

National Situational Assessment

on **HIV Financing** in
Indonesia, Malaysia,
Thailand and the Philippines



Sustainable HIV Financing in Transition (SHIFT) Programme



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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 »

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

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

Key Findings

I. Increasing Domestic Financing of National HIV responses

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

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

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

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



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

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

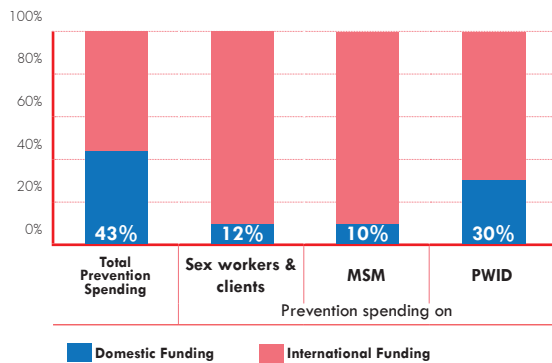


Figure 3: Distribution of prevention spending by financing source in 4 SHIFT countries, latest available year, 2014-2015⁶

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

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

III. Accessibility of Domestic Financing Sources

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

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

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

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

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

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

IV. Socio-Cultural and Political Contexts

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

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

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

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

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

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





Introduction »

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

The programme 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 a 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 were:

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 was grounded in four criteria as illustrated below:



Figure 1: Criteria for National Situational Assessment, adapted from Berman & Bitran (2011)¹⁸

Evidence-based

The assessment was based on a desk review of published data, a total of 118 resources in English, Bahasa Indonesia and Bahasa Malaysia were reviewed, 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 assessment was 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.

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

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 inform future case studies and country briefs developed for the SHIFT programme, to be released on the Knowledge Management Hub¹⁹.

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.

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 recent, 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 on²⁰. This is a perennial concern raised by key population communities on the importance of updated disaggregated information, an advocacy point that the SHIFT programme 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.

19. 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
20. Baral, S (2013). The "Data Paradox". <https://wherethereisnodata.org/2013/07/05/the-data-paradox/>



Indonesia

INDONESIA

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)

As 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 reflects an increasing trend. With a population of 259 Million, Indonesia's health expenditure of USD 99.41 is the lowest 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 are decentralised to the district level²¹.

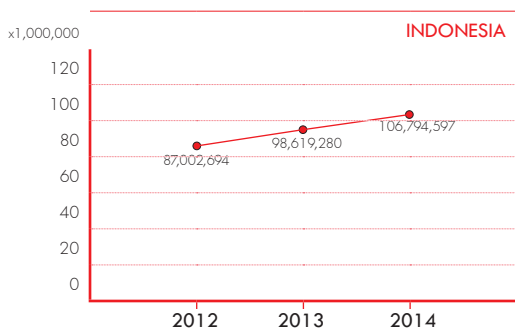


Figure 2: Trend in total HIV expenditure, Indonesia 2012-2014²²

II. HIV Financing: Domestic vs. International

The latest NASA (2015) report indicates an increase in domestic financing, overtaking international and private sources. Domestic financing was proportionally greater than 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)²³.

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 2019²⁴. The estimates and projections suggest MSM remain the worst affected by the epidemic. In 2014, an estimated 22.1% of new infection occurred among MSM. This proportion is projected to increase to 29.4% in 2019²⁵.

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

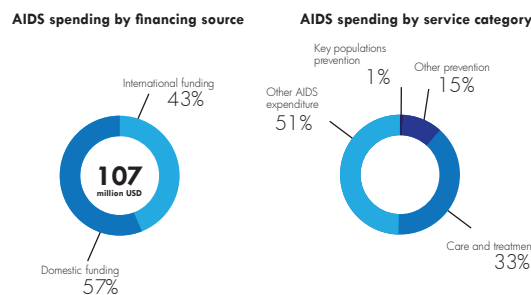


Figure 3: Proportion of HIV expenditure by financing source and service category, latest available data²⁶

21. World Bank Group (2016). Indonesia Health Financing System Assessment: Spend More, Right and Better. <https://openknowledge.worldbank.org/handle/10986/25363>
 22. UNAIDS (2017). AIDSinfoonline Key Population Atlas
 23. NASA Indonesia (2015)
 24. Ministry of Health of Indonesia, Estimates and Projections of HIV and AIDS in Indonesia. 2015.
 25. Ministry of Health of Indonesia Estimates and Projections of HIV and AIDS in Indonesia. 2015.
 26. UNAIDS Datahub (2017). Country Snapshot: Indonesia

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 on international donor funding, and the outlook for ongoing resourcing for HIV interventions for this population during 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 programmes. Lastly, there is a need for more up-to-date disaggregated financing information, as the latest data set presented here is from 2012.

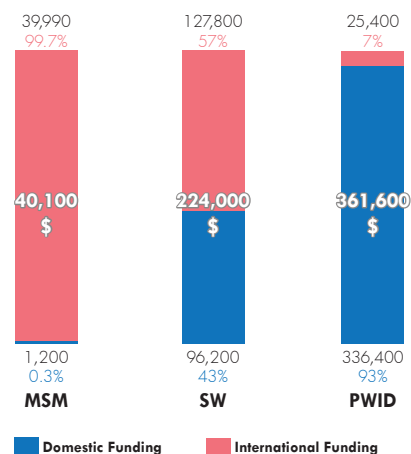


Figure 4: Share of HIV financing for Key Populations Programming in 2012²⁷

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

- Direct central government expenditure (APBN)
- 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.

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 non-core functions are channeled into three types of financing that can be used to support various health programmes at the provincial and district levels. These three are:

- 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.
- 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.
- 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.

IV. HIV Financing Mechanisms

Overview

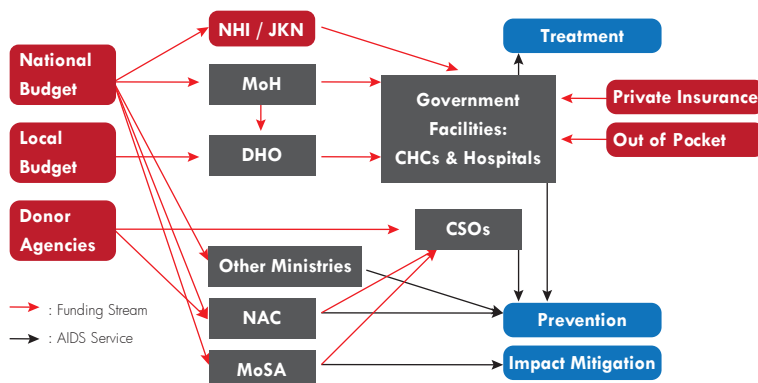


Figure 5: Indonesia's health financing sources and budget utilisation

Indonesia

Funding transferred to sub-national government is mainly used to finance subsidies on infrastructure, specific programmes 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 programmes targeting the 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 a 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% in 2014²⁸.

