National Situational Assessment on HIV Financing in Indonesia, Malaysia, Thailand & Philippines
SHIFT Program, 2017

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Acronyms

ACHIEVE	Action For Health Initiatives, Inc.
AFAO	Australian Federation of AIDS Organisations
APCASO	Asia Pacific Coalition of AIDS Service Organisations
APCOM	Asia Pacific Coalition on Male Sexual Health
CCM	Country Coordinating Mechanism
CRM	CSO resource mobilisation platform
CSO	Civil society organisation
FPM	Fund Portfolio Manager
GAPR	Global AIDS Progress Report
GDP	Gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency syndrome
IAC	Indonesian AIDS Coalition
IDR	Indonesian Rupiah
M&E	Monitoring and evaluation
MAC	Malaysian AIDS Council
MOH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NGO	Non-governmental organisation
NHSO	National Health Security Office
PHP	Philippines Peso
PLHIV	People living with HIV
PNAC	Philippines National AIDS Council
PR	Principal recipient
PWID	People who inject drugs
RM	Malaysian Ringgit
SDG	Sustainable Development Goals
SHIFT	Sustainable HIV Financing in Transition
SR	Sub-recipient
STC	Sustainability, transition and co-financing
THB	Thai Baht
TG	Transgender people
TNAF	Thai National AIDS Foundation
UHC	Universal health care
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV
USD	United States Dollar

Executive Summary

The National Situational Assessment assesses the availability and sufficiency of HIV financing resources, as well as how resources are equitably and efficiently allocated in Indonesia, Malaysia, Thailand and Philippines. By providing a current snapshot on HIV financing in the 4 SHIFT countries, the assessment outlines HIV expenditure against HIV epidemiology, identifies national HIV financing mechanisms, and describes national budget cycles and processes where available. The following summary of findings provides an overview of the key themes across the four countries.

Key Findings

I. Increasing Domestic Financing of National HIV responses

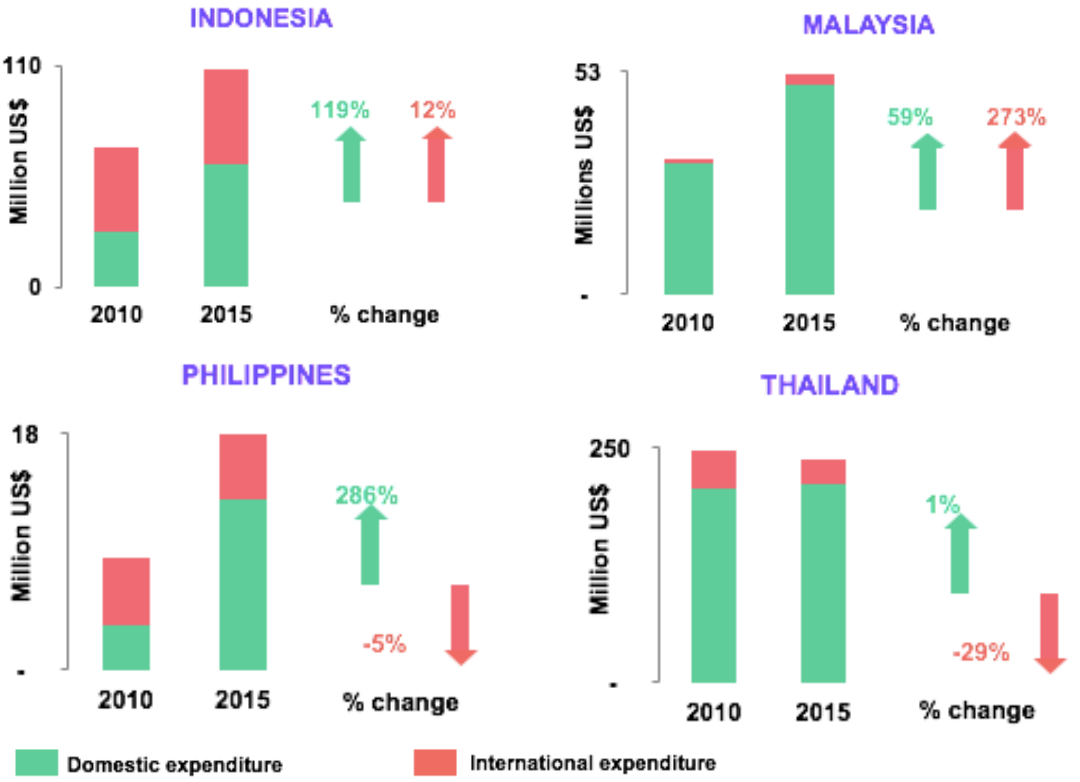


Figure 1: Increasing trend in domestic financing, SHIFT countries (latest available data)[1]

The four SHIFT countries of Indonesia, Malaysia, Philippines and Thailand are seeing an increase in the trend for domestic financing of HIV (Figure 1). By comparing 2015 to 2010 data, Philippines registered the highest increase of 286% in domestic expenditure, in response to a doubling of HIV new infections in the same time period[2].

[1] UNAIDS DataHub (2017). *Regional Overview of HIV Financing*. Presented at Regional Forum on Financing Mechanisms (SHIFT Program), 6th September 2017.
[2] UNAIDS (2017). Press Release: UNAIDS report indicates new HIV infections in the Philippines have doubled in the past 6 years, 1st August 2017.

Figure 2: Percentage share of domestic vs international sources of HIV funding (latest available data)[3]

Malaysia leads the response in domestically financing the bulk of its HIV programs, funding up to 96% in 2015. This is followed by Thailand with 89% (2015), Philippines with 74% (2015) and Indonesia with 57% (2014)[4]. Indonesia in particular recorded a shift from predominant international support to domestic financing beginning in 2013, with more than half of its HIV response funded domestically by 2015[5].

While the trend is moving towards greater domestic government support, a significant expenditure goes towards provision of care and treatment, ranging from 33% in Indonesia for 2014 to 67% in Thailand for 2015[6]. Compared to investing in prevention, especially on key populations prevention, healthcare provision through HIV care and treatment remains the predominant expenditure categories. The obvious utility of treating diseases aside, healthcare provision fits well within the mandate of the government and state actors as providers of healthcare for the people, without the political sensitivity of resourcing stigmatised or criminalised key populations. However, this overshadows the importance of the prevention approach needed to stall and reverse the epidemic, and especially the gains made possible when investing in the most affected key populations.

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

Investments in prevention spending for key populations are low, compared to epidemic trends and burden of disease in these communities. The following Figure 3 summarises the prevention spending across the three key populations in the four SHIFT countries. Of note in advocating for an allocative efficient investment, is the situation with MSM prevention spending - with 50% to 80% of new infections accounted for by MSM in the 4 SHIFT countries[7], only an average of 10% of domestic HIV prevention investment is spent on MSM.

[3] UNAIDS DataHub (2017). Country Snapshots 2017.
[4] UNAIDS DataHub (2017). Country Snapshots 2017.
[5] NASA Indonesia (2015)
[6] UNAIDS DataHub (2017). Country Snapshots 2017.
[7] UNAIDS DataHub (2017). *Men Who Have Sex Men 2017 Slides*.

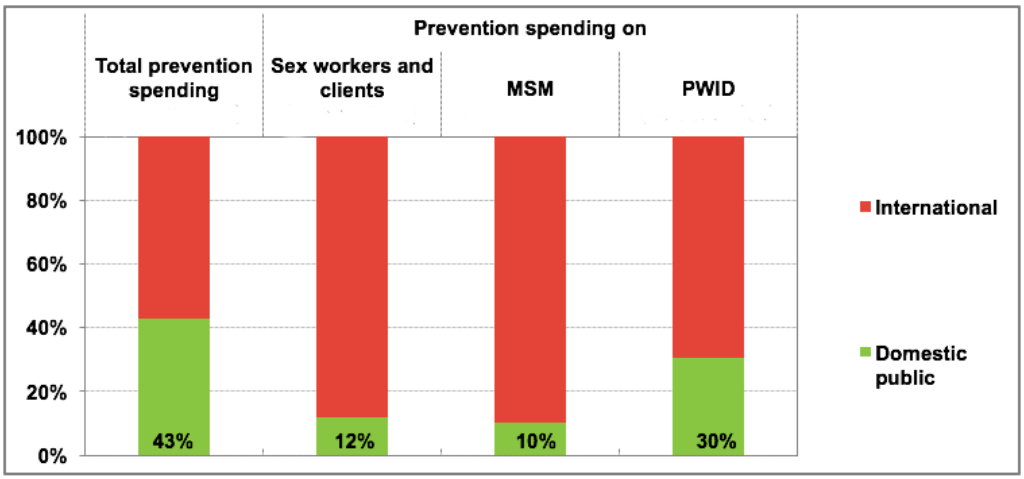


Figure 3: Distribution of prevention spending by financing source in 4 SHIFT countries, latest available year, 2014-2015[8]

HIV prevention activities have the highest impact and return on investment if it is targeted to key populations of MSM, sex workers and PWID who are disproportionately affected by the epidemic. However, countries in the region often fail to allocate appropriate resources for key populations, with an estimated of only 8% of overall HIV spending in Asia and the Pacific going to prevention for key populations[9]. A case worth noting is the response in the Philippines to the rapidly growing epidemic, with four out of five new HIV infections attributed to MSM. However, despite the disproportionally high risk of infection, only 8% of HIV spending was allocated to MSM prevention programs[10].

As seen in Figure 3 above, the bulk of prevention spending in key populations is also supported by international donor funding, raising the question of sustainability and the potential impact on the epidemic after international donor exit as countries transition to domestic financing. Of particular note highlighting the gravity of this issue is a case study in Romania by the Eurasian Harm Reduction Network, showing a dramatic increase in HIV prevalence among PWID from 1.1% in 2009 (prior to end of Global Fund support), to 6.9% in 2012 and spiking at 53% in 2013 in the years after Global Fund exit[11]. The risk for key populations prevention to fall through the cracks in this transition stage warrants an urgent allocative efficiency analysis and an evidence-based advocacy to ensure an effective response to HIV.

III. *Accessibility of Domestic Financing Sources*

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

Feedback from country partners noted key constraints existing at the level of relationships between CSOs and governments. There is a lack of government trust in CSOs, largely due to

[8] UNAIDS DataHub (2017)
[9] WHO (2016). *HIV financing status in selected countries of the Western Pacific Region (2009-2015).*
[10] UNAIDS DataHub (2017). Philippines Country Snapshot 2016.
[11] Eurasian Harm Reduction Network (2016). *The Impact of Transition from Global Fund Support to Governmental Funding On The Sustainability of Harm Reduction programs*.

concerns over financial management and issues of corruption. The case in Philippines with the pork barrel corruption scandal involving government officials establishing fake NGOs as a way to channel funds illegally has resulted in a crackdown and tightening of NGO laws[12], further prompting more stringent rules and barriers to CSO registration[13]. CSO and country partner representatives also expressed distrust of government agencies to make evidence-based decision in HIV financing, especially when it relates to financing key populations who are criminalised or marginalised.

Furthermore, understanding budget processes and meaningful engagement in budget advocacy has been limited, reflected in the complex structures and power brokers inherent in the budgetary process where CSOs have traditionally been excluded from. However, of particular note is the case in Indonesia and Philippines, where budget advocacy and accountability NGOs such a Seknas Fitra and Social Watch Philippines have led community level engagement to 'democratise' and make relevant and more widely accessible the complex information for CSOs to undertake and engage in budget advocacy.

An exception to the rule of domestic financing channels is the case in Malaysia, where a government-operated NGO - the Malaysian AIDS Council (MAC) was set up to allocate and disburse funds to CSOs[14]. However, even as MAC supports CSOs and actively includes key population representatives in its decision-making structures, many CSOs who are recipients of this centrally channeled fund lack confidence in MAC's ability and willingness to advocate for complex issues and to represent civil society in its engagement with the government. As noted by other SHIFT country partners, a principle function of CSOs rests in its capacity to advocate on behalf of the communities it represents, as well as serving as a watchdog to hold the governments accountable in a meaningful CSO engagement on national HIV responses. This fundamental capacity is potentially compromised in the context of CSOs receiving government funds, curtailing the independent function of CSOs keeping governments accountable, or risk losing significant political (and financial) capital if CSOs decide to speak out. As one community respondent puts it: "you don't bite the hand that feeds you"[15].

IV. Socio-Cultural and Political Contexts

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

Issues of criminalisation further marginalise key populations including organisations representing them to fully engage, both on the legislative front where they are deemed illegal to participate as political citizens, as well as on the socio-political front where perceptions and conservative ideologies dominate the decision-making and resource

[12] Francisco, K & Geronimo, J (2013). *Why fake NGOs got away*. https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away

[13] Philippines country partner ACHIVE noted that organisational registration can take up to 2 years.

[14] Ministry of Health Malaysia (2016). *The Global AIDS Response Progress Report 2016*.

[15] Pers. Comms. (2017). Regional Forum on CSO Financing Mechanisms and Progress Review, 4 – 6 September 2017.

allocation table. This is especially eminent in the Philippines with the "War on Drugs" – a populist policy criminalising drug use, effectively ruling out any investment and advocacy engagement with PWID and their programs[16]. In Indonesia and Malaysia, gay people and LGBT issues are routinely targeted under conservative Islamic justifications, in addition to being used as political scapegoats to solidify political power and influence during election periods[17][18]. This situation presents a major challenge for CSOs to advocate for investments in key populations, especially for MSM and transgender people, with the effect of invisibilising these communities and their needs in the advocacy for greater domestic HIV financing in order to access further political and resource capital.

A further socio-cultural challenge is the perception of Asian governments viewing CSOs with suspicion, often as antagonistic agents against governments, given that successes generated by CSOs imply a certain loss of face for the government who have failed to meet the needs of its citizens[19]. These issues raise the importance for an advocacy strategy that reframes the relationship between CSOs and government, away from an adversarial interaction to one based on the bottom line of achieving control of the HIV epidemic in the country. In particular, the economic argument to frame HIV financing investments on key populations, the dollar value saved in the long run (return on investment) and the potential to mitigate further risks of the epidemic escalating are possible advocacy in-roads for further exploration. These themes will be covered in upcoming activities of the SHIFT program looking at the cost of criminalisation and country case study examples, building the foundation to inform advocacy initiatives in the SHIFT countries and share learning and findings across the region with key partners and stakeholders.

