigns*, Philippine Studies 57, No 2 (2009)

[93] Reyes, K. and Amores, J.C. *Barriers to Early TB Diagnosis among the Poor in Highly Urbanized Areas in the Philippines,* op. cit.

[94] Riveria, K., Fighting TB by overcoming stigma, available at https://reliefweb.int/report/philippines/philippines-fighting-tuberculosis-overcoming-stigma

[95] Joint Program Review of Rural Health Units and Barangay Health Workers, 2016

[96] Joint Tuberculosis Review, 2016 op. cit., p. 46

[97] Samahan NG Lusog Baga Association Inc correspondence with DoH, September 2017

[98] WHO Philippines Tuberculosis Profile 2016, op cit; 2017 –2022 Philippine Strategic TB Elimination Plan: Phase 1 (PhilSTEP1) op cit

Some people with TB who have ceased treatment reported in focus group discussions that cost of transport to clinics, extra diagnostic tests and some add-on costs levied by services were a significant factor in their decision to stop treatment. Financial burden on families due to loss of income was also a factor. This is also reflected in other studies.[99]

Some additional costs are connected to lack of confidence in privacy or quality of service sat local clinics. People TB patients reported travelling to another clinic away from their Barangay to ensure privacy. Others reported going to private clinics to protect their privacy (and to obtain better quality service) only to find that they could not complete their treatment because of additional costs associated with being treated privately.

Some were aware of the PhilHealth financial support and also food packages and other financial support provided through the TB PR, but reported that other patients they know did not seem to know about or access these support packages. There were also reports in the focus groups that different clinics applied different PhilHealth rules or allowances. The newly-updated TB Law and the rules developed to support its implementation call for improvements in the level of PhilHealth cover for TB.

3. Issues for particular populations

- People with Drug Resistant TB

This issue of cessation of treatment due to side-effects was a particularly issue for people with DR-TB in the focus groups. They reported receiving little support for side effect management and did not seem to have a clear understanding of the ramifications of stopping their DR-TB treatment. Programmatic Management of Drug Resistant TB (PMDT) has been in place in the Philippines since 2000. Integration of PMDT into DOTS services of health facilities (iDOTS) has been in place since 2013. Despite these clear advances, the gap between the diagnosed and treated people with DR-TB has widened for 5% in 2013 to 12% in 2015.[100] People with DR-TB in the focus groups reported that they felt particularly stigmatized by healthcare workers in other (non-TB) health clinics if they needed general health care.

- Children with TB and children at risk

Key Informants raised issues in relation to children with TB and children at risk. Almost 35% of the population of the Philippines is under 15 years of age.[101] Though this did not come up in our focus groups, the 2016 Joint Program Review pointed out a set of issues in relation to TB prevention and care in children including poorly differentiated data between isoniazid prevention therapy (IPT) and treatment, lack of healthcare worker experience in treating children with TB, low coverage levels of ITP among children living in households with another person with TB (5% coverage in children less than five years of age).

- TB/HIV

The TB and HIV national programs have been involved in expanded joint activities since the 2013 Joint Program Review. In 2015, around 84% of people living with HIV

[99] Reyes, K. and Amores, J.C. *Barriers to Early TB Diagnosis among the Poor in Highly Urbanized Areas in the Philippines,* op cit

[100] Joint Tuberculosis Review, 2016 op cit p. 55

[101] Available at http://countrymeters.info/en/Philippines#age_structure

visiting HIV treatment hubs were tested for TB.[102] In 2016, around 50% of people living with HIV were on IPT.[103] There is evidence of insufficient technical training on TB among service providers in HIV treatment hubs, with the Joint Review indicating that doctors were unsure about switching TB medications when people with HIV experienced drug-induced jaundice. Some doctors also did not prescribe IST as they did not believe that it worked.