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 sources²⁹.

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

At the national level, in addition to MOH's budget, there exists a 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 on political and moral consideration and hence is not seen as a sustainable source for key populations financing.

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

Table 2: HIV expenditure other than MOH in 2014³⁰

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 with 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 during the process by 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.

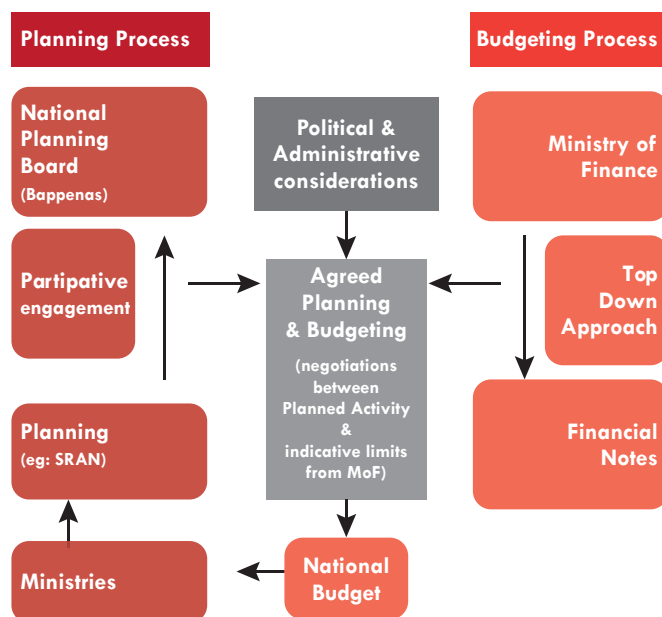
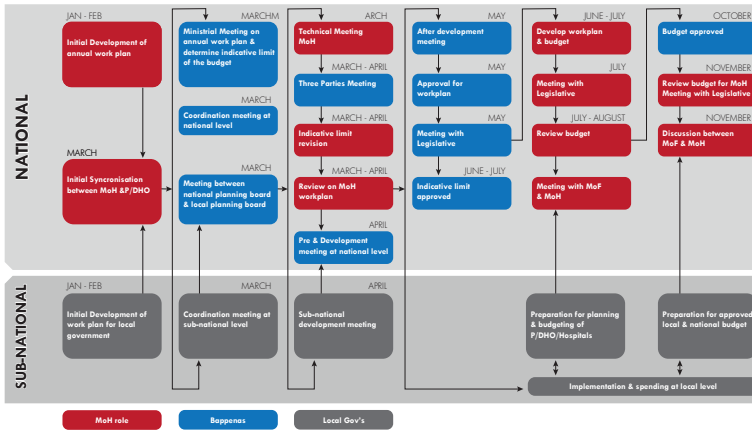


Figure 6: Budget planning process (based on interview with FITRA)

28. NASA Indonesia (2015)
29. NASA Indonesia (2015)
30. 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 process³¹.

VI. Analysis

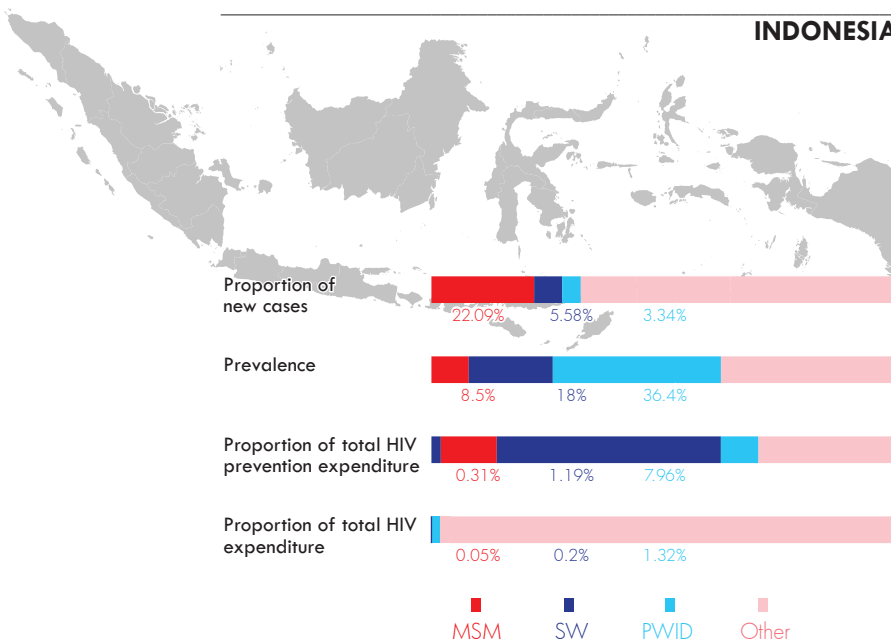


Figure 3: Key Populations Incidence and Prevalence vs Prevention and Total Spending, Indonesia 2014 ³²

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 largest with 36%, receiving more prevention investment than MSM at 8% and a total HIV expenditure of 1.3%.

An inference can be made that the bulk of funding for HIV prevention goes towards the general population (other). However, looking at the total HIV investment, which includes significant costs of care and treatment, the amount spent on the care and treatment for key populations is 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 faces the risk of becoming ineligible for Global Fund support. According to the Global Fund Eligibility Policy: Upper-Middle Income Countries that are members of the Group of 20 (G-20) countries are not eligible to receive an allocation and apply for funding unless they have an 'extreme' disease burden. Currently Indonesia is a lower-middle income country³³ but approaching upper-middle income status.

It remains unclear when Indonesia's ineligibility will be recognised. In the event of full domestic financing, a significant paradigm shift needs to occur requiring domestic governments to absorb the cost entirely. Because the bulk of key populations programmes are funded externally, except for PWID, the impact on key populations could be considerable if the transition is not managed.