[16] Human Rights Watch (2017). *"License To Kill".* https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killings-dutertes-war-drugs

[17] Azlee, A. (2016). Anthropologist: Solidarity the only way to stop victimisation of LGBT. *The Malay Mail Online*. http://www.themalaymailonline.com/print/malaysia/anthropologist-solidarity-the-only-way-to-stop-victimisation-of-lgbt

[18] Hutton, J (2017). Indonesia's Crackdown on Gay Men Moves From Bars Into the Home. *The New York Times*. https://www.nytimes.com/2017/12/20/world/asia/indonesia-gay-raids.html

[19] Kingston, J. (2017). Civil society across Asia if flowering but fragile. *The Japan Times*. https://www.japantimes.co.jp/opinion/2017/04/29/commentary/civil-society-across-asia-flowering-fragile/#.WiDvyBOCzOQ

Introduction

As countries in the region approach middle income status and transition out of international donor support, a critical issue of sustainability faces the HIV response, especially the continued investments in programs for the most affected key populations – MSM, transgender people, sex workers and people who use drugs. A Global Fund two-year regional advocacy program - the Sustainable HIV Financing in Transition (SHIFT) Program, aims to enable and empower civil society, including key population communities to advocate for sustainable HIV financing. The program is being implemented in 4 countries – Indonesia, Malaysia, Philippines and Thailand.

The program comprises AFAO as the principle recipient, APCASO and APCOM as the sub-recipients, and country sub-recipients: ACHIEVE in Philippines, IAC in Indonesia, MAC in Malaysia and TNAF in Thailand.

In order for CSOs to fully participate and advocate for sustainable HIV and CSO financing, strategic information is needed to inform and provide the necessary evidence when developing HIV financing advocacy agenda. The National Situational Assessment on HIV Financing aims to produce a consolidated situational report, providing necessary evidence on existing HIV financing practices. The information is presented in a community accessible format to inform and support civil society use in advocating for sustainable HIV financing.

Objectives

The objectives of the National Situational Assessment are:

1. Provide a current snapshot of HIV financing in the four SHIFT countries
2. Outline HIV expenditure against key population epidemiology in the respective SHIFT countries
3. Identify existing national HIV financing mechanisms and funding structures
4. Identify national budget cycles and budgetary processes

Methodology

The assessment is grounded in four criteria as illustrated below:

Figure 1: Criteria for National Situational Assessment, adapted from Berman & Bitran (2011)[20]

Evidence-based

The assessment is based on a desk review of published data, a total of 118 resources in English, Bahasa Indonesia and Bahasa Malaysia were used, including the following:

- National AIDS Spending Assessments (NASA)
- Global AIDS Response Progress Report (GARPR)
- National Health Accounts
- Costed National Strategic Plans
- Country Global Fund Concept Notes
- National UNAIDS Investment Cases
- National Annual Budgets
- National and sub-national budgetary rules, analyses and civil society guides

The research is also supplemented by database searches on:

- AIDS Datahub
- AIDS Info Online
- World Bank publications
- Google Scholar, PubMed searches on “HIV financing”, “HIV expenditure”, “key populations”, “MSM”, “Budget analysis”, “Indonesia”, “Malaysia” etc

Participatory Inclusive

The report’s initial findings were presented for feedback to the four country partners, government and CSO representatives at the Malaysian Regional Forum on CSO Financing Mechanisms on 4th September 2017. Feedback received during the forum has been incorporated into this final report.

Primary research will be undertaken to address key community identified strategic information needs and data gaps identified from this report. This follow up research will

[20] Berman, Peter; Bitran, Ricardo (2011). Health Systems Analysis for Better Health System Strengthening. Health, Nutrition, and Population (HNP) discussion paper, World Bank

inform future case studies and country briefs developed for the SHIFT program, to be released on the Knowledge Management Hub[21].

Relevant

The report aims to reflect the needs of country partners and CSOs for a consolidated and up-to-date source of country specific HIV financing information, in order to inform in-country advocacy initiatives. The scope is deliberately specific - key populations focused, domestic HIV financing mechanisms, government budget cycles and comparative epidemiological and expenditure data.

Analytical

Analyses are presented at the end of each country report to contextualise challenges and opportunities for CSO involvement and advocacy in HIV financing sustainability. The analysis highlights

Limitations

This report is informed by secondary research of available data, sourced from published literature, government sources, UN agencies and development partners. Limitations of this data are evident from the timeline of the data sets, with latest dated to 2015. The data sets are largely dependent on retrospective agency reporting timelines, such as that reflected in the National AIDS Spending Assessments (NASA) report.

Variability and inconsistency in epidemiological and expenditure data have also been identified, and presented in this report for further clarification and follow up in primary data collection and research. It is anticipated that this will involve focused interviews and collaboration with key stakeholders in government, UN agencies and CSOs.

Although disaggregated data for each key population is available for indicators such as HIV epidemiology, prevention investments and sources of domestic vs international financing for each population, they are not the most updated, with a lag time of three to four years. Moreover, most data for transgender people is invisible, subsumed within MSM as a whole. Without specific and up-to-date data that reflects the realities of key populations especially transgender people, the capacity to formulate effective policy responses are limited. Furthermore, the invisibility of data also renders these populations invisible. This has been termed the “data paradox”, without data, decision-makers deny the existence of these populations, or that they are relevant to the epidemic; no research and funds are invested in these communities; the lack of data feeds this denial and so on[22]. This is a perennial concern raised by key population communities on the importance of updated disaggregated information, an advocacy point that the SHIFT program seeks to highlight.

In light of these limitations, an on-going, iterative methodology will be followed as part of SHIFT’s strategic information management, with available and updated data presented in follow-up briefing documents and publications. All SHIFT strategic information pieces will be hosted on the Knowledge Management Hub.

[21] The Knowledge Hub will be an online platform for the SHIFT programme to collate community-friendly information briefs, programmatic documentation and key advocacy events, made accessible for civil society and partner organisations

[22] Baral, S (2013). The “Data Paradox”. https://wherethereisnodata.org/2013/07/05/the-data-paradox/

INDONESIA

PART 1

I. Background Trends

Health expenditure per capita (current USD)	**2015**	**99.41**
Share of public health expenditure in government expenditure	2015	5.73%
Share of public health expenditure in total health expenditure	2015	37.8%
Share of total health expenditure in GDP	2015	2.8%

Table 1: Essential data on Indonesia (World Bank, 2017)

The largest economy in Southeast Asia, the world's 10th largest economy in terms of purchasing power parity, and a member of the G-20, Indonesia's HIV expenditure marks an increasing trend. With a population of 259 Million, the health expenditure of USD 99.41 comes in at number four among the SHIFT countries, and below the ASEAN average of USD 544. National and subnational spending is low relative to other countries with comparable income level, with a low national revenue collection. While the revenue collection for expenditure is centralised, the expenditure and service delivery is decentralised to the district level[23].

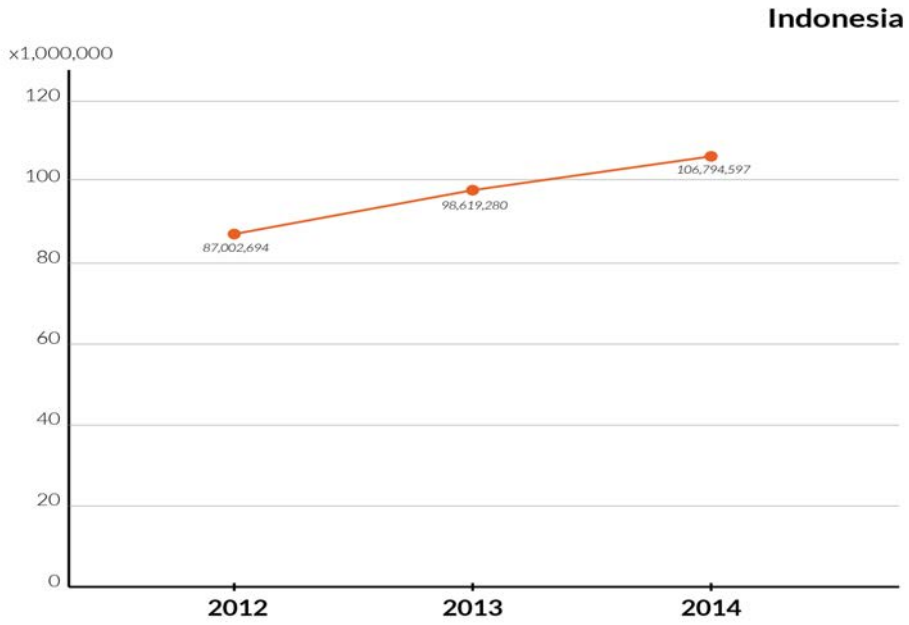


Figure 2: Trend in total HIV expenditure, Indonesia 2012-2014[24]

II. Domestic vs International HIV Financing

The latest NASA (2015) report indicates an increase in domestic financing, overtaking international and private sources. Domestic financing was proportionally greater than

[23] World Bank Group (2016). *Indonesia Health Financing System Assessment : Spend More, Right and Better.* https://openknowledge.worldbank.org/handle/10986/25363

[24] UNAIDS (2017). AIDSinfoonline Key Population Atlas

international funding at 52% for 2013 and 57% for 2014. In 2015, domestic financing sources were comprised of public funds from central government (80%), district level (15%) and 5% from Jaminan Kesehatan Nasional (National Health Insurance)[25].

III. Key Populations Epidemiology vs HIV Expenditure

According to the 2014 HIV estimates and projections, there were 668,498 people living with HIV in Indonesia with 67,217 new infections in 2015. Without improved interventions, the HIV epidemic would continue to grow in Indonesia, increasing to 777,924 in 2019[26]. The estimates and projections suggest that men who have sex with men (MSM) remain the primary driver of the epidemic. In 2014, an estimated 22.1% of new infection occured in MSM. This proportion is projected to increase to 29.4% in 2019[27].

In light of key populations epidemiology, only 1% of total HIV spending is on key populations prevention, as shown in Figure 3 below.

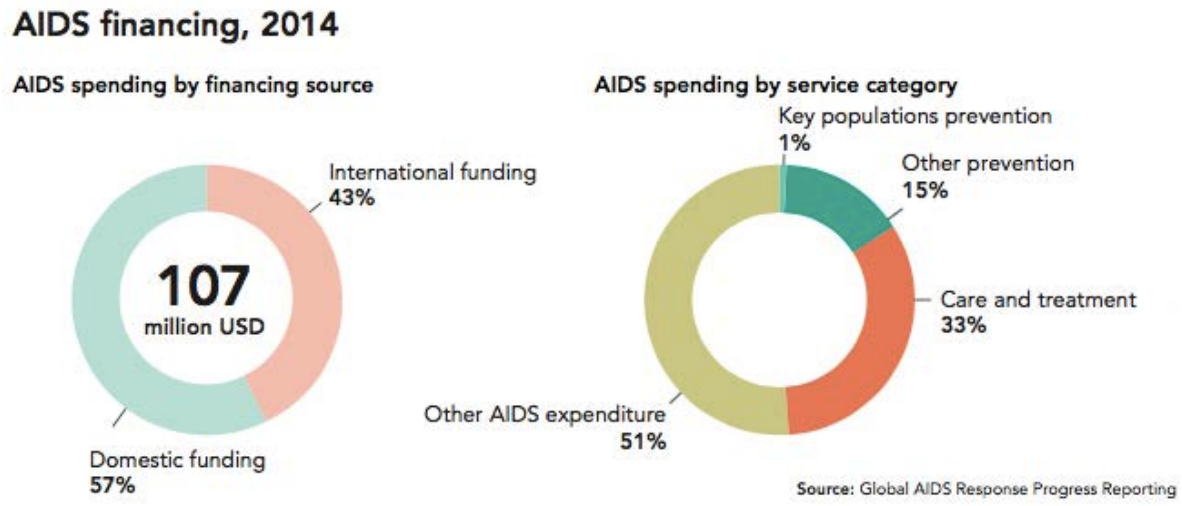


Figure 3: Proportion of HIV expenditure by financing source and service category, latest available data[28]

Expenditure data when disaggregated to each key population shows MSM receiving 99.7% of their funding from international sources, sex workers with 57% and PWID with 7% (Figure 4). Looking at the share of domestic vs international sources of funding, it is imperative to highlight the dependence especially of MSM to international donor funding, and the prospect for continued resourcing of HIV interventions for this population in the event of transition. This is further complicated by the current context of anti-gay political sentiment and the policing of homosexuality in Indonesia, which does not bode well for a transition into full government support for MSM programs. Lastly, there is a need to procure more up-to-date disaggregated financing information, as the latest data set presented here is from 2012.

[25] NASA Indonesia (2015)
[26] Ministry of Health of Indonesia, *Estimates and Projections of HIV and AIDS in Indonesia*. 2015.
[27] Ministry of Health of Indonesia, *Estimates and Projections of HIV and AIDS in Indonesia*. 2015.
[28] UNAIDS Datahub (2017). Country Snapshot: Indonesia

Figure 4: Share of HIV financing for Key Populations Programming in 2012[29]

IV. HIV Financing Mechanisms

Overview

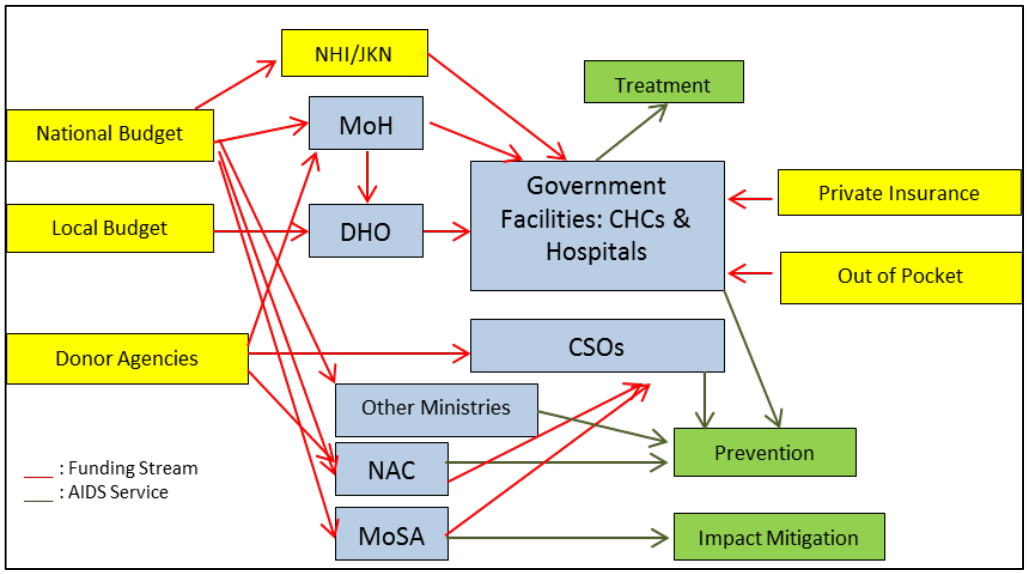


Figure 5: Indonesia's health financing sources and budget utilisation

Government health spending in Indonesia can be divided into two main categories:

i. Direct central government expenditure (APBN)
ii. Transfer to sub-national expenditure (APBD)

In direct central government expenditure, the fund can flow through two main funding channels: (1) ministries and other government institutions and (2) other channels.