- Prisoners

The Baseline Assessment involved several focus group discussions with prisoners with TB, including some with MDR-TB. Many had ceased treatment, as prisons had become increasingly more crowded (partly as a result of the National Drugs Policy), and this meant long queues for food, water and another essentials as well as for medicines and health care. Some resented the loss of privileges associated with being moved to a TB cell and preferred to stop treatment to return to general privileges. Some were concerned about privacy, particularly as people from their barangay were inmates or staff and they thought their privacy would be breached if they were on TB treatment.

Programs to address rights-related barriers to HIV services – proposed elements of a comprehensive program

Similar to HIV, it was not possible to identify specific initiatives directly aimed at addressing rights-related issues faced by people with and/or affected by TB in the Philippines. The national TB program and TB control in the country have traditionally followed a medical, formalized approach with community involvement limited to awareness-raising and referral. One of the key initiatives of the National TB Plan (NTP) over the years has been community TB care, community TB task Forces and ACSM which directly involved communities as educators, source of referrals and as treatment partners. This is reflected in the latest TB Manual of Procedures (MOP 5th), wherein community health teams (which includes Barangay Health Workers (BHW) organized to support health facilities) are organized.

The national TB program has been supported in TB control primarily by USAID/Philippines and the Global Fund.

- USAID/Philippines's five-year (2012-2017), *Innovations and Multi-Sectoral Partnerships to Achieve Control of TB* (IMPACT) project "engages both public and private sectors at the national level to detect and successfully treat people with TB, provides technical assistance to the DOH National TB Control Program and works directly with 43 provinces and cities throughout the country." The project has recently ended and is planned to be followed up by two new projects: 1) a $30 million project, *TB Innovations and Health Systems Strengthening* (2018-2023) awarded to FHI 360; and 2) a $20 million project, *TB Platforms for Sustainable Detection, Care and Treatment* (2018-2023) which has not yet been awarded.[104]
- The Philippine Business for Social Progress (PBSP) has been supported by the Global Fund since 2010 when it was selected to take over management of the existing TB Rolling Continuation Channel (RCC) grant. PBSP has continued

[102] Joint Tuberculosis Review, 2016 op. cit., p. 69
[103] WHO Philippines Tuberculosis Profile 2016, op. cit.
[104] Information available at https://www.usaid.gov/philippines/health/impact

its efforts to support the national TB program through a four-year (2014-2017) Global Fund TB grant.

This section highlights key activities to address rights-related barriers and sets out recommendations for a comprehensive program to reduce these barriers to TB services. Information is organized under the Program Areas set out in the Global Fund Technical Brief *Tuberculosis, Gender and Human Rights*.[105]

PA 1: Reducing stigma and discrimination
PA 2: Reducing gender-related barriers to TB services
PA 3: TB-related legal services
PA 4: Monitoring and reforming policies, regulations and laws that impede TB services
PA 5: Know your TB-related rights
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents
PA 7: Training of health care workers on human rights and ethics related to TB
PA 8: Ensuring confidentiality and privacy
PA 9: Mobilizing and empowering patient and community groups
PA 10: Programs in prisons and other closed settings

PA 1: Reducing stigma and discrimination

Existing/recent programming and outcomes to date:
The national TB program employs the AIDERS strategy – Accelerating Implementation of DOTS Enhancements to Reach Special Sub-Groups – which aims to bring TB services to Geographically Isolated and Disadvantaged Areas (GIDA) in the country. AIDERS are trained healthcare workers who are deployed to GIDA areas and provide TB services. Their presence in the communities helps to correct misinformation about TB, thus indirectly reducing stigma and improving community acceptance of people with TB.

The USAID-supported CHANGE project (2013-2018) supported three nationwide TV campaigns on TB that reached over 17 million target individuals per campaign, contributing to increasing demand for TB services.[106] These TV campaigns were aimed at raising general awareness about the signs and symptoms of TB, encouraged testing and treatment adherence and essentially helped to normalize TB as a curable disease. While not measured, those working on TB control in the country regarded the campaigns as generally helpful in reducing stigma related to the disease.