31. Seknas Fitra, 2012. Budgetary Reform in Indonesia. Budget Brief September 2012
 32. AIDS Info Online (2017)
 33. World Bank 2017, Country classification by income. <http://www.piscomed.com/wp-content/uploads/2017/03/Income-classification.pdf>

Indonesia

Recommendations for Further Areas of Research

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

- How was 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?
- 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 the majority (43% and 32%) of the total expenditure respectively, there is a need to clarify what populations and intervention makes up these grouping, and why they are classified this way. See Table 3 below:

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. The HIV budget is also only a small fraction of the total health budget, indicative of a potential ease in negotiating budgetary reconsiderations³⁵.

Since decentralisation, 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 programmes are limited as they are not significantly involved in designing the AIDS response. As district level offices play a role in funding and administrative arrangements more than programme implementation, there is an opportunity to position CSOs as capable of complementing this work as programme implementers.

The National AIDS Commission (NAC) has pushed for the Ministry of Home Affairs to encourage provincial and district government to create local policies enabling provincial funding (APBD) for HIV responses 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 interpreting what these policies mean in the implementation stage. This results in programmes that may not be appropriate for the HIV response at the provincial level.

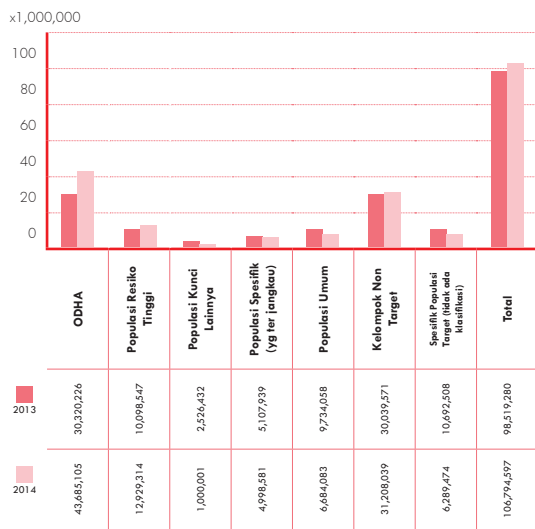


Table 3: HIV expenditure by population, Indonesia 2013-2014 (USD Million), translation provided in footnotes³⁴

34. 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).
35. Pers. Comms with Seknas Fitra (2017)

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 community organisations. These strategies are aimed to empower community organisations to be partners of the government in development process. Empowerment strategies include providing funds for the community organisations to implement their programmes (see Figure 7).

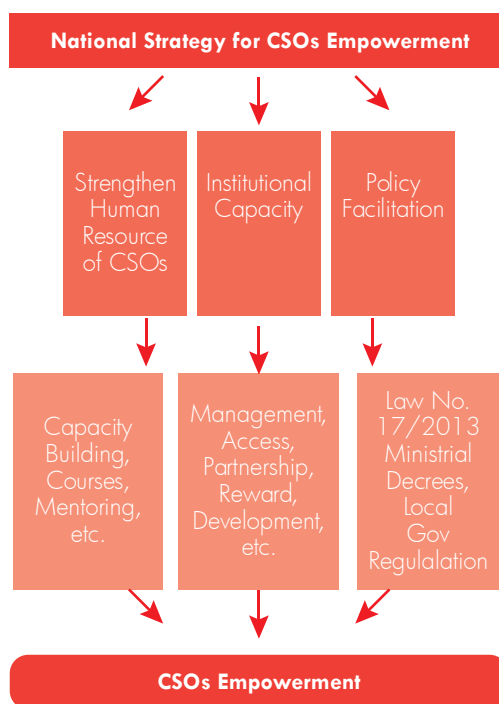


Figure 7: MOHA National Strategy for CSO Empowerment³⁶

CSOs and CBOs working in the HIV response across Indonesia are eligible for receiving funding from MOHA or other ministries because they are mostly registered as community organisations at Ministry of Law and Human Rights or at local government office³⁷. 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)³⁸.

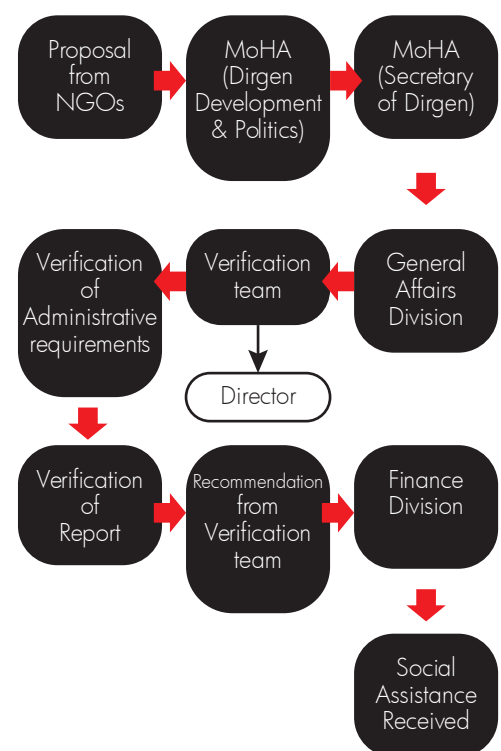


Figure 8: Procedure to Access Social Assistance based on Home Affairs' Ministerial Decree No.44/2009 and Home Affairs' Ministerial Regulation No.20/2013

36. MOHA (2015). Empowering Community Organisation based on Law No. 17/2013, presented at Indonesia Health Policy Forum, Padang, August 26, 2015
37. Koalisi Kebebasan Berserikat (2015). Monitoring Report 2nd Year of the Implementation of Act on Societal Base Organisation (Act Number 17/2013)
38. MOHA (2015). Empowering Community Organisation based on Law No. 17/2013, presented at Indonesia Health Policy Forum, Padang, August 26, 2015

Malaysia

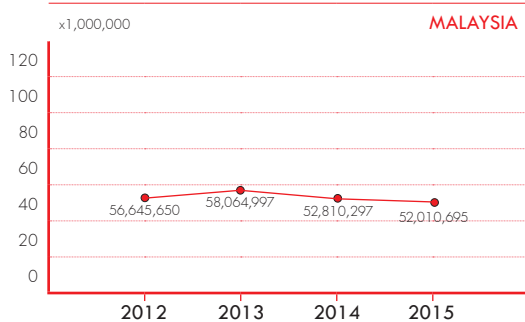
MALAYSIA

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%

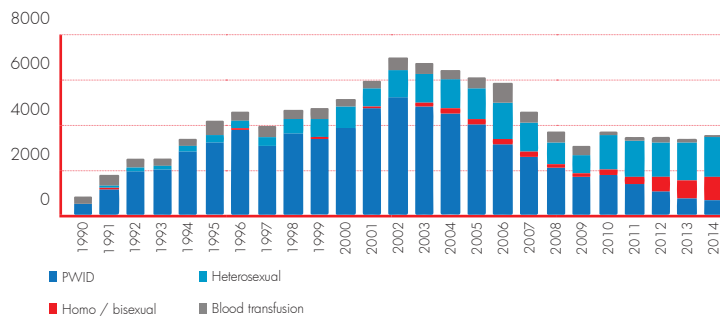
As a country shifting from upper-middle to high-income status, Malaysia is not short of resources for healthcare. With a population of 31 million, health expenditure per capita for Malaysia is at USD 456, the highest among the four SHIFT countries. Malaysia's total share of GDP on health expenditure however remains low for an upper-middle-income country.