[29] AIDS Info Online (2017)

There are two functions covered by funding for ministries and other government institutions: core functions and non-core functions. Funding for core functions are designated to cover administrative structures of central and local government. Funding for noncore-functions are channeled into three types of financing that can be used to support various health programs at the provincial and district levels. These three are:

i. De-concentration fund (Dekon): grant used for central government-sponsored activities. District should submit a proposal to receive the grant for implementing the activities. The proposal will be approved by provincial level based on the regulations determined by the Ministry of Health.
ii. Support Assignment Fund (Tugas Pembantuan): this type of grant is intended to support district government including health office for physical assets, infrastructure, and equipment. The allocation and use of these funds are approved by the central Ministry of Health.
iii. Grant for Operational Costs at Community Health Centre Level (Bantuan Operasional Kesehatan-BOK): supplemental funding directed for public health activities such as promotion, prevention and outreach activities. These funds cannot be used to support personnel or infrastructure.

For funding transferred to sub-national government, these are mainly used to finance subsidies on infrastructures, specific programs or operational cost of health services.

Based on NASA 2015, central government spending was used predominantly to finance care, support and treatment for PLHIV by providing ART for free, reagents or medical equipment, while local government spends most of their funds for health promotion programs targeting general population. International partners usually focus on prevention programmes for key populations by providing direct funding to CSOs or CBOs. Other ministries spend their funds to support general community education, while the Ministry of Social Affairs (MoSA) provides small amount of funding to support PLHIV or key populations.

Funding Sources

The main source of funding for health is increasingly domestic, with the central government expenditure (APBN) at 40%, sub-national expenditure (APBD) at 11% and national health insurance (JKN) at 6% for 2014[30].

The remaining funding comes from bilateral and multilateral sources (Global Fund, USAID, UN System) or foreign foundations. Global Fund remains the biggest international donor in 2014, accounting for 60% of international funding sources[31].

Other domestic resources came from corporate sector through CSR or company contribution coordinated by IBCA (Indonesian Business Coalition on AIDS), standing at 0.02% of total source.

At the national level, in addition to MoH's budget, there exists budgetary allowance for HIV response from Ministry of Social Affairs, Ministry of National Education, and Ministry of Youth and Sports (NAC). However, the amount of budget of these ministries are dependent

[30] NASA Indonesia (2015)
[31] NASA Indonesia (2015)

on political and moral consideration and hence is not seen as a sustainable source for key populations financing.

Ministry	Total
Ministry of Social Affairs	USD 1,534,687
Ministry of Defense	USD 91,945
Ministry of Labour	USD 69,364
Ministry of Justice	USD 57,350

Table 2: HIV expenditure other than MoH in 2014[32]

Health Budget Planning Processes

In the process of health financing, Ministry of Finance has a list of "indicative limits' usually called *the financial note* for budgeting processes developed by ministries and local governments (see Figure 6 below, right column). This budgeting process is a "top-down" mechanism where the ministry determines the budget items and limitation of these items.

On the other hand, the planning process is a "bottom-up" approach, started from sub-national level and finalised at the national level, with provision for participative engagement of civil society. Ideally, the two mechanisms should meet in the middle to discuss the financial note, but this is usually not the case. The Ministry of Finance would have already prepared the financial notes, and the proposed budget developed by the ministries are negotiated in the process at the National Development Planning Board (Bappenas). This essentially makes the budget planning mechanism a "top down" approach, a significant challenge for civil society to engage and effectively influence budget advocacy.

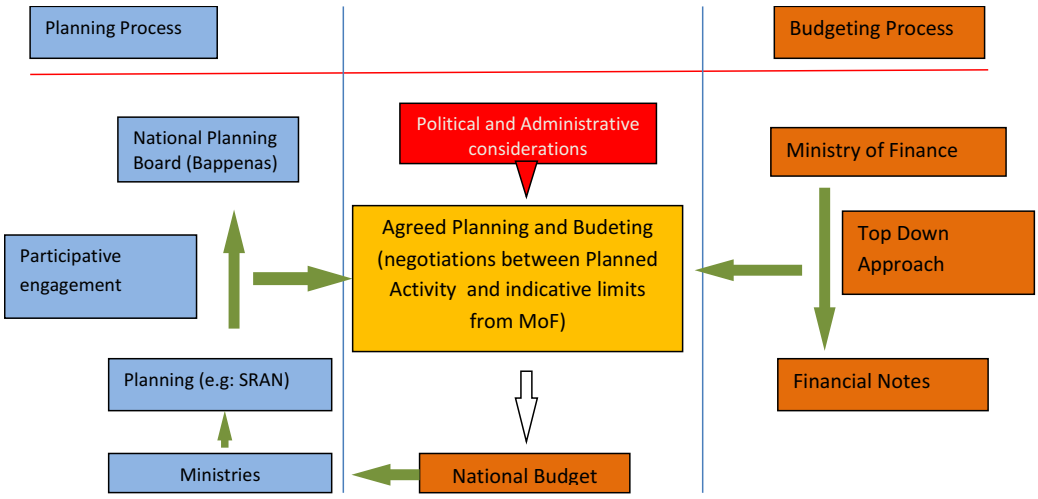
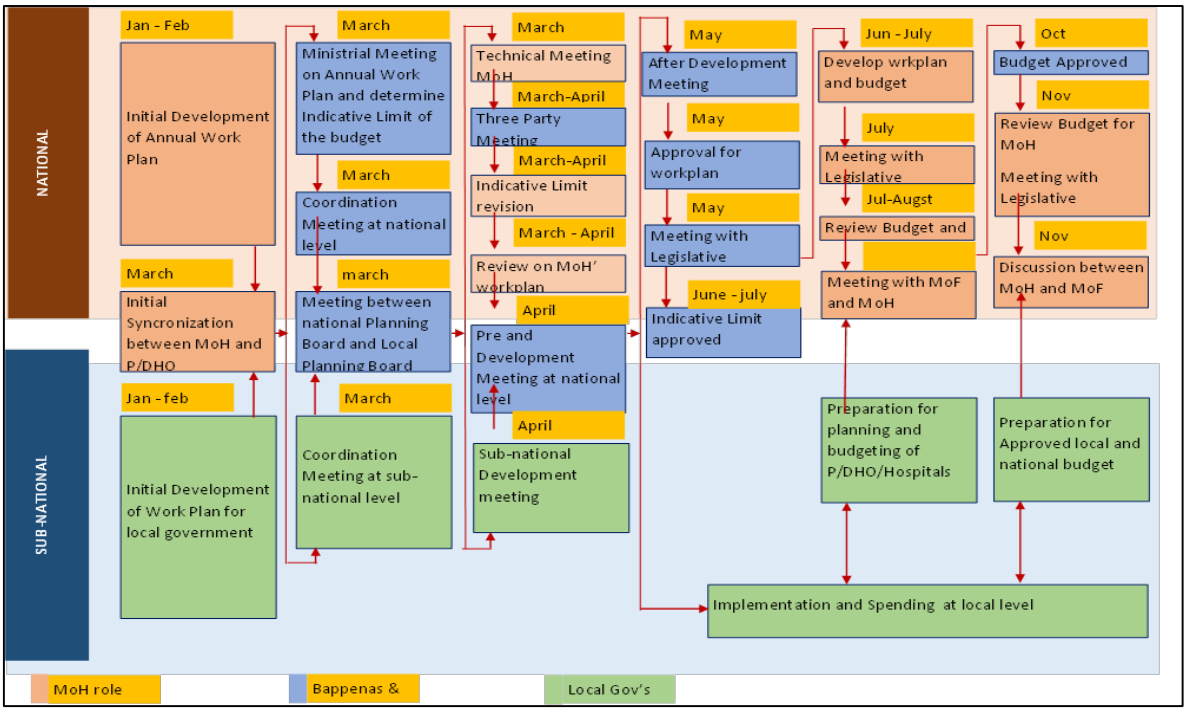


Figure 6: Budget planning process (based on interview with FITRA)

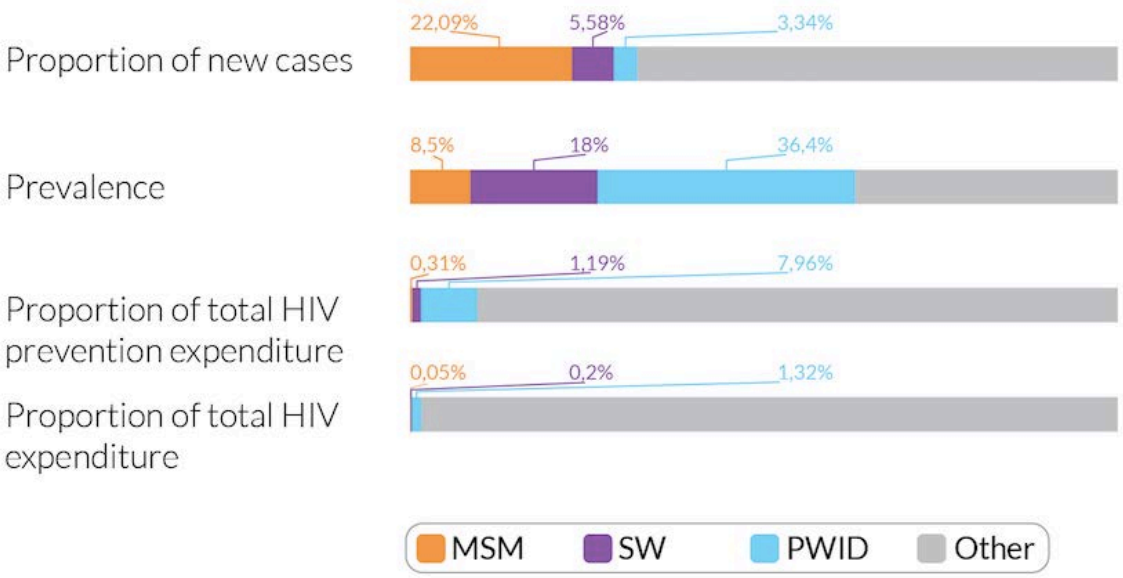
[32] NASA Indonesia (2015)

V. National Budget Mechanisms



A flowchart of budgeting process on health as described in MoH's Regulation no. 7/2014 is shown above. This flowchart explains in detail the processes at each level (national and sub-national) and the timeline for each process to take place. However, civil society involvement is not indicated specifically, as seen in the budget cycle above. There is no document-based evidence that shows civil society's influence on the sub-national and national health budgeting process[33].

VI. Analysis



[33] Seknas Fitra, 2012. Budgetary Reform in Indonesia. Budget Brief September 2012

Figure 3: Key Populations Incidence and Prevalence vs Prevention and Total Spending, Indonesia 2014[34]

With the 2014 data disaggregated further, MSM registered the highest in incidence rate at 23%, while receiving investments of only 0.3% of prevention and 0.05% of total HIV expenditure. Looking at prevalence, PWID is the highest with 36%, receiving a higher prevention investment than MSM at 8% and total HIV expenditure of 1.3%.

An inference can be made that the bulk of HIV investment for prevention goes towards the general population (other). However, looking at the total HIV investment which includes significant costs of care and treatment, care and treatment investments for key populations are not as readily deduced, as treatment data for key populations are not routinely captured.

G-20 and Eligibility for Funding Support

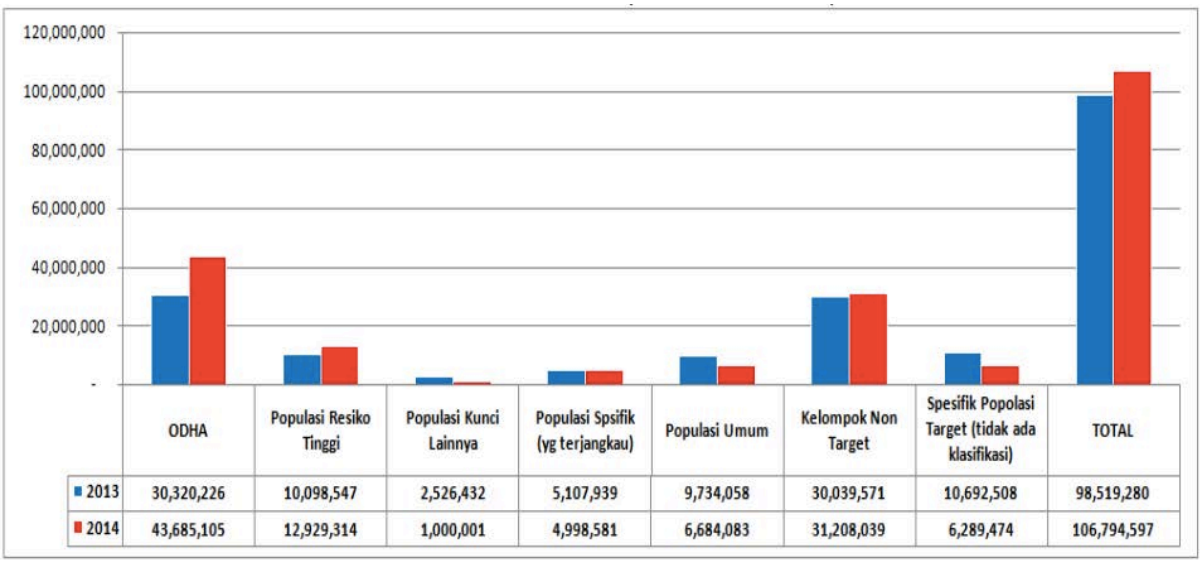
As a member of the G-20, Indonesia now qualifies for the criteria of ineligibility for receiving Global Fund support. The prospect remains unclear however, with no indication of when this will be happening. In the event of full domestic financing, significant paradigm shift needs to occur requiring domestic governments to absorb the cost entirely. With the bulk of key populations program funded externally, except for PWID, the impact could be considerable with key populations based programs falling through the cracks if sustainable transition does not occur.