The Global Fund project conducted activities to reduce stigma around TB through organized interactions with people affected by the two diseases, survivors of MDR-TB and PLHIV and staff from Programmatic Management of Drug-resistant TB (PMDT) facilities, HIV treatment hubs, satellite treatment hubs, Social Hygiene Clinics, provincial coordinators, Category A and B areas, high prevalence municipalities for HIV, low performing LGUs for TB, and private practitioners.

PA 1 RECOMMENDATIONS

Many of the activities under the other PAs below have the additional effect of reducing stigma and discrimination. Improving attitudes and behaviors in health clinics for example will go a long way to reducing stigma and discrimination and

[105] Technical Briefs *HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017);
[106] Information available at https://www.usaid.gov/philippines/health/change

other factor behind the cessation of TB treatment cited by people with TB in the focus groups.

The following recommendations are made to move towards comprehensive programming in reducing stigma and discrimination experienced by people with and affected by TB.

PA 1.1: Establishment of a national hotline to provide basic TB information and as a place for people to report service access/quality problems and stigma and discrimination related to TB

This is connected to PAs 3 and 5 below. There is no single, confidential access point for basic information about TB for people with symptoms and for people with TB who are experiencing difficulties with treatment or in accessing supportive, high-quality health services. The availability of basic TB information and referrals will assist people with symptoms to understand treatment options and find the services they need (including legal and social protection services) and also assist people on TB treatment who for some reason have become disconnected from services to reconnect. It would be hosted by an NGO working closely with the DOH so that it could feed information about complaints and service access problems back into the program design and delivery system. It could also refer people to redress mechanisms such as local complaints mechanisms and legal services.

Proposed sub-activities and responsibilities Partners: DoH, implementing NGO	
Operational/cost elements	*Agency*
1. Set-up, protocol development, guidance documents, staff training	Consultant, NGO
2. Establish and run the free-call phone service	NGO, legal services

PA 1.2 implementation of TB stigma assessment

There is little information available about the exact nature of discrimination against people with TB and families affected by TB. Better information would assist in guiding the development of strategies to reduce specific discrimination. There are reports about discrimination in health services, particularly experienced by people with MDR-TB.
It is recommended that a TB stigma assessment be implemented twice in the time of the 5-year strategy.

Proposed sub-activities and responsibilities Partners: DoH, PBSP, NGOs	
Operational/cost elements	*Agency*
1. TB stigma assessment methodology agreed upon	Consultant
2. Carrying out TB stigma assessment	NGO/Consultant/DoH, PBSP

PA 1.3 Support from religious leaders for TB compassion and care

Religious leaders can play a key role in 'normalizing' TB in the community, assisting people with symptoms to feel comfortable to seek care and assisting communities to be more compassionate and less discriminatory towards individuals and families affected by TB. A national coalition of religious leaders will be established to provide a reference group for the development of strategies and messages to integrate attention to TB and care for people affected by TB into their religious care programs

and into their ministry and engagement with congregations and followers. This should be integrated where possible with the recommendation in the HIV section.

Proposed sub-activities and responsibilities Partners: DoH, PBSP, Religious leaders, Support NGO	
Operational/cost elements	*Agency*
1. Establish a coalition of religious leaders to develop messages and strategies	Religious leaders, NGOs
2. Support activities – including training for support staff, events	Religious leaders, support NGO

PA 2: Reducing gender-related barriers to TB services

Existing/recent programming and outcomes to date:
The National Tuberculosis Prevalence Survey 2016 found that TB prevalence among males is nearly three times higher than in females. The Joint Tuberculosis Program Review 2016 did not identify specific gender-related barriers to TB services, but recommended that the "NTP should systematically collect, analyze and use data that are disaggregated by sex, age, geographical location and population group in order to develop specific targets for different vulnerable groups." In interviews, some voiced the need to provide TB services for men who work in offices and recommended establishing something similar to "sundown" clinics for PLHIV and key populations. It was noted that TB services targeted towards women are needed but less so because women tend to have more interactions with the health system due to pregnancy and child health visits and are therefore captured more frequently.