Total HIV expenditure (USD Million)

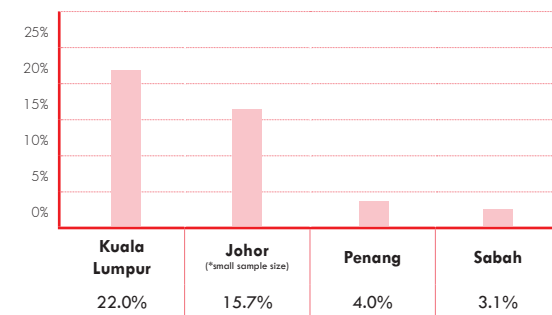


According to HIV estimates and projections, there were 92,895 people living with HIV and 5,200 new infections in 2015. The HIV prevalence (age 15-49, medium estimate) is 0.4%. The majority of HIV reported cases were from five states, including: Johor, Selangor, Kelantan, Pahang and Terengganu. The epidemic 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 transgender people (5.6%). The case reporting suggests that number of HIV infections among MSM would grow fastest. In 2014, MSM accounted for 30% of all reported HIV infections in the country (Figure 1 and 2)³⁹.

Reported HIV cases by mode of transmission, 1990-2014

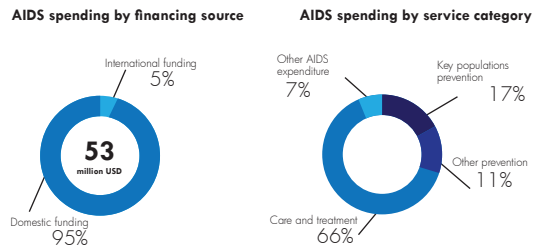


High HIV prevalence among MSM in big cities in Malaysia (Source: IBBS, 2014)



39. 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 epidemic⁴⁰. In 2014, 17% of total expenditure was invested in key population prevention⁴¹.

III. Key Populations Epidemiology vs. HIV 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, with the increasing incidence in MSM.

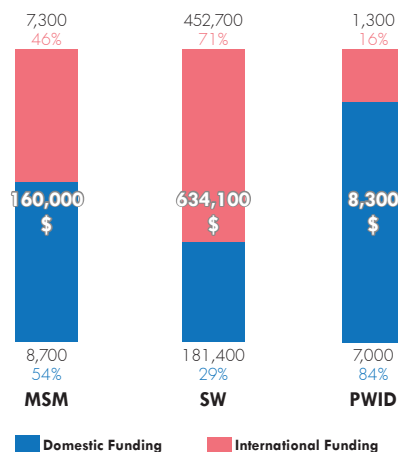


Figure 1: Share of HIV Financing for Key Populations Programmes in 2014

IV. HIV Financing Mechanisms

Unlike other regional counterparts, HIV programmes in Malaysia are heavily financed by public funding from the Ministry of Health⁴². Domestic financing accounts for 89% of the total HIV spending. Other sources of funding such as domestic, private and international sources contribute to between 2% and 5% of the HIV national expenditure, see figure below.

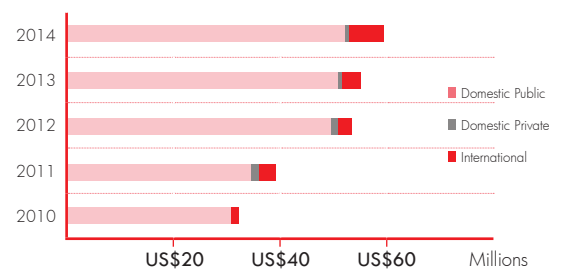


Figure: Malaysia HIV Financing based on Sources, 2010-2013⁴³

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, spending on prevention shrunk to less than 20%. The health system strengthening is the third most spent component ranging from 12% to 15% while other components such as enabling environment, human resources, social

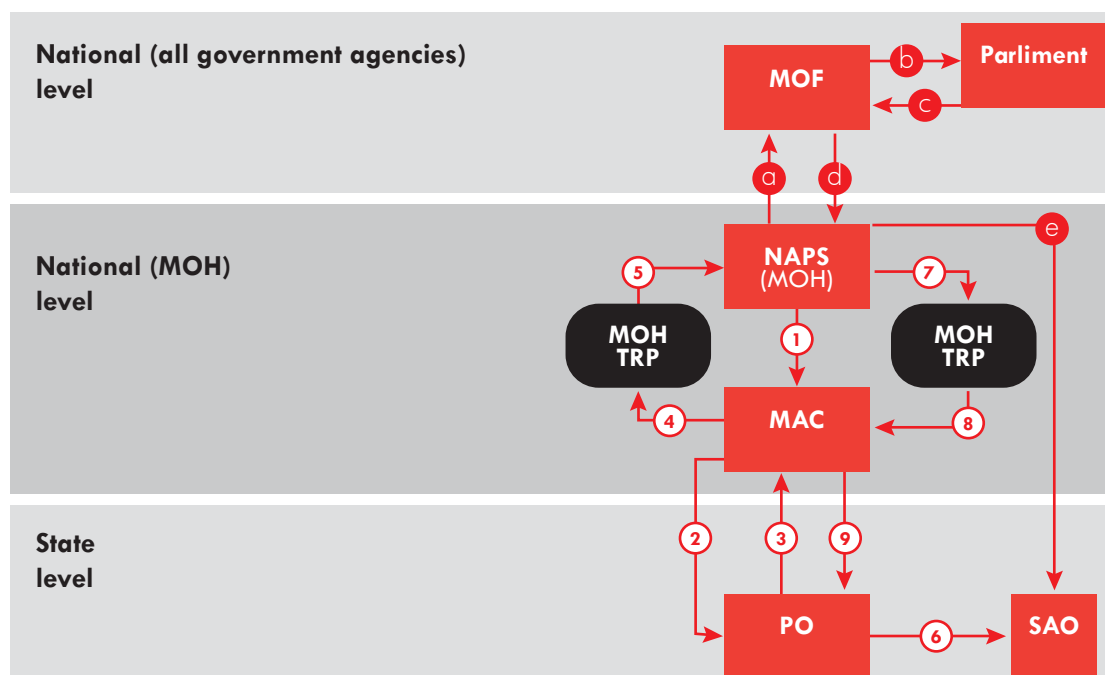
40. Huang M, Hussein H. The HIV/AIDS epidemic country paper: Malaysia. AIDS Educ Prev. Guilford Press; 2004;16: 100-109
 41. UNAIDS DataHub (2017). Country Snapshot: Malaysia
 42. Ministry of Health (2014). Country Progress Report Malaysia, 2010-2013
 43. Ministry of Health (2016)