Recommendations for Further Areas of Research

The epidemiological and expenditure data presented require further clarification, especially for use to inform advocacy measures, namely:

i. How were key populations data collected for total HIV expenditure, considering care and treatment data does not differentiate routinely between key populations and general population. Would prevention spending be a better strategic information focus for advocacy purposes?
ii. What constitutes key populations in routine data collection, as evident from the 2015 NASA reporting, there are multiple categories such as high-risk populations, other key populations, specific populations etc. With PLHIV (ODHA) and non-target groups (Kelompok Non Target) receiving majority (43% and 32%) of the total expenditure respectively, there is a need to clarify what populations and intervention make up these grouping, and why they are classified this way. See Table 3 below:

[34] AIDS Info Online (2017)



	ODHA	Populasi Resiko Tinggi	Populasi Kunci Lainnya	Populasi Spsifik (yg terjangkau)	Populasi Umum	Kelompok Non Target	Spesifik Popolasi Target (tidak ada klasifikasi)	TOTAL
2013	30,320,226	10,098,547	2,526,432	5,107,939	9,734,058	30,039,571	10,692,508	98,519,280
2014	43,685,105	12,929,314	1,000,001	4,998,581	6,684,083	31,208,039	6,289,474	106,794,597

Table 3: HIV expenditure by population, Indonesia 2013-2014 (USD Million), translation provided in footnotes[35]

Decision makers

One of the key decision makers in the process of AIDS budgeting is the Directorate General of Disease Control at the Ministry of Health. The institution decides on activity items in the budget, with the Director General a good ally for CSOs in advocating for HIV budgeting. Budget categories for HIV are included within the budget for infectious diseases at the Ministry of Health, they are not specific for HIV. HIV budget is also only a small fraction of the total health budget, indicative of a potential ease in negotiating budgetary reconsiderations[36].

Since decentralization, province-level health offices have mainly been responsible for training and coordination efforts as well as oversight of provincial hospitals, but they have limited resource allocation responsibilities. In contrast, districts have major responsibilities for delivering health services and allocating resources. By design, districts are now responsible for public service planning and budgeting, but their capacity to implement programs are limited as they are not significantly involved in designing the AIDS response. As district level offices play the role of funding and administrative arrangement more than programmatic implementation, there is an opportunity to position CSOs as capable of complementing this work as programmatic implementers.

The National AIDS Commission (NAC) has advocated to the Ministry of Home Affairs to issue a decree to encourage provincial and district government to create local policies enabling provincial funding (APBD) for HIV response at these administrative levels. However, the result has not been as expected. Only 98 districts out of about 500 districts have local HIV policies that enable funding from local government. It seems that there is a lack of clarity in

[35] NASA Indonesia (2015). Translation: ODHA (PLHIV), Populasi Risiko Tinggi (high risk populations), Populasi Kunci Lainnya (Other key populations), Populasi Umum (general population), Kelompok Non Target (non-targeted group), Spesifik Populasi Target "tidak ada klasifikasi" (non-classified specific target population).
[36] Pers. Comms with Seknas Fitra (2017)

interpreting what these policies mean in the implementation stage. This result in programs that may not be appropriate for the HIV response at the provincial level.

Innovative Financing Sources

A funding stream that has not been utilised optimally for supporting AIDS response especially by CSOs are grants or social assistance funds from Ministry of Home Affairs (MoHA) and local government. According to Law No. 17/2013 on Community Organisations, the government has the obligation to guide and strengthen the existing community organisations in Indonesia through policy facilitation, institutional capacity strengthening and strengthening for human resources in the community organisations. These strategies are aimed to empower community organisations as partners of the government in development process. Empowerment strategies include providing funds for the community organisation to implement their programs (see Figure 7).

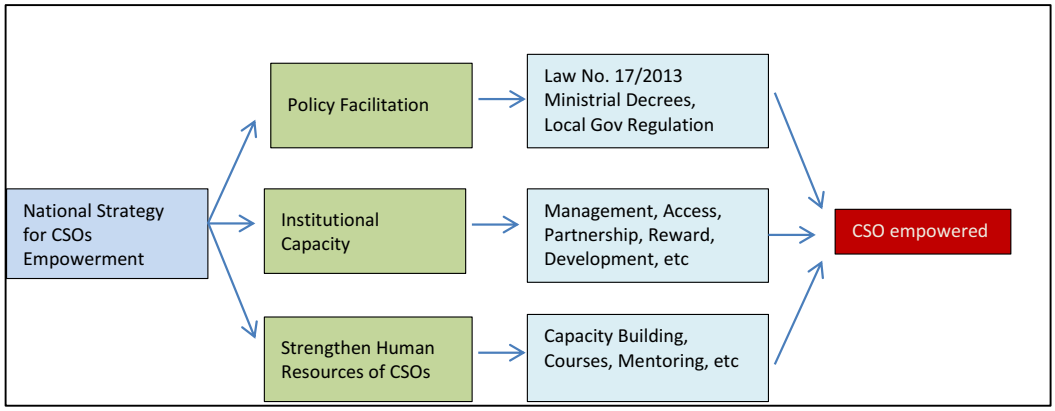


Figure 7: MoHA National Strategy for CSO Empowerment[37]

CSOs and CBOs working in the HIV response across Indonesia are eligible for receiving the fund with this scheme from MoHA or other ministries because they are mostly registered as community organisations at Ministry of Law and Human Rights or at local government office[38]. This legal status is the main pre-requisite to access the grants or social assistance. There is a clear procedure developed by MoHA to access this grant or social assistance fund (see Figure 8)[39].

[37] MoHA (2015). *Empowering Community Organization based on Law No. 17/2013,* presented at Indonesia Health Policy Forum, Padang, August 26, 2015

[38] Koalisi Kebebasan Berserikat (2015). *Monitoring Report 2nd Year of the Implementation of Act on Societal Base Organization (Act Number 17/2013)*

[39] MoHA (2015). *Empowering Community Organization based on Law No. 17/2013,* presented at Indonesia Health Policy Forum, Padang, August 26, 2015

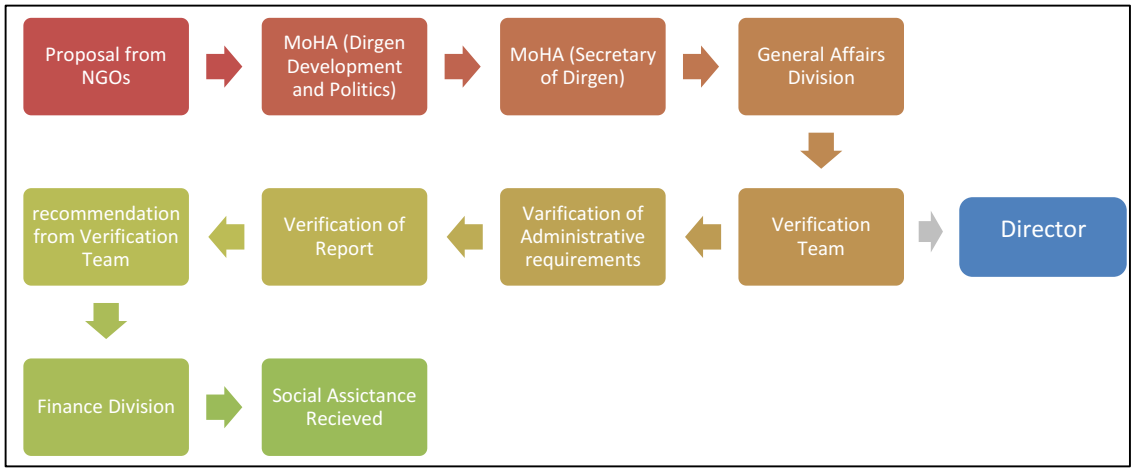


Figure 8: Procedure to Access Social Assistance based on Home Affairs' Ministerial Decree No.44/2009 and Home Affairs' Ministerial Regulation No.20/2013

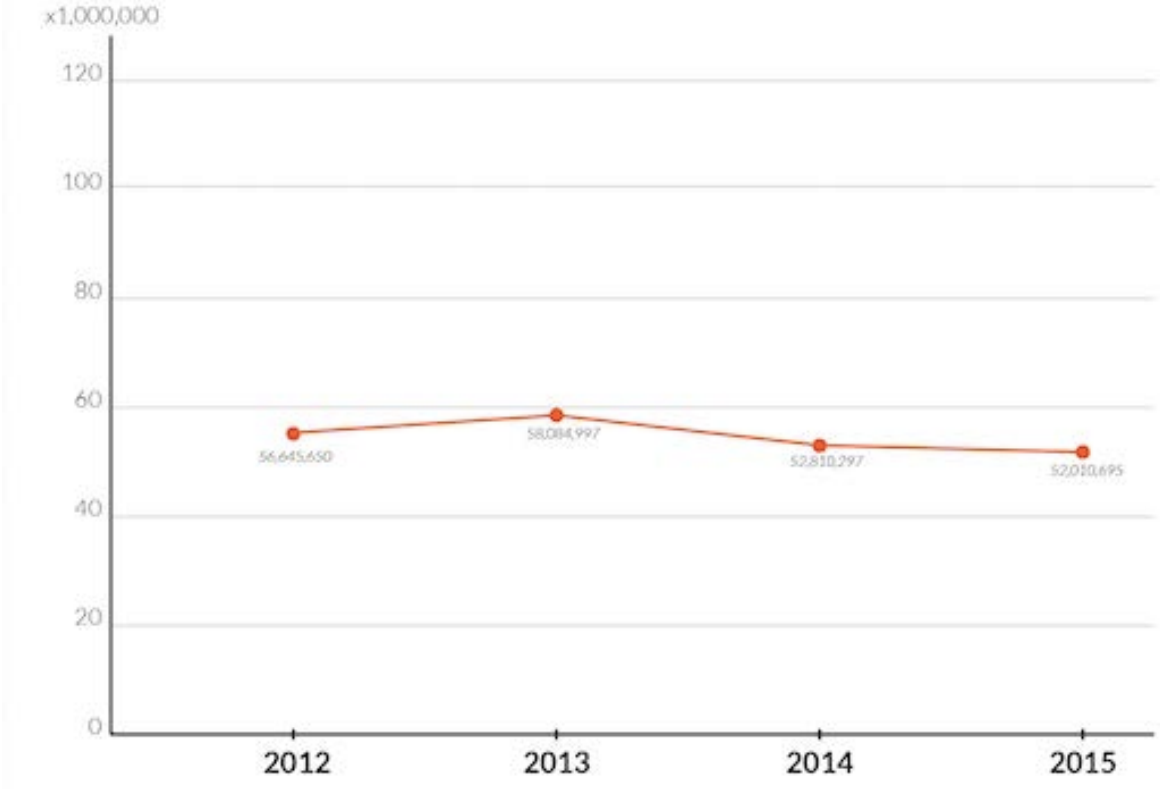
MALAYSIA

I. Background Trends

Health expenditure per capita (current USD)	**2014**	**455.83**
Share of public health expenditure in Government Expenditure	2014	6.45%
Share of public health expenditure in total health expenditure	2014	55.2%
Share of total health expenditure in GDP	2014	4.2%

A high-income country, Malaysia is not short of resources for healthcare and displays a rather privatised approach to healthcare, with public health spending registering above average - 55% of health expenditure. With a population of 31 million, health expenditure per capita for Malaysia is at USD 456, the highest among the 4 SHIFT countries. Malaysia's total share of GDP on health expenditure however remains low for an upper middle income country.

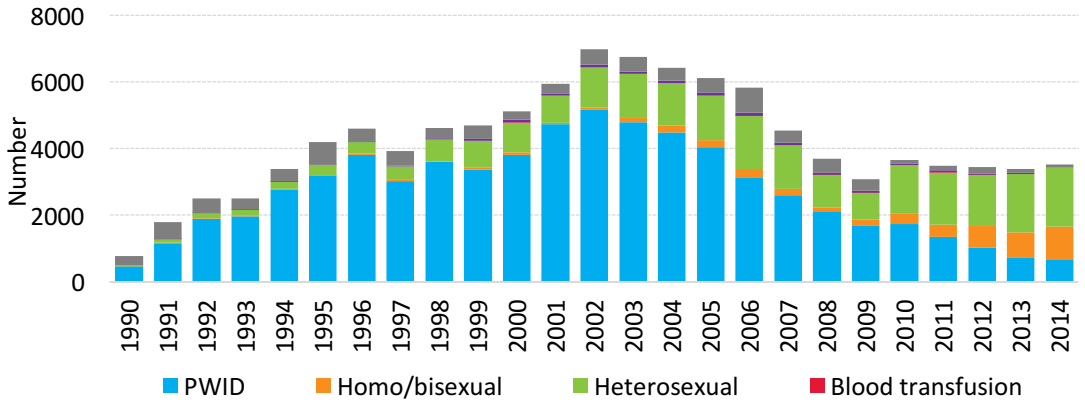
Total HIV expenditure (USD Million)



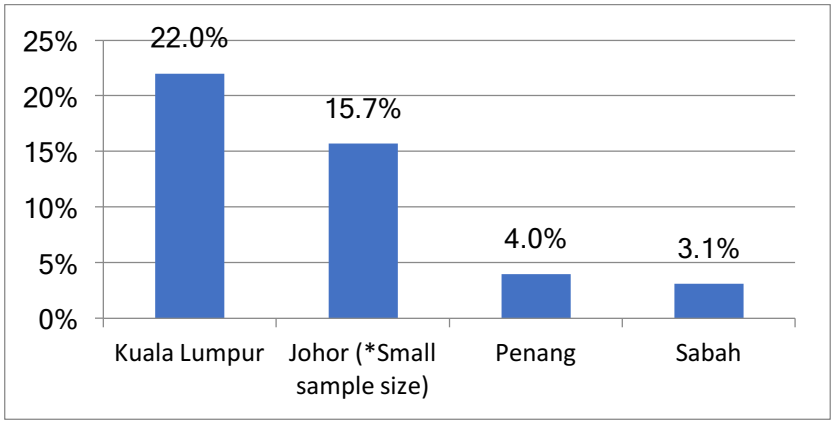
According to the HIV estimates and projections of the country, there were 92,895 people living with HIV with 5,200 new infections in 2015. The HIV prevalence (age 15-49, medium estimate) is 0.4%. The majority of HIV reported cases were from five states, including: Johor, Selangor, Kelantan, Pahang and Terengganu. The epidemic in Malaysia is still concentrated among key populations. As of the 2014 IBBS, the HIV prevalence was highest among PWID (16.6%), followed by MSM (8.9%), female sex workers (7.3%) and TG people (5.6%). The case reporting suggests that number of HIV infections among men who have sex with men

(MSM) would grow fastest. In 2014, MSM accounted for 30% of all reported HIV infections in the country (Figure 1 and 2)[40].