USAID has conducted a gender assessment, which is expected to be ready for release end April and will be used to inform a gender-related approach for the new TB Innovations project implemented by FHI 360.

No existing programs that specifically addressed gender and TB were identified, though this is a key performance target of the PhilSTEP: 90% of DOTS facilities are adapting gender sensitive, non-discriminatory and patient-centered services

PA 2 RECOMMENDATIONS

Men are the most affected (particularly smokers) and they generally have poor health seeking behavior. There is a need to find ways to make health checks routine for men and promote men's health. Office workers find it difficult to access clinics during working hours, or to find public clinics that are open after-hours. People in informal or casual employment find it particularly difficult to access clinics as it involves loss of wages for time off.

PA 2.1 Support for the recommendations of the TB gender assessment

Women bear the burden of care (and loss of household income if men are on treatment and unable to work) – strategies to support women, particularly in assisting their male partners to complete treatment. USAID has recently conducted a TB gender assessment (the report is still in preparation). Funds are set aside here to take forward the priority recommendations of this assessment.

Proposed sub-activities and responsibilities Partners: DoH PBSP, TB groups	
Operational/cost elements	*Agency*
1. Support for policy/program change	DoH, PBSP

2. Piloting targeted interventions	DoH, Implementing agency

PA 3: TB-related legal services

Existing/recent programming and outcomes to date:
Activities focused on providing TB-related legal services were not identified. Stories of MDR-TB patients being refused treatment by nurses at local clinics and told that they have to go to a specialized MDR-TB treatment facility were raised in interviews. In the absence of a legal redress mechanism, these cases go unaddressed. There were reports of people with TB accessing the Commission on Human Rights mobile legal clinics in some provinces, but little data is available on activity levels, cost or outcomes.

PA 3 RECOMMENDATIONS

PA 3.1: Strengthening the connection between TB groups and legal services

This involves facilitating round tables between services, then trainings provided by lawyers and paralegals for TB community group staff and volunteers.

TB community groups with significant reach will be identified in several provinces and supported with paralegal services. These groups will use the regionally-developed HIV Community Legal Centre model to establish part-time legal services in community legal groups (with referral to community legal centers for more complex assistance). Where possible, this should be integrated with activities recommended in the HIV section above.

Proposed sub-activities and responsibilities Partners: Legal services (large firms with pro-bono component, community legal services), TB groups	
Operational/cost elements	*Agency*
1. Round tables in selected provinces where appropriate legal services exist	Community and private legal services, TB groups
2. Payment for legal service staff to provide in-service training in TB community groups	Community and private legal services, TB groups
3. Placement of paralegals in TB community groups	Community or private legal services, TB Groups
4. Alliance-building with alternative law groups to work with NGOs on rights proportion (fund the NGOs and pay legal groups for planning meeting, development of combined services	Alternative law groups, NGOs, TB groups

PA 3.2: Integration of greater attention to issuers of TB in Legal Aid provided by Philippine Public Attorney's Office

The Philippine Public Attorney's Office (public legal aid provider in all provinces) will be assisted to identify ways to bring greater attention to TB (and HIV) issues and remedies – could be achieved by funding a position in the PAO national office with some funds for roundtables, workshops, development of relevant materials.

Proposed sub-activities and responsibilities Partners: Philippine Public Attorney's Office, PBSP	
Operational/cost elements	*Agency*

1. Identification of entry-points into training and operations of Philippine Public Attorney's Office legal aid system	Consultant, Philippine Public Attorney's Office, PBSP
2. Development of guidance materials to increase awareness of TB (and HIV) issues for legal aid	Consultant, Philippine Public Attorney's Office, PBSP
3. Pilot greater collaboration and integration in selected provinces, evaluate, disseminate results	Consultant, Philippine Public Attorney's Office, PBSP

PA 3.3: Greater attention to TB issues in mobile legal clinics

HIV/general population mobile legal clinic services provided by the branches of the Commission on Human Rights (or other mobile legal clinic providers) will be assisted to integrate greater attention to TB issues and to provide support to people affected by TB.