Malaysia

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
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

Table: Malaysia AIDS Spending Category, 2010-2013 ⁴⁴

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 deadline.
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 clarified with POs if there's any query. After the 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 Programme 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 process 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 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, and the 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. Programme reporting deadlines are five days after the completion of each calendar quarter.

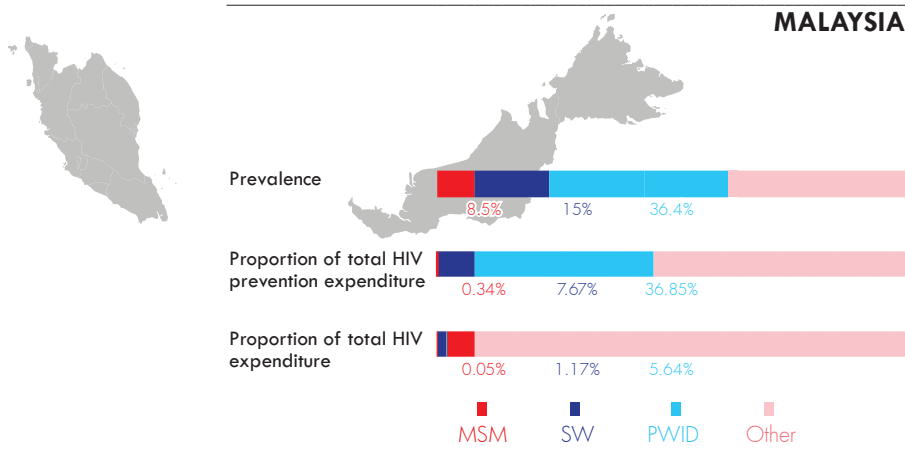
Malaysian AIDS Foundation (MAF)

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 programmes. 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 programmes for marginalised communities.

44. Ministry of Health (2014), Country Progress Report Malaysia, 2010-2013

Malaysia

VI. Analysis

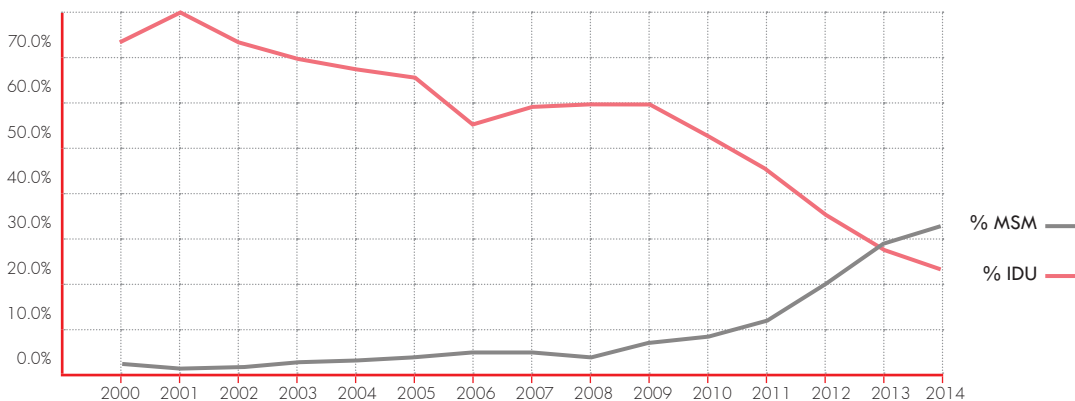


Mismatch between HIV expenditure and disease burden

Data collected from AIDS Info Online for 2014 indicates only a 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, investment in treatment and infrastructure.

While acknowledging the high HIV financing investments in Malaysia, the issue of investing in key populations remains a political obstacle. Religious conservatism in political leadership hampers public funding going to community-based interventions. A robust key populations-focused response is thwarted by high levels of stigma and discrimination, especially in the Muslim community, and a poor CSO environment which is challenged in maintaining financial sustainability with on-going operational costs and limitations of management.

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



Population size

An up-to-date estimation of the size of the key populations is not 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 behavior⁴⁵.

Currently, a survey of the population size is being undertaken by MOH with support from Global Fund, with the report expected 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). It's chaired by the Ministry of Health with membership including all the Secretary Generals of 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. Key population 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 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 environmental issues, such as raids by enforcement officers on key populations which hamper the quality of HIV service delivery. 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 GONGO⁴⁶ financing model, several windows of opportunity are available to CSOs to negotiate in the budgeting process. Firstly, after a submission of proposal to MAC, Partner Organisations (PO) are actively sought 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 the MOH decides. 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 its financing is from the government. With more evidence collection and improved data on cost effectiveness of harm reduction programmes, for example, a stronger case can be made for investing in growing epidemics among key populations.

45. MOH & WHO (2009). National consensus workshop on estimation and projection of the Malaysian HIV epidemic, Kuala Lumpur

46. GONGO: government organised non-governmental organisation



Philippines

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%

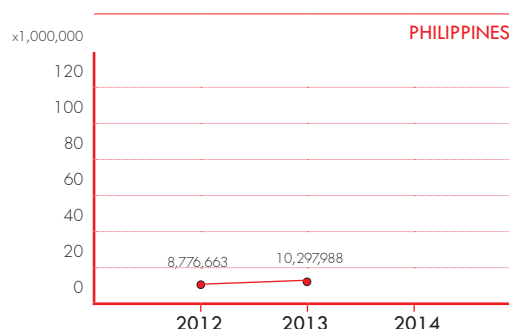
As a lower-middle income country, health expenditure per capita in the Philippines is about average for the region. With a population of 103 million, the per capita health expenditure is USD 135.20, ranking third among the SHIFT countries. The share of total health expenditure in GDP is also average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

The epidemic in the Philippines is primarily concentrated among MSM and PWID, depending on location and sub-populations⁴⁸. The estimated HIV prevalence among the general population in 2013 was 0.051%. According to the 2013 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)⁴⁹. HIV transmission via MSM has become the predominant mode of transmission since 2007 and is the driving force of the epidemic in the country⁵⁰.