Reported HIV cases by mode of transmission,1990-2014

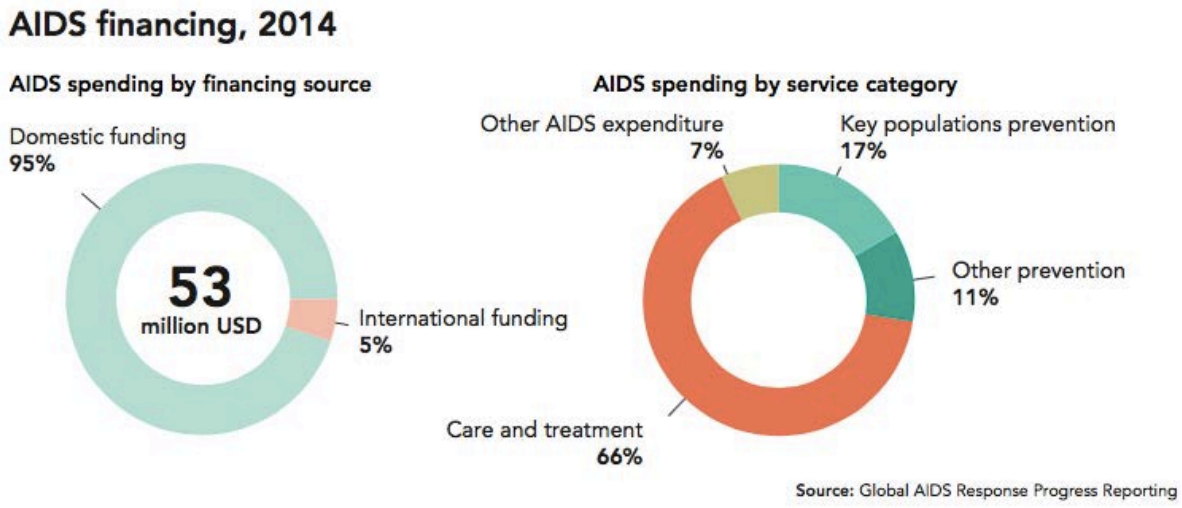


High HIV prevalence among MSM in big cities in Malaysia (Source: IBBS, 2014)



[40] MoH Malaysia (2016). *Global AIDS Response Progress Report: Malaysia 2016 country response to HIV/AIDS. Reporting period: January 2015 - December 2015*. HIV/STI Section - Disease Control Division, Minister of Health of Malaysia

II. HIV Financing: Domestic vs International



The Government of Malaysia has led its HIV response with relatively few international resources since the beginning of the epidemic[41]. In 2014, 17% of total expenditure was invested in key population prevention[42].

III. Key Populations Epidemiology vs Expenditure

Disaggregated expenditure data for 2014 shows the share of domestic vs international funding for each population. Of particular note is MSM: while having a sizeable share of domestic funding, the actual amount is very small, only USD 7,300 out of USD 16,000. Again, this spending is disproportionate to the epidemiological trends seen in recent years as described above, with the increasing incidence in MSM.

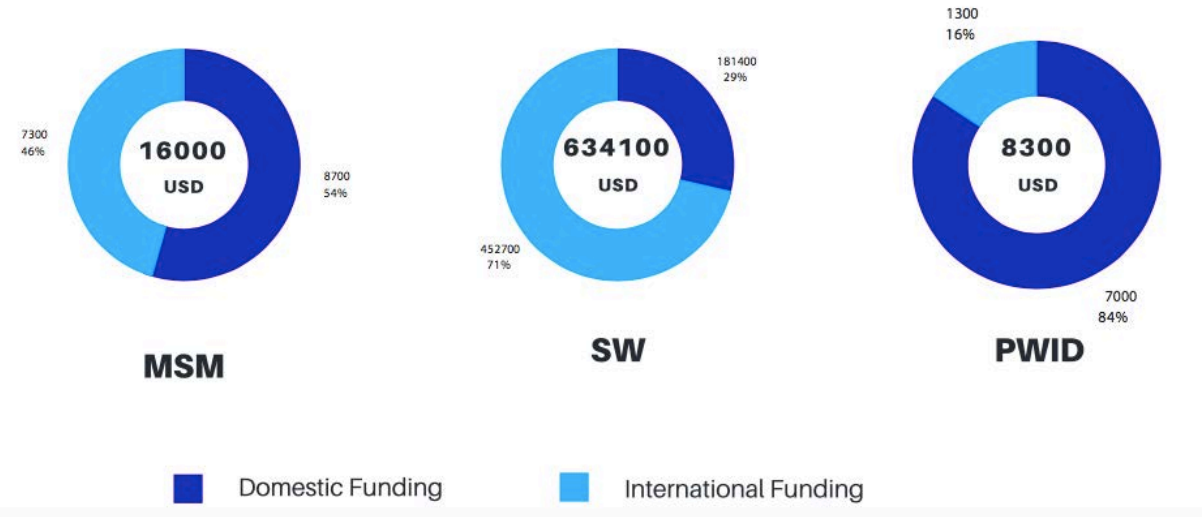


Figure 1: Share of HIV Financing for Key Populations Programming in 2014

[41] Huang M, Hussein H. The HIV/AIDS epidemic country paper: Malaysia. AIDS Educ Prev. Guilford Press; 2004;16: 100–109
[42] UNAIDS DataHub (2017). Country Snapshot: Malaysia

IV. HIV Financing Mechanisms

Unlike other counterparts in the region, HIV programs in Malaysia is heavily financed by public funding coming through the Ministry of Health[43]. Domestic financing accounts for 89% of the total HIV spending. Other sources of funding such as domestic private and international sources contribute to around 2% to 5% of the HIV national expenditure, see figure below.

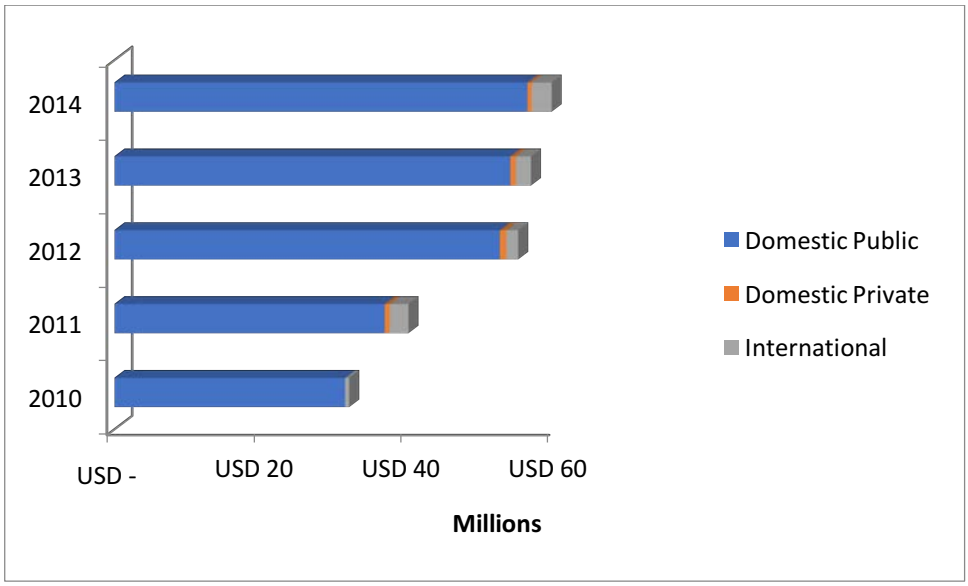


Figure: Malaysia HIV Financing based on Sources, 2010-2013[44]

A retrospective financial report showed that HIV expenditure increased by 86% in 2014 (Table 3). In a yearly basis, more than 50% of the expenses went to care and treatment and at least 25% in prevention. However from 2012 onwards, it shrunk to less than 20% spent in prevention. The health system strengthening comes as the third most spent component ranging from 12% to 15% while other components such as enabling environment, human resources, social protection and orphans contributed to less than 1% in the expenses. See Table below:

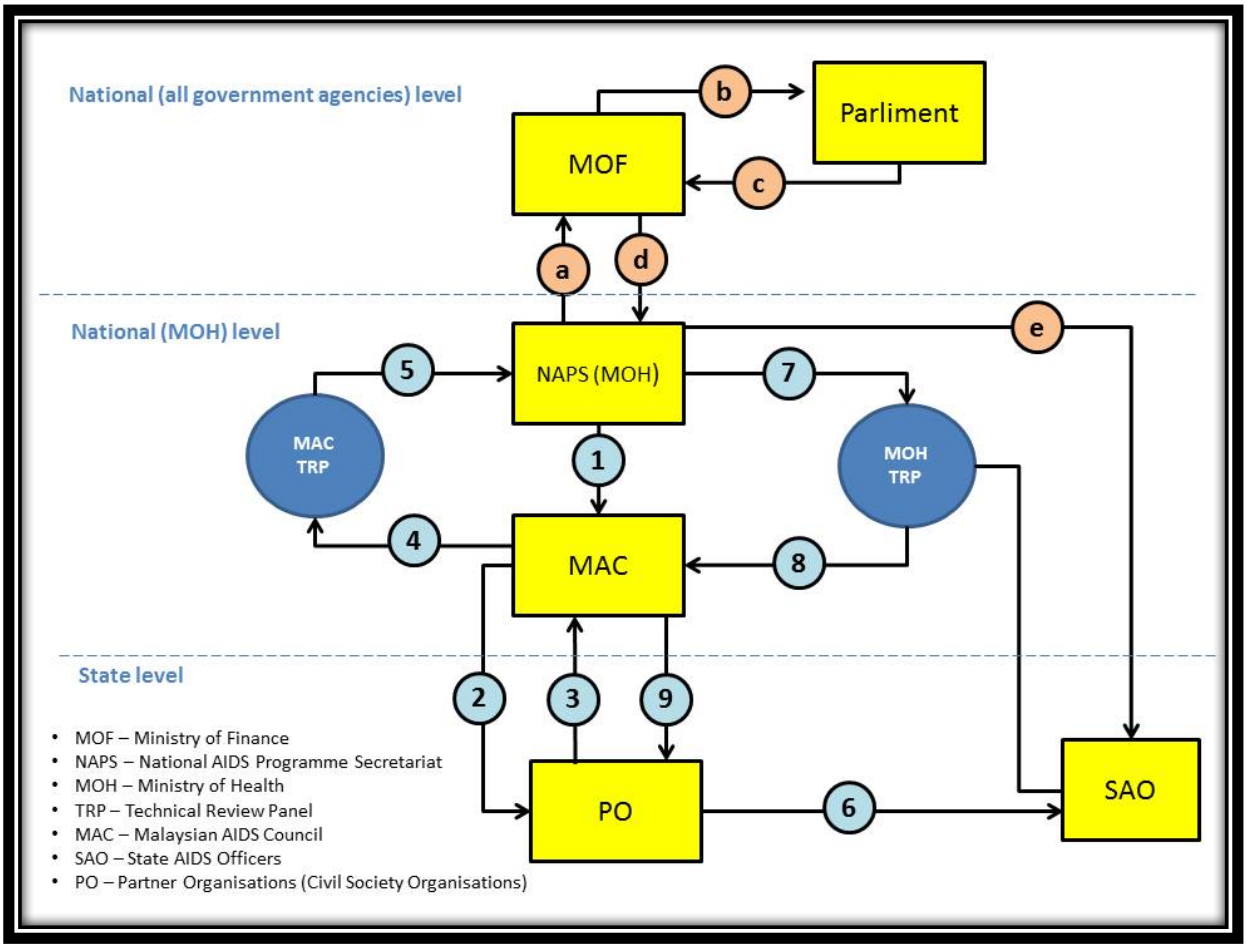
Table: Malaysia AIDS Spending Category, 2010-2013[45]

		US$				
AIDS Spending Category	**2010**	**2011**		**2012**	**2013**	**2014**
Prevention	8,420,996.86	9,881,368.81		7,972,887.05	9,729,816.76	9,072,615.78
Care and treatment	16,755,458.09	21,641,136.25		37,168,187.40	36,052,496.06	38,604,743.89
Orphans and vulnerable children (OVC)	623,586.14	790,880.79		1,072.51	817,215.30	861,247.58
System Strengthening and programme coordination	4,458,259.26	4,763,892.29		8,022,242.04	8,574,517.44	9,226,362.25

[43] Ministry of Health (2014), Country Progress Report Malaysia, 2010-2013
[44] Ministry of Health (2016)
[45] Ministry of Health (2014), Country Progress Report Malaysia, 2010-2013

Incentive for Human Resources (HR)	626,671.20	491,298.34		608,288.43	555,150.06	604,293.24
Social protection and social services including Orphans and Vulnerable (SSPS)	660,066.01	782,119.21		723,262.84	626,382.98	606,060.61
Enabling environment	293,012.28	1,521,959.39		157,468.26	140,466.28	211,489.24
Research	1,650.17	1,655.63		109,758.31	-	117,682.27
Total	**31,839,700.00**	**39,874,310.72**		**54,763,166.84**	**56,496,044.88**	**59,304,494.85**

V. National Budget Mechanisms



Process	Descriptions
1	MOH inform MAC to submit proposal
2	PO requested to submit the proposal with the budget within the given dateline.
3	PO submit proposal to MAC
4	MAC's Internal Technical Review process involved few processes. Firstly, the proposal will be reviewed by respective MAC's focal point and clarify with POs if there's any query. After clarification process, all proposals will be compiled and reviewed by MAC's technical panel which consist of Executive Director, Programme Director and representative from M&E and Audit department. The

	proposals are reviewed and discussed by MAC's internally and recommend approval based on the M&E achievements, financial performance, POs capacity and other related criteria.
5	MAC submit proposal together with MAC' recommendation for approval for MOH
6	To get support from State AIDS Officer, PO is recommended to meet their respective State AIDS Officer to explain their proposal prior to the MOH technical review process.
7	The National AIDS Program Secretariat which is the HIV/STI Sector of Control Disease Division of MOH, will review the recommended proposal submitted by MAC. The technical review process includes the State AIDS Officer and MAC focal points as the panel reviewer. POs are given the opportunity to present their proposal to MOH directly and justify of any queries raised by the panels.
8	MOH finalised and notified MAC of the approved proposal.
9	MAC will then inform successful PO. This process includes organisation assessment on the successful PO and negotiation on budget breakdown.
A	Government agencies, including the MOH submit proposals to the Treasury
B	After review and approval by the Minister of Finance and Cabinet, the proposal budget will be presented and debated in the Parliament
C	Approved budget by Parliament
D	The Ministry of Finance will produce the General Warrant to government agencies to proceed with approved budget
E	The HIV/STI Sector of Control Disease Division of Ministry of Health will decide approved funding for respective states and distribute accordingly. Approved funding is usually based on past expenses. At state level, the State AIDS Officer will distribute funding to respective district, also based on past expenses.