Proposed sub-activities and responsibilities Partners:	
Operational/cost elements	*Agency*
1. Identification of entry-points – legal clinic roll-out and scale-up	CHR or other implementing agency

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

Existing/recent programming and outcomes to date:
The national TB program and related government agencies have developed a number of guiding documents and policies for the control of TB, TB/HIV and MDR-TB in various settings. However, efforts by USAID to monitor implementation have revealed that in some areas, doctors are not diagnosing and treating according to international or national standards. Reports of MDR-TB patients being refused treatment at some health clinics imply a need to improve understanding of the guidelines. In addition, reports of employers refusing to hire candidates based on X-ray results which do not necessarily mean the candidate has TB indicate a need to educate employers about TB.

PA 4 RECOMMENDATIONS

PA 4.1: Community monitoring/feedback mechanism between TB groups and DoH/provincial health on standards of care and treatment

Linked to PA 10 below and to the telephone reporting system in PA 1. This will involve the establishment of a standardized mechanism for TB groups to feed directly from their constituents to provincial and national (and private providers) breaches of national standards or guidelines in relation to the diagnosis and treatment of people with TB, including discriminatory exclusion from services. Local problem solving will be prioritized, but implications for national guidance and intervention also identified.

Proposed sub-activities and responsibilities Partners: NGO, TB groups, DoH, Provincial Health Authorities	
Operational/cost elements	*Agency*
1. Working group to establish mechanism	NGO, TB groups

2. Development of feedback protocols, toolkit for TB community groups, training materials e-training	NGO, TB groups
3. Development of local health advisory groups (linked to HIV initiatives above)	NGO, TB groups

PA 4.2: Access to TB diagnosis and treatment for minors – particularly those not living with parents

Establishment of a working group to clarify consent and treatment issues for minors to prepare materials to assist in more consistent implementation of minors' consent policies. This should be carried out in collaboration with the HIV program as it affects both HIV and TB.

Proposed sub-activities and responsibilities Partners: UNICEF, DoH, Provincial Health Authorities	
Operational/cost elements	*Agency*
1. Working group to identify and clarify policies, provincial round tables, development and dissemination of materials	UNICEF, DoH, Provincial Health Authorities

PA 5: Know your TB-related rights

Existing/recent programming and outcomes to date:
Activities focused on educating communities about their TB-related rights were not identified. Rather, community organizations supported by PBSP, USAID and the DOH focus on general awareness-raising aimed at increasing case finding and referrals to health facilities for TB testing.

PA 5 RECOMMENDATIONS

PA 5.1: Communication materials on rights and TB

Linked to PA 4.1 above. Plain-language gender-sensitive materials on TB rights, quality of service standards, appropriate behavior by health-care workers, employers and others will be developed, tested and disseminated.

Proposed sub-activities and responsibilities Partners: DoH, PBSP, TB groups, communication agency	
Operational/cost elements	*Agency*
1. Development of materials on TB rights	DoH, PBSP, TB groups, communication agency

PA 5.2: Training and coaching for TB patient groups on rights approach, rights promotion, negotiation

Linked to PA 3 above and PA 9 below. Training materials, training and follow-up coaching for TB groups to increase understanding across communities about the Patients' Charter, health standards, patient rights and how to make complaints. Materials will contain information on PhilHealth and other benefit/financial coverage schemes.

Proposed sub-activities and responsibilities Partners: TB groups, NGO, legal services	
Operational/cost elements	*Agency*
1. Materials development (plain language, comic style) for community and Patient Charter/standards posters for clinics	DoH, TB groups, NGO, legal services

2. Training and on-going coaching for TB groups	DoH, TB groups, NGO, legal services

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

Existing/recent programming and outcomes to date:
Activities focused on sensitizing law-makers were not identified.