The “War on Drugs” has had a significant impact not just on lives lost from extra-judicial killings but has also made harm reduction and HIV health promotion interventions more challenging. In particular, advocacy for investment and services for PWID is significantly silenced in the current political climate, impacting the ability for the response to address the needs of key populations⁵¹.

II. HIV Financing: Domestic vs. International

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



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

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

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

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

47. World Bank (2017). Essential Information Philippines
 48. Philippine National AIDS Council (2014). Global AIDS response progress reporting. Country progress report of Philippines
 49. Department of Health of Philippines (2013) National Epidemiology Center, 2013 Integrated HIV behavioural and serologic surveillance
 50. Philippines National AIDS Council, Philippine Estimates of the Most At-Risk Population and People Living with HIV. 2011 Philippines MARP and PLHIV estimates 2011, Philippine National AIDS Council: Manila.
 51. Human Rights Watch (2017). “License To Kill”. <https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killing-deter-tes-war-drugs>
 52. Gotsadze, T (2017). The Philippines HIV/AIDS Programme Transition from Donor Support – Transition Preparedness Assessment
 53. GARPR (2014). Country Progress Report – Philippines PNAC

Philippines

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

Table: HIV Expenditure by category (Peso), 2014⁵⁴

III. Key Populations Epidemiology vs. HIV Expenditure

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

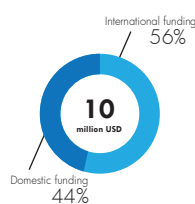
Type	KAP	2011	2012	2013	2014	2015
Prevalence	PWID*	13.6	13.6	46.1	44.9	29.0
	SW**	0.3	0.3	1.8	0.6	0.6
	MSM**	1.7	1.7	3.3	3.3	4.9

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

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

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

AIDS spending by financing source



AIDS spending by service category

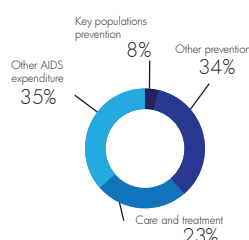


Figure: Share of AIDS spending by financing source and service category, 2013⁵⁹

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

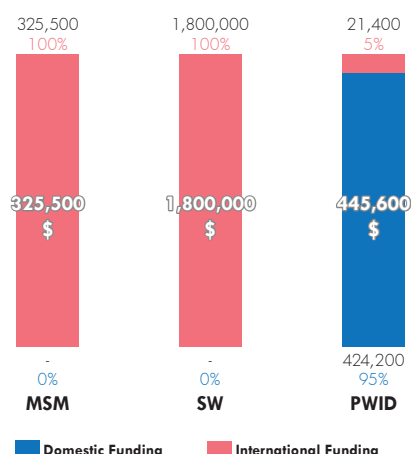
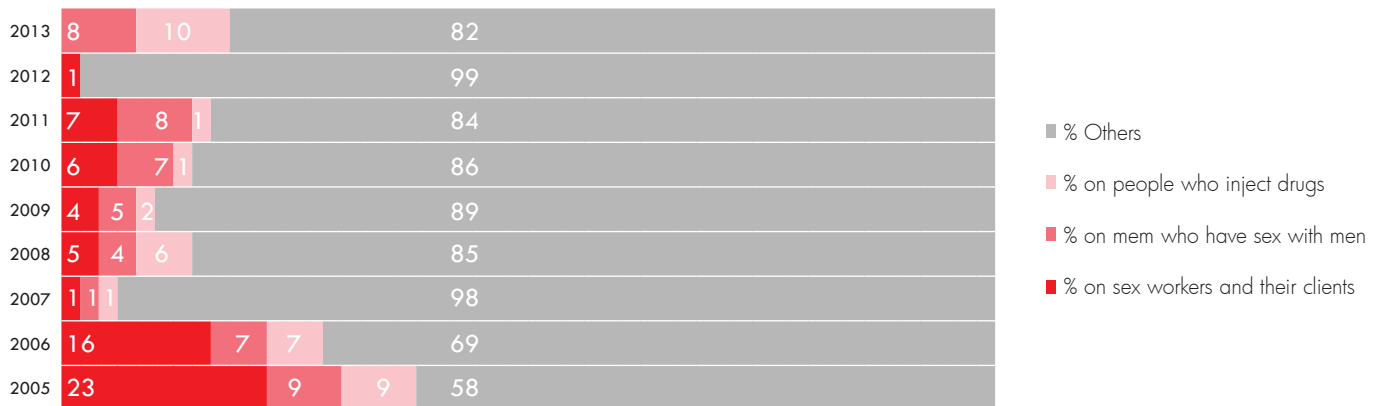


Figure: Share of Prevention Investments in Key Populations (Philippines, 2013), latest available data⁶¹