Funding Allocation Processes

In Malaysia, the HIV funding allocation processes is a top-down approach. The fiscal year for all institutions in Malaysia runs from January through December. The Government budget is prepared on a yearly basis. Budget planning commences in the first quarter of the calendar year and proposals are submitted to the Treasury by the end of the first quarter of the year. The Treasury evaluates the proposals and a consolidated national budget is tabled to Parliament by September. Approved funds are disbursed by early January of the following year to Heads of Departments.

Once approved by the cabinet, the budgetary funds for the National Strategic Plan for HIV/AIDS 2006-2010 are managed in total by the National AIDS Programme Secretariat (NAPS), the AIDS/STI Sector of the Disease Control Division, Ministry of Health. The AIDS/STI sector reports directly to the Director of Disease Control Division and the Deputy Director

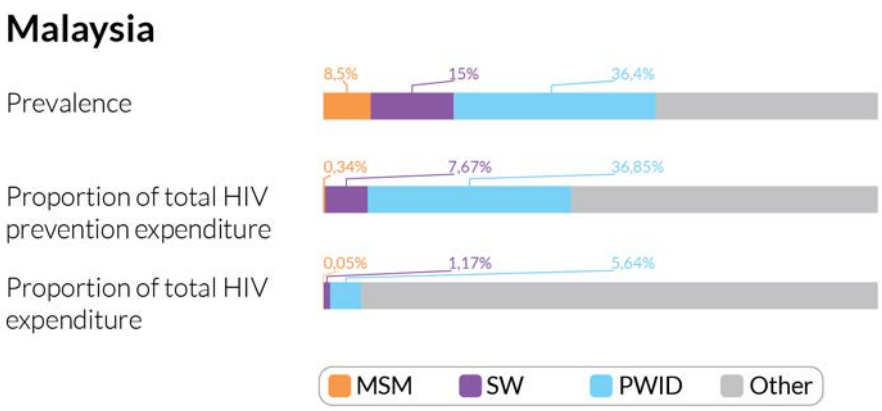
General of Health (Public Health). The Section serves as the secretariat to the Ministerial, Technical and Coordinating committees and coordinates and streamlines the national response supported by the AIDS Officers in every state. The funds are then distributed to government agencies.

However, the Ministry of Health grants for civil society are decided by the AIDS/STI sector which is disbursed and managed through the Malaysian AIDS Council. The civil society grant funding cycle process commences every October and advance payments to project implementers are scheduled to be disbursed in January. Programmatic reporting deadlines are five days after the completion of each calendar quarter.

Malaysian AIDS Foundation (MAF)

While the national budget mechanism provides a centralised government funding source, MAC established a dedicated fundraising arm the Malaysian AIDS Foundation (MAF) to help bridge gaps in government funding for HIV programs. Established in 1993, MAF works closely with corporate organisations and institutional funders to raise funds for MAC's 47 partner organisations. Activities supported by the fund include shelter homes for PLHIV, needle and syringe exchange programme (NSEP) for injecting drug users and outreach programs for marginalised communities.

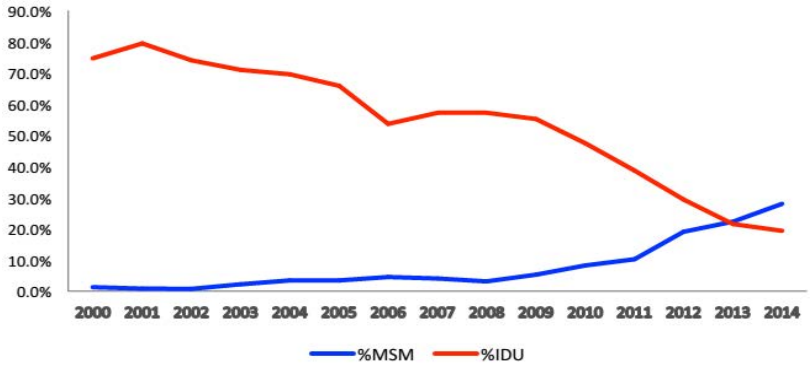
VI. Analysis



Mismatch between HIV expenditure and disease burden

Data collected from AIDS Info Online for 2014 indicates only prevalence rate, with no proportion of new cases (see below). Based on IBBS (2012) data, the HIV epidemic in Malaysia is concentrated with a very high burden in MSM, supplanting PWID as the main driver of new HIV cases. There is also a correspondingly low coverage on ART for MSM, despite excellent care and treatment investments and infrastructure.

Proportion of reported cases by mode of transmission – comparison between MSM and PWID, 2000 - 2014



While noting the high HIV financing investments in Malaysia, the issue of investing in key populations remains a political obstacle. Religious conservatism in political leadership is hampering public funding going to community-based interventions. High levels of stigma and discrimination especially in the Muslim community, and a poor CSO environment experiencing challenges in maintaining financial sustainability with on-going operational costs and limitations of management capacities have significantly impeded a more robust key populations response.

Population size

Up-to-date size estimation for key populations have not been available. According to a survey conducted in 2006, and reported in the GARPR 2016, the MSM population would be approximately 170,000. This would account for 2.3% of males aged 15-49 years having practiced same-sex behavior[46].

Currently, population size estimates are being undertaken by MoH with support from Global Fund, with an anticipated report available in the coming year.

Civil Society Engagement

Involvement of key civil society stakeholders in national level policy and programme development continues to be dependent on issues of capacity and relevance. Currently, the highest decision-making body related to HIV and AIDS policies in the country is led by the National Coordinating Committee in AIDS Intervention (NCCAI), chaired by the Ministry of Health with membership including all the Secretary Generals of the relevant ministries and agencies as well as civil society representatives, including the Malaysian AIDS Council.

Civil society is also represented on the Country Coordinating Mechanism (CCM) which provides governance for Global Fund related programme. In the CCM, key populations representatives (e.g. sex workers, PLHIV and transgender) have been elected onto the CCM by their respective communities. MAC and its partner organisations were involved with the

[46] MoH & WHO (2009). *National consensus workshop on estimation and projection of the Malaysian HIV epidemic*, Kuala Lumpur

development of the National Strategic Plan Ending AIDS 2016-2030, as well as a member of the Harm Reduction Committee and Technical Review Panel for HIV funding for CSO.

At the sub-national level, civil societies are actively involved in regular stakeholder meetings but the discussion is focused on issues with enabling environment, such as raids conducted by enforcement officers hampering quality HIV service delivery to key populations. Since the HIV budgeting process at National AIDS Programme Secretariat (NAPS) is a top-down approach, little opportunity is provided when it comes to HIV budget discussion at the MOH state level.

CSO Participation in Budget Negotiation

Through MAC's GONGO[47] financing model, several windows of opportunity are available to CSOs to negotiate in the budgeting process. Firstly after submission of proposal to MAC, the focal point is actively in contact with Partner Organisations (PO) for clarification and finalising the budget prior to internal technical review. Secondly, during the MOH technical review, POs are given the opportunity to present and justify their proposal before MOH makes a decision. POs could also meet their respective state AIDS officer to get their buy-in prior to the MOH technical review.

With the long standing engagement between POs and MAC, and the space provided for in the decision making processes within this financing mechanism, there exists further opportunities to fine tune the efficacy of MAC to advocate for civil society responses. An issue raised by CSOs is the inability for MAC to be fully critical of the government, considering the source of financing is from the government. With increased evidence generation and improved data on cost effectiveness of harm reduction programs for example, a stronger case can be made for investing in growing epidemics among key populations.

[47] GONGO: government organised non-governmental organisation

PHILIPPINES

I. Background Trends

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

A middle-income country, health expenditure per capita in the Philippines is on the average for the region. With a population of 103 million, the per capita health expenditure is USD 135.20, ranking third among the SHIFT countries. The share of total health expenditure in GDP is also on the average for the ASEAN region[48].

The epidemic in Philippines is primarily concentrated among men who have sex with men (MSM) and people who inject drugs (PWID), with variation across locations and sub-populations[49]. According to the 2012 HIV estimates and projections, there were 36,910 people living with HIV in Philippines in 2015 with around 4-5,000 new infections each year. The estimated HIV prevalence among general population in 2013 was 0.051%. According to the 2013 IHBSS, the HIV prevalence was 2.93% among MSM (21 sites), 48.24% among male PWID (2 sites), 30.39% among female PWID (Cebu City), 0.07% among RFSW (10 sites), and 1.03% among FFSW (9 sites)[50]. HIV transmission via MSM has become the predominant mode of transmission since 2007 and is the driving force of the epidemic in the country[51].

The "War on Drugs" is exerting a significant impact not just on lives lost from extra-judicial killings, but also on the harm reduction and HIV health promotion interventions made more challenging under the regime. In particular, advocacy for investments and services for PWID is significantly silenced in the current political climate, impacting the ability for the response to address the needs of key populations[52].

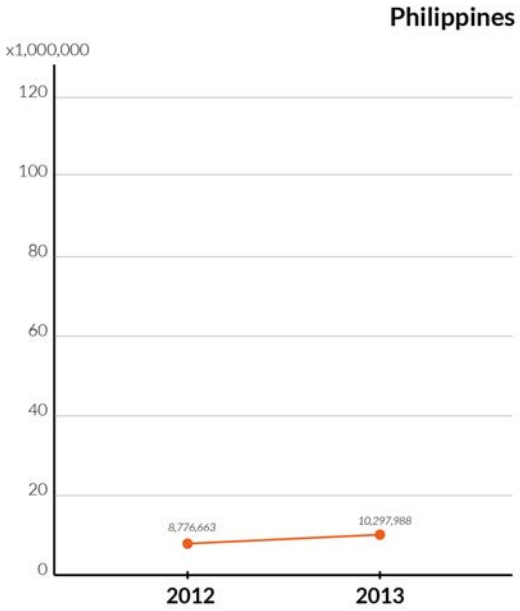
II. HIV Financing: Domestic vs International

For the period 2011 to 2013, the country spent about Php 1.3 billion for HIV/AIDS. This is an annual average of Php 453 million.Total spending from international and public sources are increasing (PhP 346 million in 2011; PhP 401 million in 2012; and PhP 412 million in 2013). HIV/AIDS spending from international sources has been steadily decreasing since 2013. In 2015 spending from international donors represented only 35% of total HIV/AIDS spending, with the Global Fund being the biggest contributor[53].

Other sources of financing include multilateral agencies (UN agencies, Asian Development

[48] World Bank (2017). Essential Information Philippines
[49] Philippine National AIDS Council (2014). *Global AIDS response progress reporting. Country progress report of Philippines*
[50] Department of Health of Philippines (2013) National Epidemiology Center, *2013 Integrated HIV behavioural and serologic surveillance (IHBSS): Males who have sex with males and Male injecting drug users*. 2014.
[51] Philippines National AIDS Council, *Philippine Estimates of the Most At-Risk Population and People Living with HIV. 2011 Philippines MARP and PLHIV estimates* 2011, Philippine National AIDS Council: Manila.
[52] Human Rights Watch (2017). *"License To Kill".* https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killings-dutertes-war-drugs
[53] Gotsadze, T (2017). *The Philippines HIV/AIDS Program Transition from Donor Support – Transition Preparedness Assessment*

Bank, World Bank), and USAID. Other government agencies that contributed include the Department of Social Welfare and Development, Department of Education, selected local government units (Quezon City, Makati City)[54].



HIV/AIDS spending from international sources has been steadily decreasing since 2013 (see table below). In 2015 spending from external sources represented only 35% of total HIV/AIDS spending, with the Global Fund the biggest contributor. Other international sources include various UN agencies and USAID[55]. Since 2004, the Global Fund has allocated more than US$ 44 million to support the HIV response in the Philippines.

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

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

Spending Category (excluding private)	2011	2012	2013
Prevention	153,054,158	242,071,135	165,672,105
Care and treatment	42,107,334	68,111,215	77,488,595
OVC	0	0	0

[54] GARPR (2014). Country Progress Report – Philippines PNAC
[55] GARPR (2014). Country Progress Report – Philippines PNAC

Program Management and Administrative Strengthening	122,329,314	76,763,661	140,549,256
Incentives for Human Resources	4,409,181	617,400	2,237,572
Social Protection and Social Services	2,604,877	2,250,000	2,350,000
Enabling Environment	19,928,145	9,113,680	12,182,774
Research	2,020,031	1,686,022	11,348,142
Total	**346,453,040**	**400,613,113**	**411,828,444**

Table: HIV Expenditure by category (Peso), 2014[56]

Prevention spending is also following an erratic trend, with available data (GARPR 2014) showing marked increase in 2012 and a drop in 2013 (see table above). However, it is important to highlight that reporting against budget categories is not fully standardised across countries. In the case of Philippines, the expenditure for HIV testing is included as part of treatment, complicating the feasibility for a meaningful cross-country comparison.

III. Key Populations HIV Epidemiology vs HIV Expenditure

Starting from 2009, the predominant mode of transmission shifted from heterosexuals to MSM, and it has continually increased since then. From January 2011 to October 2016, 85% (26,019) of new infections through sexual contact were among MSM[57]. HIV prevalence for transgender people is also disaggregated for 2015, standing at 1.7%[58].

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

*Source: 2015 IHBSS for Male PWID: Cebu, Mandaue. 2015 IHBSS for Female PWID: Cebu
** Source: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx

Figure: HIV prevalence among MSM, PWID and sex workers in sentinel sites, 2007 – 2015[59]

Reported cases are centred in three highly urbanized areas: Greater Metro Manila Area (which includes the provinces adjacent to Metro Manila - Rizal, Cavite, Laguna and Bulacan), Metro Cebu, and Davao City. These three areas plus Angeles City and Davao City are the highest priority areas for HIV intervention control[60].