PA 6 RECOMMENDATIONS

None identified.

PA 7: Training of health care workers on human rights and ethics related to TB

Existing/recent programming and outcomes to date:
The PBSP and USAID projects both include healthcare worker training components aimed at improved case-finding, support for people on TB treatment, compliance with national guidelines and improved quality of care. Support will be provided to ensure that training materials contain practical information on rights, standards for ethical behaviour and reinforcement for the connection between client-centered health care and treatment adherence.

PA 7 RECOMMENDATIONS

PA 7.1: Development of a set of materials to better define and support patient-centered care

This activity refers back to TB focus group information about the reasons for ceasing treatment and being reluctant to return to clinics for re-commencement. Clients wanted assistance and support to manage side effects and a supportive, encouraging, non-punitive environment if they returned after a treatment break. Changes in health worker practice are rarely brought about by training alone. They require standard setting and policing, coaching and support, good human resource management and a commitment to quality patient care.

Proposed sub-activities and responsibilities Partners: USAID, DoH, PBSP, TB groups	
Operational/cost elements	*Agency*
1. Development of plain-language explanations, practice notes and case studies on client-centered care for people with TB	PBSP, TB groups

PA 7.2: Integration of attention to ethics and rights in all TB training and coaching provided to health workers

This activity includes pre-service, in-service, continuous medical education, public and private sector training and will promote a follow-up on-the-job coaching methodology. There will be a focus on client-centered care and on MDR-TB to ensure a reduction in stigma and discrimination experienced by people with MDR-TB in general health services. Focus group participants complained about systems in clinics that prevented them from getting private, quality time with health workers so that they could discuss the problems they were experiencing. In addition to integrating this into TB curricula in general health worker training and coaching, the toolkit

developed in PA 4.1 above, a tool will be developed to assist clinics to examine systems that affect patient privacy, patient flows, consultation time and care quality. Links to PA 8 below.

Proposed sub-activities and responsibilities Partners:	
Operational/cost elements	*Agency*
1. Scan of entry-points for TB content in pre- and in-service health worker training	Consultant, working group
2. Development of modular training materials for integration	Consultant, working group
3. Familiarization workshops	NGO, TB groups
4. Development of clinic system scanning tool, testing, dissemination	NGO, health systems group

PA 8: Ensuring confidentiality and privacy

Existing/recent programming and outcomes to date:
Under the Global Fund RCC grant, PBSP initiated the creation of an Integrated TB Information System (ITIS), which "aims to establish a standardized recording and reporting framework that will be web-based and have the capability to update records in real time."[107] ITIS is now functional and is currently being piloted. Health care workers across all levels of the TB control system have been trained on its use. However, who has access to what data and issues of protecting confidentiality and privacy of patient records are pending issues in need of clarity and decision – and eventually policies, guidelines and further training of healthcare workers.

PA 8 RECOMMENDATIONS

PA 8.1: Promotion of systems that protect privacy

This activity responds to the many complaints in focus groups about confidentiality and privacy. Fears about a lack of privacy cause people to travel to distant services to avoid being recognized in local services, and cause loss to follow-up. This will involve the development of materials (print and web) on privacy and confidentiality in health care and in human resource management in employment. Strategies to enhance privacy in health clinics and in the health services provided in prisons will be addressed in broader activities in PA 7.2 above.

Proposed sub-activities and responsibilities Partners:	
Operational/cost elements	*Agency*
1. Development of materials (print and web) on privacy and confidentiality in health care and in human resource management in employment.	DoH, communication agency, TB groups
2. Privacy included in clinic system scan in PA 7.2 above	

PA 9: Mobilizing and empowering patient and community groups

Existing/recent programming and outcomes to date:

[107] Breaking New Ground: Sustaining TB Control and Ensuring Access to Comprehensive TB Care Project – Accomplishment Report 2010 to 2011. Philippine Business for Social Progress (PBSP).