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

Philippines



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

IV. HIV Financing Mechanisms

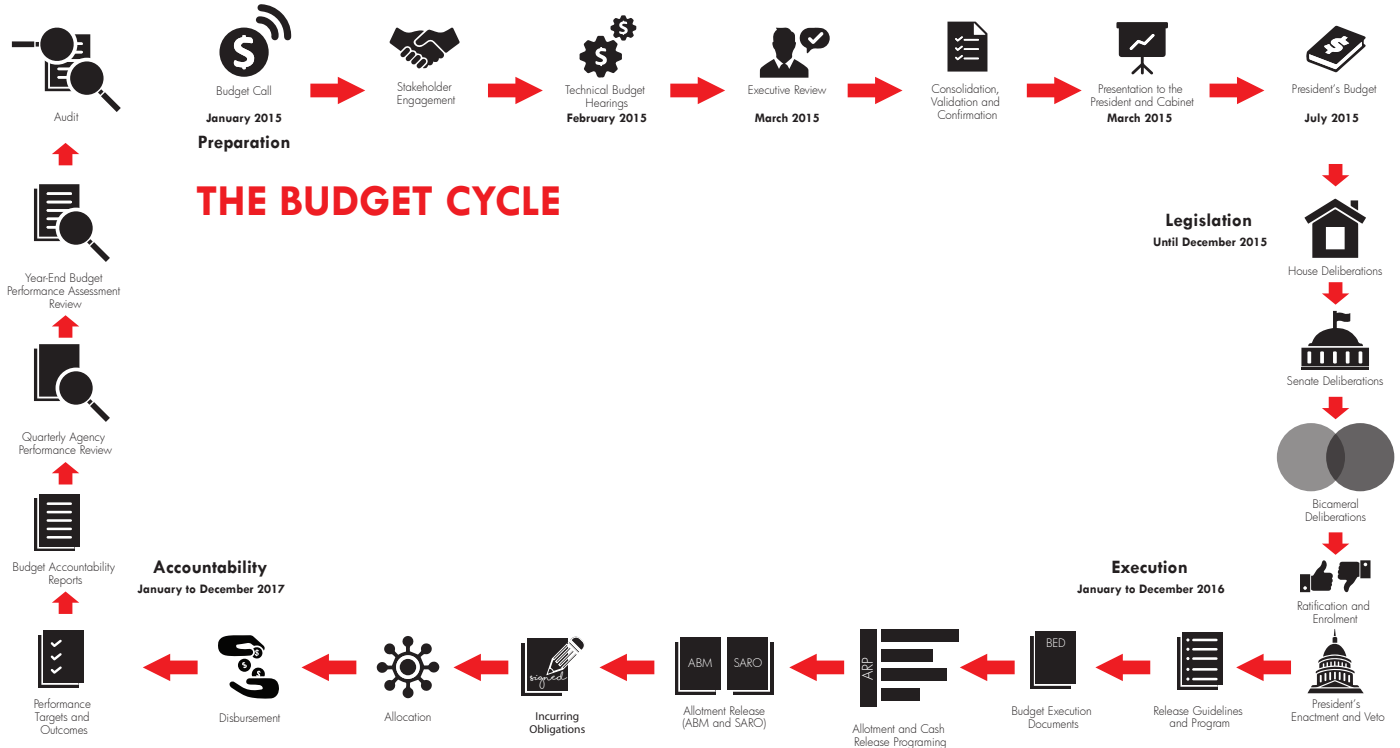
While the Department of Health accounts for a substantial proportion of the national government's health spending, there has been increased health spending in recent years by other national government agencies such as the Office of the President and the Philippine Charity Sweepstakes Office. Health expenditures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

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

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

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

V. National Budget Mechanisms



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

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

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

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

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

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

Philippines

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

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

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

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

VI. Analysis

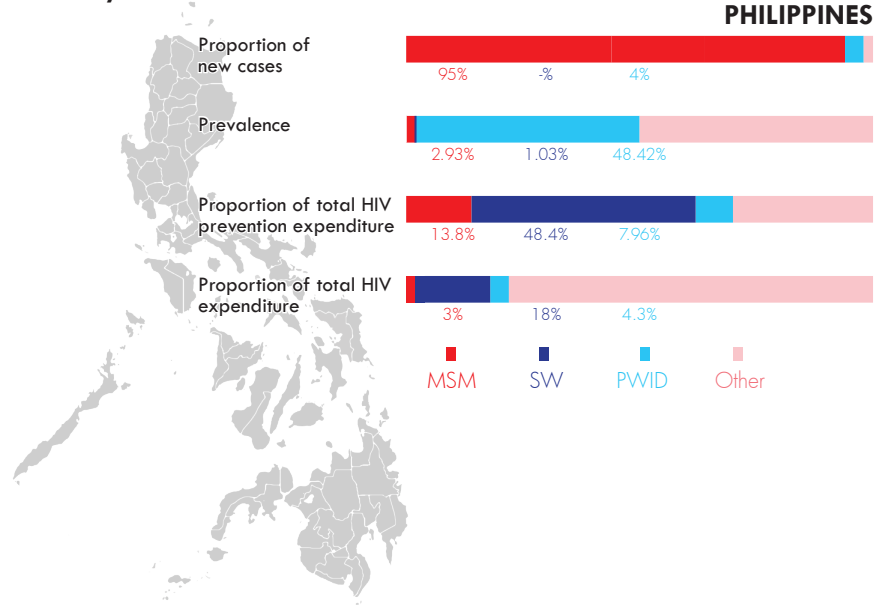


Figure: Mismatch between HIV expenditure and disease burden

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

68. National Anti-poverty Commission (2015)

Philippines

CSO Financing issues

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

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

System Efficiency and Fund Absorption

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

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

69. UNAIDS Country Office (2016)

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

71. WHO (2011) The Philippines Health System Review



Thailand

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 nations in Southeast 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 care policies, and a comparatively better legal environment for key populations that does not explicitly criminalise them.

II. HIV Financing: Domestic vs. International

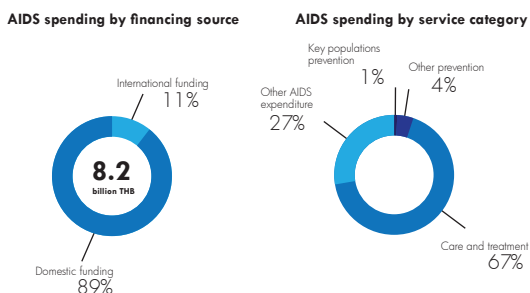


Figure: Proportion of HIV expenditure by financing source and service category, latest available data⁷²

Second to Malaysia in terms of domestic 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 million⁷³. Currently, only THB 50 million (approximately USD 1.4 million) is available on an annual basis for all CSOs and key population-based HIV programmes in the country through the NHSO fund.

III. Key Populations 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 annually⁷⁴. HIV infection is estimated to continue declining but at a slow pace, and with high proportion of new infections attributed to MSM, PWIDs, 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 FSW⁷⁵. Recent survey results as well as the most updated estimates and projections of HIV suggest an explosive rate of infection among MSM 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%⁷⁶.

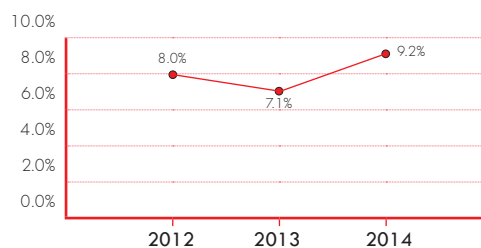


Figure: HIV prevalence among MSM 2010-2014⁷⁷

72. UNAIDS Datahub (2017). Country Snapshot: Thailand
73. Thailand TB and HIV concept Note (2016), p43.
74. National AIDS Committee of Thailand (2016). Thailand Global AIDS Response Progress Report. Reporting period: 2014.
75. National AIDS Committee of Thailand (2015). Integrated Biological and Behavioral Survey (IBBS) in 2014
76. Thailand Working Group on HIV/AIDS Projection (2014). Projection for HIV/AIDS in Thailand 2010-2030.
77. National AIDS Committee of Thailand (2015). Integrated Biological and Behavioral Survey (IBBS) in 2014

Thailand

Studies conducted in cities indicate a much higher HIV prevalence for MSM. In Bangkok, cross-sectional HIV prevalence assessments reveal 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%.