[56] GARPR (2014). Country Progress Report - Philippines
[57] Gotsadze, T (2017). *The Philippines HIV/AIDS Program Transition from Donor Support – Transition Preparedness Assessment*
[58] UNAIDS DataHub (2016). Philippines Country Snapshot 2016
[59] Gotsadze, T (2017). *The Philippines HIV/AIDS Program Transition from Donor Support – Transition Preparedness Assessment*
[60] Gotsadze, T (2017)

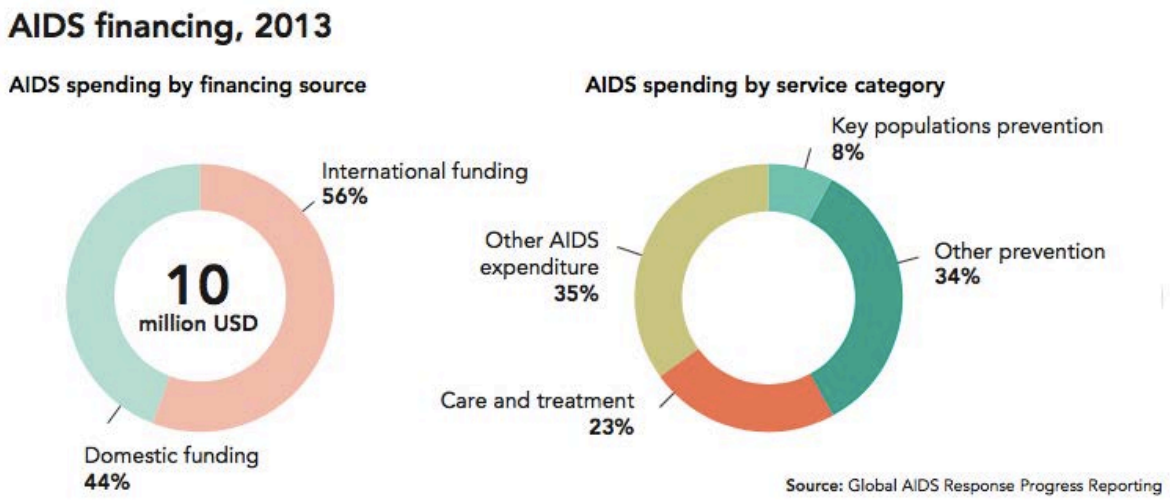
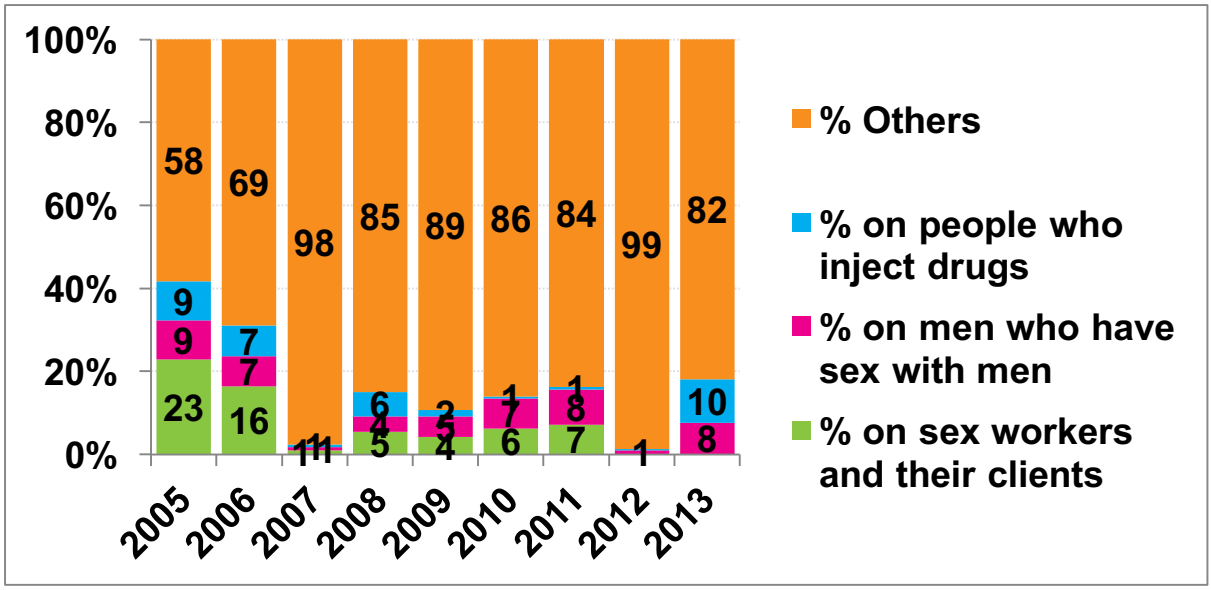


Figure: Share of AIDS spending by financing source and service category, 2013[61]

Latest available data (2013) indicates 18%[62] of spending on key populations prevention (note data incongruency in UNAIDS country snapshot 2016 above). This is contrasted against the major share of the burden of HIV at 95% of new infections. Key populations expenditure is also heavily financed by international donors, accounting for 100% of MSM and sex worker prevention investments. However, a highlight is the overwhelming domestic investment for PWID of 95%. This is based on latest available 2013 data which pre-dates the Duterte administration with its "War On Drugs" approach. It is imperative that up-to-date data be sourced to shed light on subsequent spending, which most likely will indicate a different reality.

Figure: Share of Prevention Investments in Key Populations (Philippines, 2013), latest available data[63]

[61] UNAIDS DataHub (2016). Philippines Country Snapshot 2016
[62] UNAIDS Datahub (2017).
[63] http://www.aidsinfoonline.org/kpatlas



Proportion of total prevention programme spending on key populations at higher risk, 2005-2013[64]

IV. HIV Financing mechanisms

While the Department of Health accounts for a substantial proportion of national government health expenditures, there has been increased health spending in recent years by other national government agencies such as the Office of the President and the Philippine Charity Sweepstakes Office. Health expenditures by other national government agencies are sometimes implemented by the DOH but not usually covered by the medium-term planning carried out for the sector by the DOH, as this funding source is usually erratic, subject to fund availability and could be motivated by reasons other than national health goals. As this non-DOH national government spending becomes relatively larger, there is a greater need to coordinate these two expenditure streams so that overlaps and crowding out are minimized and gaps are properly identified and addressed[65]

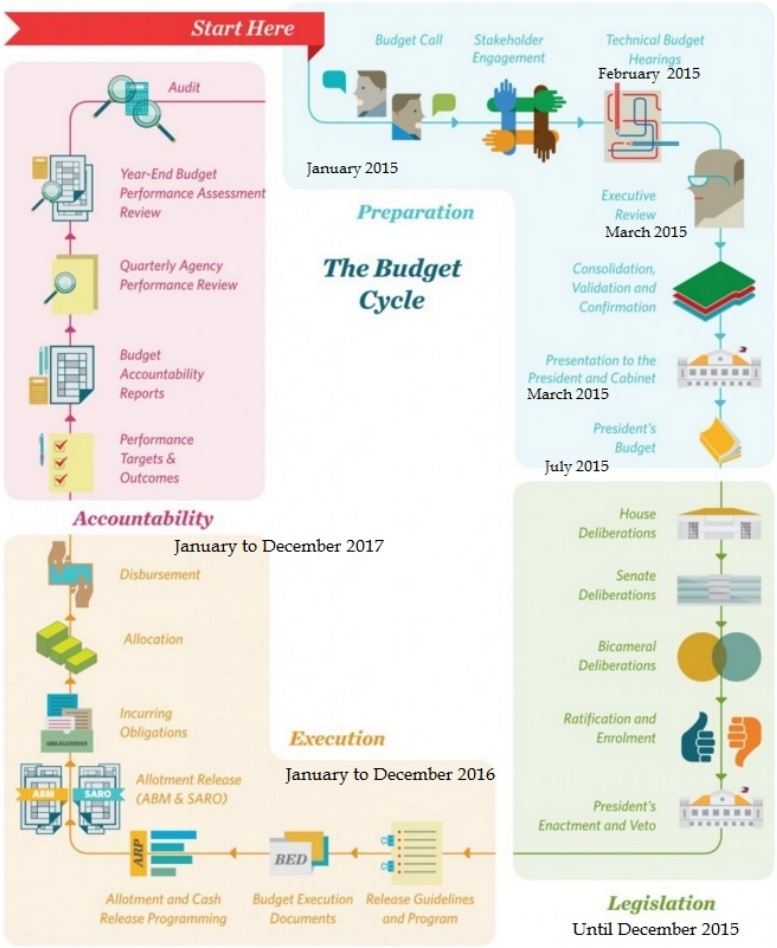
In the Philippines, the National Health Insurance Programme is the largest insurance programme in terms of coverage and benefit payments. The two main agencies that pool health care resources are the government and PhilHealth (the Philippine Health Insurance Corporation). The annual process of developing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

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

[64] UNAIDS DataHub (2017)
[65] TPA (2016)

passed jointly by both houses of Congress. LGU health budgets are developed in a similar way to the DOH budget.

V. National Budget Mechanisms



Philippines budget cycle begins with the budget preparation. A budget call is issued in December of the previous year to aim for the completion of the President's budget for submission to Congress by July. The budget call contains budget parameters (including macroeconomic and fiscal targets and agency budget ceilings) as set beforehand by the Development Budget Coordination Committee (DBCC); and policy guidelines and procedures in the preparation and submission of agency budget proposals[66].

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

Until 2012, only the appropriation stage has the provision for citizen's participation in the entire budget process. Participation on taxation and revenue issues are limited to professional groups and participation in the budget process is only during the budget

[66] Budget ng Bayan (2012)

legislation phase. Some citizens group are now starting to monitor some government expenditures[67]. In 2012, the Department of Budget and Management issues National Budget Circular No. 536 which provides the guidelines on partnership with civil society organizations and other stakeholders in the preparation of agency budget proposals. The circular aims to institutionalize participatory budgeting by allowing agencies enter into a budget partnership agreement (BPA) with CSOs. The BPA is a formal agreement between the national government agency and the partner civil society organization that defines the roles, duties, responsibilities, schedules, expectations and limitations with regard to implementing the CSO's participation in budget preparation, execution, monitoring and evaluation of specific programs/ activities/ projects of the partner national government agency. The circular also outlines the requirements for CSOs to enter into a BPA with a government agency[68].

The Department of Budget and Management seeks to increase citizen participation in the budget process by tasking government agencies to partner with civil society organizations and citizen-stakeholders in the preparation of the agency's budget proposals. Government agencies were mandated to conduct CSO consultations[69].

The aim of the bottom up budgeting process is to promote inclusive growth and poverty reduction. It seeks to "increase citizens' access to local service delivery through a demand-driven budget planning process and to strengthen government accountability in local public service provision"[70] Priority poverty reduction projects are identified at the city/municipal level through the bottom up participatory planning and budgeting.

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

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

Under the Local Government Code of 1991, LGUs serve as stewards of the local health system and are therefore required to formulate and enforce local policies and ordinances related to health, nutrition, sanitation and other health-related matters in accordance with national policies and standards. LGUs are also in charge of creating an environment conducive for establishing partnerships with all sectors at the local level. Provincial governments are mandated to provide secondary hospital care, while city and municipal

[67] Briones (2010)
[68] Department of Budget and Management (2012)
[69] Budget ng Bayan (2012)
[70] National Anti-poverty Commission (2015)

administrations are charged with providing primary care, including maternal and child health, nutrition services, etc. Rural health units were created for every municipality in the country to improve access to health care.

VI. Analysis

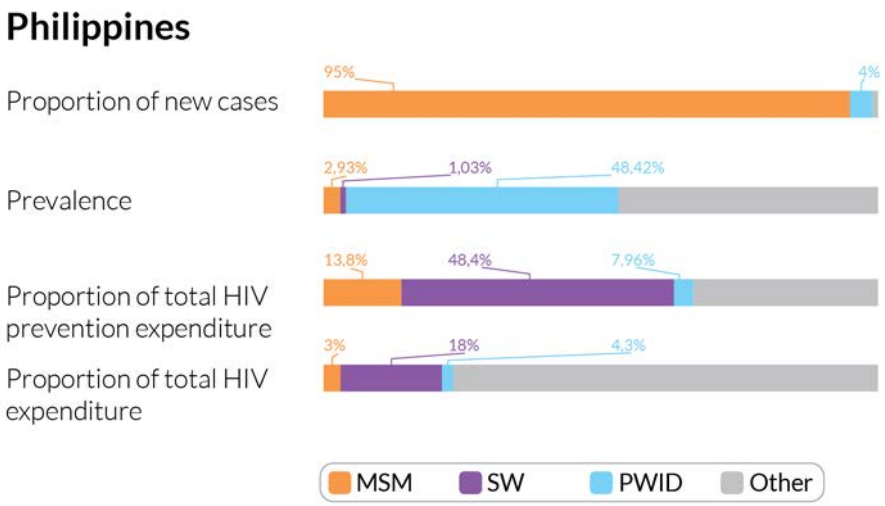


Figure: Mismatch between HIV expenditure and disease burden

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

CSO Financing issues

Current needs are estimated at 50-60 million USD, markedly above actual HIV expenditure which is in the range of 20 million USD in 2016 (domestic and international). However, the new administration is considering the rising epidemic seriously, with allocation of 21 million USD for 2017. Indicated within this is a substantial allocation to MSM activities (6% were allocated to MSM in 2013, final amount has not been confirmed)[71].

The confidence for CSOs financing has suffered a blow, stemming from recent scandals of "ghost NGOs" set up by government officials to siphon public money into private purses. This drew skepticism on the system's transparency and initiated a tightening of NGO regulations, with the government investigating new mechanisms with a stronger focus on financial control and accountability[72]. No formal mechanisms has been implemented as yet,

[71] UNAIDS Country Office (2016)
[72] Francisco, K & Geronimo, J (2013). *Why fake NGOs got away*. https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away

but a barrier raised in community consultations suggest accreditation of CSOs as a chief barrier, with upwards of 2 years wait time for the process.

System Efficiency and Fund Absorption

A comparison of the allocation and actual spending of the "obligated funds" points to underutilised resources. There are two possible explanations for the inability of the DOH to maximize the spending of available resources. The first relates to weaknesses in the capacity of the central DOH, CHDs and LGUs to spend resources effectively. Another reason for low fund utilization relates to weak incentives among managers to push spending[73].

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

[73] WHO (2011) The Philippines Health System Review

THAILAND

I. Background Trends

Health expenditure per capita (current USD)	**2014**	**360.38**
Share of public health expenditure in Government Expenditure	2014	23.25%
Share of public health expenditure in total health expenditure	2014	86%
Share of total health expenditure in GDP	2014	6.5%

Table 1: Thailand background data (World Bank, 2016)

One of the most developed nation in South-East Asia, Thailand has strong economic resources to invest in healthcare. With a population of 69 million, the health expenditure per capita is USD 360.38, ranking second after Malaysia among the SHIFT countries. With strong support from the government, the bulk of medical costs in the country are covered under comprehensive UHC schemes, with highly subsidised access to HIV treatment, comprehensive HIV continuum and care policies, and comparative better legal environment for key populations that does not explicitly criminalise them.

II. HIV Financing: Domestic vs International

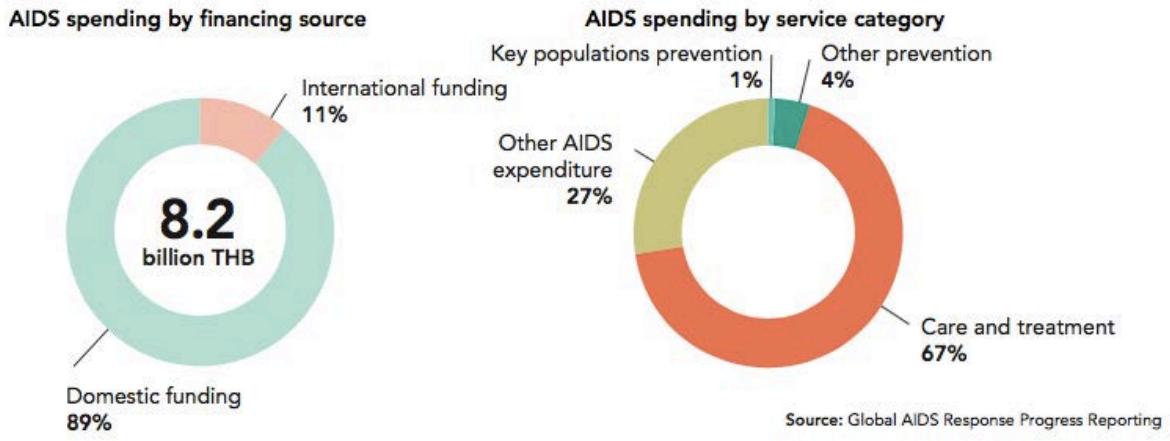


Figure: Proportion of HIV expenditure by financing source and service category, latest available data[74]

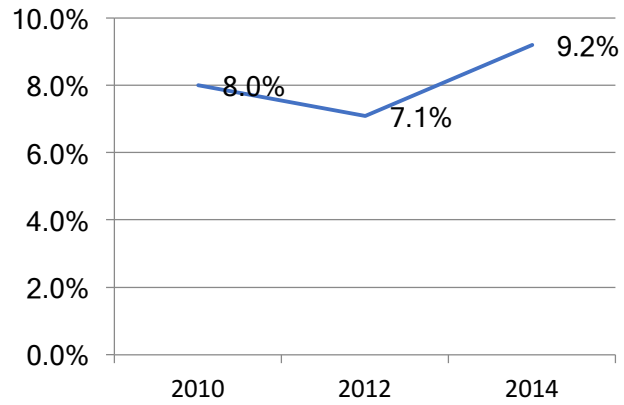
Second to Malaysia in terms of domestically driven support in HIV financing, Thailand funds 89% of its HIV programmes. The government has committed to transition to a fully domestically funded HIV and TB response in 2017. However, for 2017 of the total of USD 436.1 million required, it is estimated only USD 378.7 million will be funded domestically - including USD 332.3 million from government revenues, USD 46.3 million under social health insurance and USD 0.1 million from the private sector. In addition, external funding from Global Fund will contribute USD 6 million, leaving a gap of USD 51.4 million[75]. Currently, only THB 50 million (approximately USD 1.4 million) is available on an annual basis for all CSOs and key population based HIV programs in the country through the NHSO fund.

[74] UNAIDS Datahub (2017). Country Snapshot: Thailand
[75] Thailand TB and HIV concept Note (2016), p43.

III. Key Populations HIV Epidemiology vs HIV Expenditure

Thailand is among the most severely affected countries by HIV in region. The country has a population of more than 68 million with an estimated 445,000 people living with HIV in Thailand in 2014 with around 7,800 new infections pear year[76]. HIV new infection is estimated to continue declining but at a slow pace, and with high proportion of new infections attributed to MSM, IDUs, and sex workers. The HIV prevalence in 2014 was 19% among PWID, 11.7% among MSW, 9.2% among MSM, and 1.1% among venue-based FSW[77]. The recent surveillance results and most updated estimates and projections of the HIV epidemic suggest an explosive epidemic among MSM that is driving the epidemic. MSM HIV prevalence was 8% in 2010, 7.1% in 2012, and 9.2% in 2014 (figure below). Among new infections occurring in 2012-2016, MSM account for 44%[78].

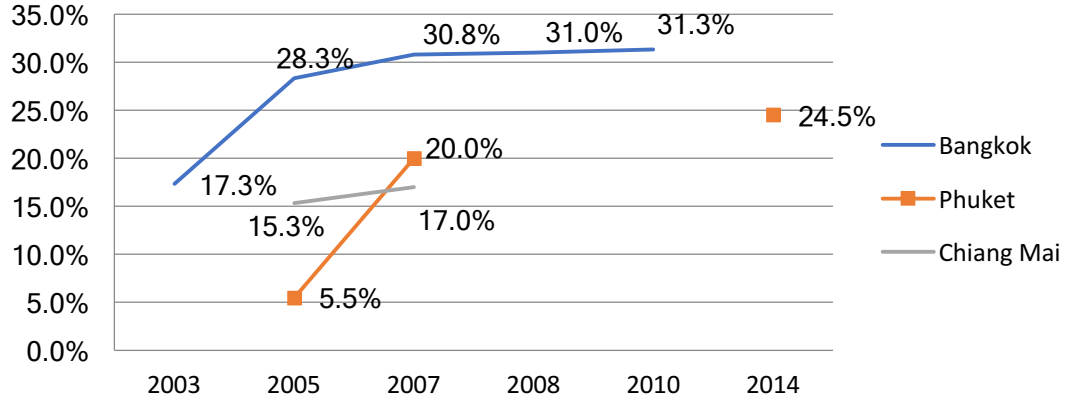
Figure: HIV prevalence among MSM 2010-2014[79]



Studies conducted in cities indicate a much higher HIV prevalence for MSM. In Bangkok, cross-sectional HIV prevalence assessments reveals an increase of the HIV prevalence from 17.3% in 2003 to 31.3% in 2010. In Phuket, the HIV prevalence increased from 5.5% in 2005 to 20% in 2007 and 24.7% in 2014. In Chiang Mai, the prevalence was as high as 15.3% in 2005 and increased to 17% in 2007. In Udonthani and Pattalung, the HIV prevalence was 5%.

[76] National AIDS Committee of Thailand (2016). *Thailand Global AIDS Response Progress Report. Reporting period: 2014*.
[77] National AIDS Committee of Thailand (2015). *Integrated Biological and Behavioral Survey (IBBS) in 2014*
[78] Thailand Working Group on HIV/AIDS Projection (2014). *Projection for HIV/AIDS in Thailand 2010 -2030.*
[79] National AIDS Committee of Thailand (2015). *Integrated Biological and Behavioral Survey (IBBS) in 2014*

Figure: HIV prevalence among MSM in Bangkok 2003-2010[80]



Compared to the epidemic trends, latest disaggregated 2013 data from AIDS Info Online indicates a bulk of key populations investments coming from international donors, except for PWID with a marginally higher 32% coming from domestic sources.

Figure: Share of Prevention Investments in Key Populations (Thailand), latest available data[81]

IV. HIV Financing Mechanisms

Trends from health expenditures based on the National Health Account up to 2011 has reflected a steady increase from US$ 11,794 million in 2012 to US$ 20,260 million in 2017. As an upper middle income country, Thailand does not receive a large amount of external donor funding, and the vast majority of health spending is from domestic resources.

The National AIDS Spending Assessment in 2014 reveals that total AIDS spending was US$283 million in 2012, and increased to US$ 287 million in 2013. Growing country ownership for prevention interventions has been documented. Domestic funding has risen as a share of total investments from 85% (in 2011) to 89% in

[80] National AIDS Committee of Thailand (2015)

[81] UNAIDS (2017). AIDSinfoonline Key Population Atlas

2013. Notably, there is a small but discernible increase in prevention spending from less than 13% in 2011 (US$43 million), to 17% (US$49million) in 2013. External donor assistance from multi-lateral and bi-lateral partners (excluding the GF) is limited to technical assistance, research support or demonstration activities relating to MSM Test and Treat strategies. The total combined assistance for HIV/AIDS in Thailand during 2012-2013 was US$3.2 million.

Thailand proposes to strategically invest in the Global Fund country grant to 'front-load' investment for 'Ending AIDS' while domestic resources are being secured. In addressing the funding need, there is the aim to diversify domestic financing through budgetary provisions and funding across various Ministries (Health, Education, Social Welfare, Human Security), as well as local administrations, private sector, civil society and communities.

The HIV prevention sub-committee of the NAC is discussing a HIV prevention fund partly financed by the government. In addition, Thai National AIDS Foundation (TNAF) is exploring various channels of funding to support CSO activities beyond the Global Fund country grant, including reviewing and engagement with corporate social responsibility (CSR) and local administrations.

The National Health Insurance Office will provide USD 6.6 million (as a start-up fund), for CSO led HIV prevention activities including Community Strengthening Systems for task shifting and sharing to reduce reliance on health facilities.

Additionally, in 2015 the National Health Security Office allocated USD 9.5 million to the National AIDS Management Center to implement prevention activities for KP, including peer-led interventions, community mobilisation, and demand generation for testing; and to improve linkages and quality of services at the district, sub-district and community levels[82].

[82] Thailand TB and HIV concept Note (2016), p44.

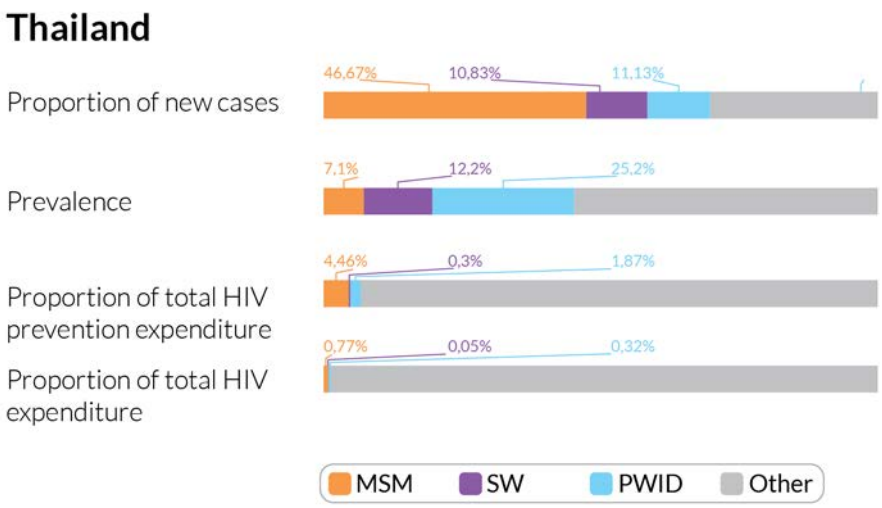
Funding Source	Investment in HIV (US$ million)		Projected resources for 2014-2017 (US$ million)			
	2012	2013	2014	2015	2016	2017
Domestic source-Government revenues	221.0	227.1	260.6	309.7	315.9	332.3
Domestic source-Social health insurance	32.7	29.5	35.3	43.4	45.8	46.3
Domestic source-Private sector contribution	0.3	0.1	0.1	0.1	0.1	0.1
Total Domestic	253.9	256.8	296.0	353.2	361.7	378.7
United States Government (USG)	1.0	1.9	4.2	4.2	4.2	4.2
World Health Organization (WHO)	0.0	0.1	0.2	0.2	0.2	0.2
World Bank (WB)	0.1	0.4	0.1	0.1	0.1	0.1
UN agencies	0.9	0.9	1.5	1.6	1.6	1.6
Total External - excluding Global Fund	2.0	3.2	6.0	6.1	6.0	6.0
Total External - Global Fund	27.0	27.3	39.2			
Total	282.9	287.3	341.1	359.3	367.7	384.7
Resource needs according to NSP and Ending AIDS Plan approved from NAC 2014-2016 and estimated for 2017			393.9	422.5	450.4	472.9
Resource Gaps			52.8	63.2	82.6	88.2

V. National Budget Mechanisms

Thailand's national budget mechanisms especially under the current military government presents limited inroads for civil society advocacy. As national budgets are predetermined from in a top down process, there are no provisions for civil society actors to influence the decision making. The work to advocate for better engagement of civil society and key populations needs instead rests on scaling up civil society organisation's ability to receive government funding. With the only legal requirement for CSOs to access HIV-related government resources is legal recognition as an established entity, the Thai government has been wary about contracting or funding CSOs because of alleged misappropriation of government-issued funds. Currently, there is no system in place to evaluate CSOs for their organizational capacity, accountability or ability to deliver services effectively and efficiently.

Starting in 2017, there is a move to formalise a CSO accreditation process led by Raks Thai Foundatio. RTF has been working to develop CSO accreditation guidelines that aim to promote accountability and increase the management capacities of CSOs, leading to better government confidence in funding CSOs for HIV prevention services.

VI. Analysis



2015 data shows almost half of the proportion of new cases coming from MSM, however prevention spending on MSM is only 4.5% of total expenditure. While Global Fund and USAID funding will continue to support MSM and PWID based programs especially prevention in the current round of funding, there is an urgent need to scale up CSO's especially key populations based organisations to access domestic funding.

CSOs in Thailand are seen as key partners to the national program, having a long history of setting epidemic control and being prioritized for resource allocation, as well as monitoring service quality and performance. The Thailand National Operational Plan Accelerating Ending AIDS 2015-2019 recognizes CSOs as central to its health system strengthening strategy to close the gap between the current and optimal response.[83] However, a main barrier identified is the general low managerial capacities in CSOs with few actors being able to lead implementation without external technical support. Absorption capacities of CSOs also remain a problem, with a lack of investment in capacity development and sustainability of organisations due to funding constraints and emphasis on client-centred deliverables. The above mentioned CSO accreditation process led by Raks Thai Foundation seeks to address these issues[84].

In response to transition from external funding, the government and CSO are conducting parallel initiatives to expand the resource base for HIV programs. The government has created a fund called the 3 Disease Fund (previously known as the 'Thai Fund'), which is substantially designed to mobilise resources from the private sector. The 3 Disease Fund will be led by a multi-stakeholder committee, including both business sector and civil society leaders.

The CSO Resource Mobilisation (CRM) Platform is a CSO led initiative, also aiming to raise resources from the private sector. A work plan of transition activities has been developed in negotiation with Global Fund to support a range of initiatives in capacity building and

[83] Siraprapasiri T, Ongwangdee S, Benjarattanaporn P, Peerapatanapokin W, Sharma M. The impact of Thailand's public health response to the HIV epidemic 1984–2015: understanding the ingredients of success. Journal of Virus Eradication. 2016;2(Suppl 4):7-14.

[84] For more information, please refer to APCOM (2018). Thailand Case Study

advocacy engagement. These activities aim to strengthen civil society implementation of HIV services, advocate the government and support the 3 Disease Fund and CRM work to mobilise resources.