Community groups have been a main partner of the national TB program and donor-supported TB projects. The PBSP-managed Global Fund project supported the creation of TB patient groups to provide existing TB patients with support and encouragement to stay the course with treatment. The project also supported community groups as important and consistent partners in awareness-raising activities, active case finding, advocacy and treatment of TB patients. Strategies to improve coordination and communication between groups will assist in strengthening advocacy.

PA 9 RECOMMENDATIONS

PA 9.1: Advocacy materials and skills-building for patient groups

TB groups can play a key role in improving service quality, in keeping people on TB treatment connected with clinics, and in reducing stigma and discrimination related to TB. They can also assist to mobilize barangay-level support for families affected by TB. This component will involve the development of advocacy materials for TB groups – assisting them to maintain a constructive engagement with provincial, city and local-level health systems.

Proposed sub-activities and responsibilities Partners: TB groups, DoH, PBSP	
Operational/cost elements	*Agency*
1. Development of advocacy training materials	TB groups, DoH, PBSP
2. Advocacy skills training curricula and training and coaching in TB groups	TB groups, DoH, PBSP

PA 9.2: Exploration of models of TB peer involvement in multi-disciplinary teams for case-finding, adherence support

There are models in HIV clinical care of PLHIV involvement in multi-disciplinary teams to assist in treatments literacy and adherence support. These will be adapted and trialed in TB clinics. This cadre will also be trained in community engagement to reduce stigma and increase community care and support.

Proposed sub-activities and responsibilities Partners: TB groups, DoH, PBSP	
Operational/cost elements	*Agency*
1. Exploration of extended role for TB patient peer supporters	TB groups, DoH, PBSP
2. Advocacy skills training curricula and training and coaching in TB groups	TB groups, DoH, PBSP
3. Health human resources/employment policy analysis and development to embed this role in local level health budgets for sustainability	DoH

PA 10: Programs in prisons and other closed settings

Existing/recent programming and outcomes to date:
In the Philippines, prisoners have been identified as a vulnerable population for TB. A pilot project for the management of TB in the Quezon City Jail was implemented by the International Committee of the Red Cross (ICRC) in partnership with the Philippine Bureau of Jail Management and Penology (BJMP).[108] Under its Global Fund RCC grant, PBSP supported the establishment of a new drug-resistant TB

[108] Available at https://www.icrc.org/en/document/philippines-pilot-project-improves-tb-control-quezon-city-jail

treatment center in the Quezon City Jail. These efforts have been recognized as good models in the management of TB and DR-TB among prisoners in the Joint TB Program Review of 2016. Results from these pilots were used to inform the update of DOH policy on TB control in jails and prisons in 2015. This will involve the review of results to date and advocacy for a scale-up plan.

PA 10 RECOMMENDATIONS

PA 10.1: Advocacy for improvements of TB diagnosis and care in prisons (linked to HIV)

This activity involves convening people working in TB and in prisons health to determine strategies to improve access to health for people with TB (and with HIV) in prisons, particularly in relations to the stigma associated with treatment and diagnosis and the lack of privacy that are causing people with TB and/or HIV to cease their treatment.

Proposed sub-activities and responsibilities Partners: DoH, DoJ, STC, PBSP, HIV & TB groups	
Operational/cost elements	*Agency*
1. Work with DoJ to develop a plan for the scale-up of successful models fore improved TB (and HIV) care in prisons and other closed settings including long-term drug rehabilitation	DoH, DoJ, STC, PBSP, HIV & TB groups
2. Facilitate a national conference on HIV and TB in prisons and other closed settings	DoH, DoJ, STC, PBSP, HIV & TB groups

2016 TB investments and proposed comprehensive program costs

The latest WHO TB Country Profile for the Philippines indicates that the national TB budget is US$104 million of which 19% is from domestic sources, 53% from international sources and the remaining 28% is unfunded. Contributions from international sources have increased steadily since 2013. The 2016 Joint Tuberculosis Program Review found that 60% of the NTP budget is for procurement with another 26% to support TB control in the various Regions of the country. The JPR also noted a heavy reliance on the Global Fund particularly around human resources, which raises flags for sustainability.

It is estimated that a total of US $440,000 was allocated in the Philippines to reduce barriers to TB services. Major funders in 2016 were as follows: [109]

Funding Source	**Amount**
USAID	$ 245,000
Global Fund	$ 195,000
Total	**USD 440,000**

The table below allocates that funding to Program Areas – though many programs do not fit neatly within one area. As explained above, the national TB program and other donor-funded programs are designed and implemented as fully comprehensive

[109] It is difficult to accurately estimate these figures as the barriers reduction content area is often embedded in a broader program – for example, the TB television campaign advertisements covered basic TB symptoms and services, so only a proportion of costs is included.

programs that focus primarily on diagnosis and treatment with wraparound support by civil society and community-based organizations to conduct general awareness-raising, active case finding, referral and treatment adherence support. Specific activities and associated costs related to the human rights PAs for TB were difficult to extrapolate from these large, comprehensive programs. The table below presents estimates of activities that were found to address the various PAs.

TB Service Access Barriers Program Area	**2016 allocation**
PA 1: Stigma and discrimination reduction	$95,000
PA 2: Reducing gender-related barriers to TB services	$0
PA 3: TB-related legal services	$10,000
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	$25,000
PA 5: Knowing your TB-related rights	$15,000
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	$50,000
PA 7: Training of health care providers on human rights and medical ethics related to TB	$120,000
PA 8: Ensuring confidentiality and privacy	$60,000
PA 9: Mobilizing and empowering patient and community groups	$50,000
PA 10: Programs in prisons and other closed settings	$15,000
Total	**$440,000**

Costs for the recommended interventions for the five-year comprehensive program set out are set out in the table below. Details of yearly budgets are set out in the main report below and costing information is available in Annex 4.

TB Service Access Barriers Program Area	**Total**
PA 1: Stigma and discrimination reduction	$949,218
PA 2: Reducing gender-related barriers to TB services	$500,000
PA 3: TB-related legal services	$1,654,772
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	$239,384
PA 5: Knowing your TB-related rights	$324,891
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	$0
PA 7: Training of health care providers on human rights and medical ethics related to TB	$229,343
PA 8: Ensuring confidentiality and privacy	$10,468
PA 9: Mobilizing and empowering patient and community groups	$68,900
PA 10: Programs in prisons and other closed settings	$105,532
Total	**$4,082,528**

TB Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction	$211,645	$177,459	$177,459	$205,198	$177,4599	$949,218
PA 2: Reducing gender-related barriers to TB services	$100,000	$100,000	$100,000	$100,000	$100,000	$500,000
PA 3: TB-related legal services	$370,337	$321,109	$321,109	$321,109	$321,109	$1,654,772
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	$133,444	$51,355	$18,862	$18,862	$18,862	$239,384
PA 5: Knowing your TB-related rights	$109,640	$53,813	$53,813	$53,813	$53,813	$324,891
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	$0	$0	$0	$0	$0	$0
PA 7: Training of health care providers on human rights and medical ethics related to TB	$126,730	$23,962	$42,345	$8,962	$27,345	$229,343
PA 8: Ensuring confidentiality and privacy	$10,468	$0	$0	$0	$0	$10,468
PA 9: Mobilizing and empowering patient and community groups	$68,900	$0	$0	$0	$0	$68,900
PA 10: Programs in prisons and other closed settings	$52,766	$0	$0	$52,766	$0	$105,532
Total	**$1,181,930**	**$727,697**	**$713,586**	**$760,709**	**$698,586**	**$4,082,528**