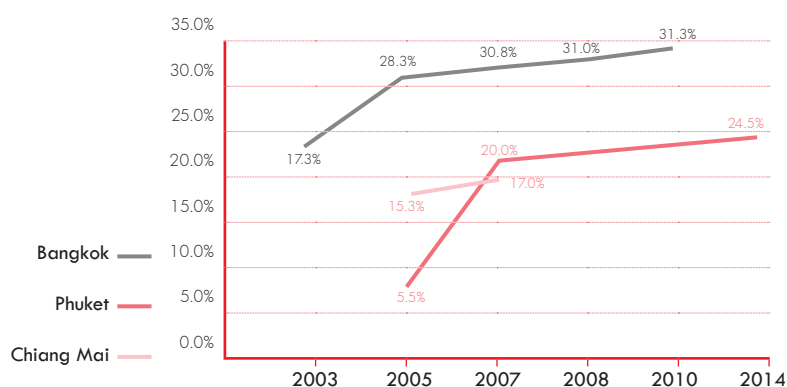


Figure: HIV prevalence among MSM in Bangkok 2003-2010 ⁷⁸

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

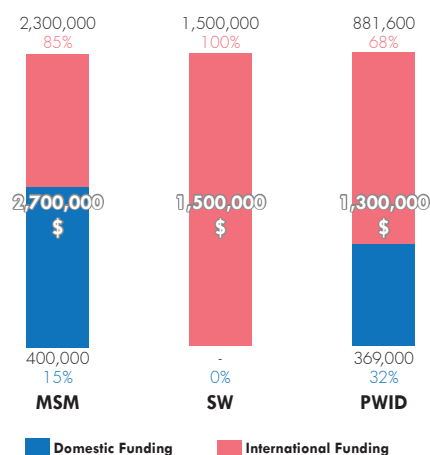


Figure: Share of Prevention Investments in Key Populations (Thailand), latest available data⁷⁹

IV. HIV Financing Mechanisms

Trends in health expenditure based on the National Health Accounts reflects a steady increase from USD 11,794 million in 2012 to USD 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 USD283 million in 2012 and increased to USD 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 2013. Notably, there is a small but discernible increase in prevention spending from less than 13% in 2011 (USD 43 million), to 17% (USD 49 million) in 2013.

External donor assistance from multi-lateral and bi-lateral partners (excluding the Global Fund) 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 USD 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 levels⁸⁰.

Thailand

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	4,523	44%
Domestic Source - Social Health Insurance	32.7	29.5	35.3	43.4	5,810	56%
Domestic Source - Private Sector Contribution	0.3	0.1	0.1	0.1	18	0.2%
Total Domestic	253.9	256.8	296.0	353.2	10,351	100%
United States Government (USG)	1.0	1.9	4.2	4.2	4.2	4.2
World Health Organisation (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, present limited inroads for civil society advocacy. As national budgets are pre-determined in a top down process, there are no provisions for civil society to influence 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 organisational capacity, accountability or ability to deliver services effectively and efficiently.

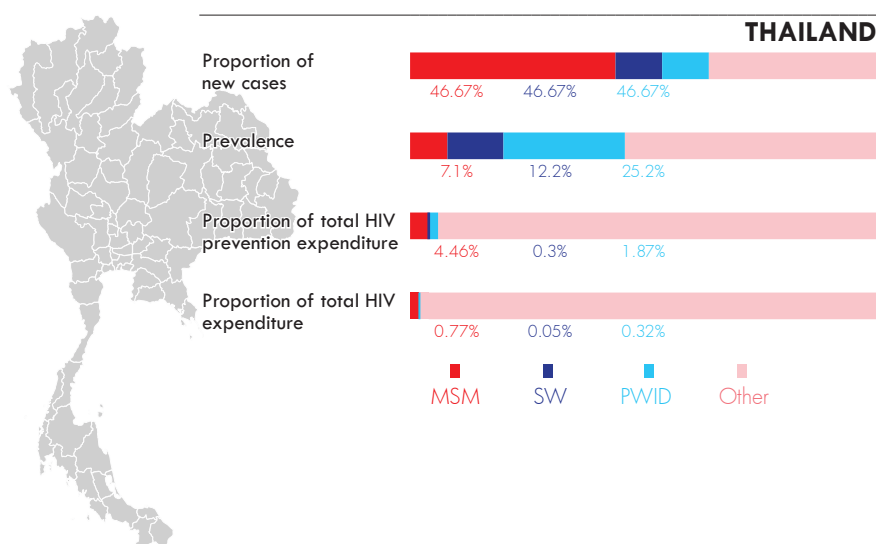
Starting in 2017, there has been a move to formalise a CSO accreditation process led by Raks Thai Foundation. RTF has been working to develop CSO accreditation guidelines that aim to promote accountability and increase the management capacity of CSOs, leading to better government confidence in funding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

78. National AIDS Committee of Thailand (2015)

79. UNAIDS (2017). AIDSinfoonline Key Population Atlas

80. Thailand TB and HIV concept Note (2016), p44.

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 programmes, especially prevention, in the current round of funding, there is an urgent need to improve CSO's access to domestic funding, especially for key population-based organisations.

CSOs in Thailand are seen as key partners to the national programme, having a long history of setting epidemic control and being prioritised for resource allocation, as well as monitoring service quality and performance. The Thailand National Operational Plan Accelerating Ending AIDS 2015-2019 recognises CSOs as central to strengthening its health system strategy to close the gap between the current and optimal response.⁸¹ 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 issues⁸².

In response to transition from external funding, the government and CSO are conducting parallel initiatives to expand the resource base for HIV programmes. The government has created a fund called the 3 Disease Fund (previously known as the 'Thai Fund'), which is largely 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 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.

81. Sirapapassiri T, Ongwangdee S, Benjarattanaporn P, Peerapatapokin 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.
82. For more information, please refer to APCOM (2018). *Civil Society Accreditation In Pursuit of Improving CSO Access to Domestic Funding: The Case of Thailand*.

SHIFT

Sustainable HIV Financing in Transition

Regional Partners:



AUSTRALIAN FEDERATION
OF AIDS ORGANISATIONS



Strengthening community systems
Advancing human rights



Sustainable HIV Financing in Transition

Country Partners:

