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GUIDING PRINCIPLES FOR COMPACT DEVELOPMENT

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POLICY BRIEF #3: GUIDING PRINCIPLES FOR AGREEMENTS TO SMOOTHEN THE TRANSITION FROM DONOR TO DOMESTIC PROGRAMMING AND FINANCING FOR HIV RESPONSES

Produced by: Oxford Policy Management (OPM) - APW with UNAIDS 2016/637467

As the HIV and AIDS community enters a new era of financing, we are seeing a major transition from global to domestic financing, particularly in middle-income countries. With external donor assistance expected to plateau and in some places go down, the importance of domestic financing will continue to increase. This comes at a time when there is a clear global commitment to the twin goals of Universal Health Coverage and Ending AIDS by the year 2030 – both of which have major implications for the funding and expansion of health and HIV programmes.

The goal is to smoothen the transition from global to domestic sources, and making sure that the resulting programmatic and financing mix is sustainable. It is imperative to maintain and expand effective programming to address HIV and AIDS. The necessary transition is not only from external funding to domestic resources, but often also from externally implemented programmes to locally designed, managed, implemented and monitored interventions.

The Economics Reference Group commissioned "Results for Development" to review existing agreements between donors and countries for smooth transition of programmes and related funding for different externally funded programmes, with a view to identify key guiding principles for the transition processes. The paper argues for transition processes to be guided by a clearly defined compact that in essence is an explicit agreement between a country's government and one or more donors. It outlines programmatic and financial commitments to the country's HIV and AIDS programme, and specifies mechanisms to hold parties accountable

Overall, the country agreements should reflect the principles of "fair share"- how much low- and middle-income countries can and should be expected to contribute to their HIV programmes – and "global solidarity" - the responsibility and capacity donors have to honour commitments and continue to contribute financially to the fight against HIV and AIDS. Rapid economic growth means many countries can steadily increase domestic resources for HIV if they were willing to. It is also important that countries are able to support programmes that provide the most effective services in an efficient way that leads to a reduction in HIV cases. In many cases this requires increased capacity at country level to develop and analyse policies, put in place domestically-maintained mechanisms for

programme delivery, and identify domestic capacity, including in the private and non-governmental sectors.

In addition, the agreements:

- are made between one or more country government departments or representatives, and one or more donors;
- include programmatic and financial commitments made by one or, ideally, all parties to the country's HIV and AIDS programme
- specify accountability mechanisms for donors, governments and other signatories

Analysis

For the development of these principles, a sample of country-donor financing agreements and compacts from PEPFAR, the Global Fund, the World Bank, the Millennium Challenge Corporation (MCC), the GAVI Alliance, and the International Health Partnership (IHP) was reviewed. In total, this involved 21 compacts from thirteen countries and four donors. The desk review was supplemented with interviews with key people at PEPFAR, the Global Fund, the World Bank, and the MCC.

- The review identified six key features including:
- the duration of agreement
- the actors included
- the programmatic targets including tools and input for setting these targets
- the financing targets including tools and input for setting these targets
- the monitoring and evaluation mechanisms
- the accountability mechanisms - consequences of not meeting the conditions of the agreement and incentives for over performing.

Goals of country agreements

Country agreements or compacts are designed to stabilize the changing HIV financing situation in low- and middle-income countries with the ultimate goal of ensuring uninterrupted high-quality service delivery for specific programmes (including for key populations) during and following the transition process.

Guiding principles

The following key guiding principles form a strong starting point for the development of country compacts for sustainable financing for HIV and AIDS.

- **Timelines - set a standard time period of five years at minimum.** A compact agreement requires a long enough time period to allow countries and donors to visualize and plan for a financing trajectory that can align with the achievement of programme targets. An agreement that spans only one or two years would not provide enough time for substantial programme and financial targets to be reached. In addition, single year and shorter-term agreements result in higher transaction costs for all stakeholders and partners compared to multi-year agreements. A period of five years would follow the practice of PEPFAR and MCC.
- **Actors involved - Select a key financing or high-level political authority together with a programmatic authority in a country as a signee on compact agreements to ensure that fair share commitments are met.** A compact agreement lays out important responsibilities and expectations for all parties. Signing partners

should be accountable under the compact against clear and substantial roles – whether financial or programmatic. Key signatories may include donors, country government ministries (Finance, Health), and non-governmental organizations (NGOs), but the specific combination and number of actors will depend on a specific country context and policy. More actors mean higher transaction costs, but also more coherence. Even if compacts do not include multiple donors as signees, there should be some attempt to ensure donor coordination within a country.

- **Programmatic targets – Define sequence and degree of programmatic transition on a year to year basis and ensure allocative efficiency.** Programmatic transitions might require thorough analysis and changes of the current service delivery modes, including social contracting (especially for programmes for key populations) integration to broader health facilities and task shifting to lower levels of health cadres including to community health care workers. In addition, parallel service and cost structures and information systems operated by donors should gradually be aligned with domestic cost structures, localised planning systems and systems to enable smooth absorption of costs and different programme elements

- **Financing targets - Specify domestic and external financing commitments - not just estimates - and include projected financial plans for the next five years.** Country compacts vary in the type of financing provided by the donor and in whether or not they contain domestic financing requirements for the recipient country. While different donors have different mechanisms for funding that are unlikely to change, the presence of domestic funding commitments or requirements in a compact may be more flexible for donors. Including country financing targets in a compact is an important step in achieving one of the main objectives of country compacts: that they ensure smooth and sustainable funding transitions. In addition, while donor predictability is important for country governments to plan and budget, domestic funding predictability will allow donors to coordinate better with the countries in which they operate. It should also be borne in mind that domestically resourced and implemented programmes may be less expensive than externally-driven programmes, so that costing work needs to be country specific.

- **Inputs and tools for setting programmatic and financing targets** – Identify a mix of appropriate strategies, quantitative approaches and country dialogue. While programmatic and financing targets will evolve through country and donor discussions, there are ways to ensure that they are grounded in country context and in accordance with country strategies. Donors' standards and rules for setting programmatic and financing targets must also be somewhat consistent across countries. If countries do start providing their "fair share" of the resources for HIV and AIDS, it will be increasingly important for donors to achieve country buy-in for donor supported activities. It is also important for donors to ensure that their resources are allocated strategically and that they are targeting funding where it is needed the most. Donors and countries therefore have a range of tools to choose from for setting financing targets, including country income and epidemic data and country policies, strategies and plans based on rigorous analysis.

- **Monitoring and evaluation - Identify a combination of programmatic and expenditure tracking tools and regular meetings that will annually monitor both programmatic progress and country finances and, where applicable, donor funding commitments too. Where possible, these should be aligned with existing programmatic and financial monitoring processes.** Without tools and processes for monitoring and evaluating the programmatic and financing commitments made in a compact, it will be impossible to tell if these commitments are being met. Country compacts can provide mechanisms to promote greater transparency and trust between donors and countries, and to evaluate whether both are meeting their commitments. Compacts can identify specific tools and processes which can be used to monitor financing flows.

- **Accountability - specify clear consequences of failing to meet various financing conditions set out in the compact.** The objectives of country compacts can only be realized if the commitments made in these compacts are binding, or at least heavily respected, for all parties involved. One way of ensuring that compacts have leverage is by including specific consequences for not meeting the conditions that they specify.

How to get started

Actions for countries:

- **Review programmatic targets** – in particular to analyse the connection between goals and outputs, design programmes to deliver the goals, cost those programmes, and then develop financing targets based on that costing.

- **Innovative consideration of consequences** - do additional research on 'less traditional' incentives and consequences (other than withholding or delaying funding disbursements), such as CSO engagement, Results Based Financing, and ways of using media or other forms of public engagement. Analyse how these could help produce guidance for developing compacts that, so even if they're not legally binding, they still offer significant leverage.

- **Develop expenditure tracking mechanisms.** While there are many tools available, some are less able to be incorporated into routine reporting systems and require longer turnaround time, while others create an additional burden for countries. There's no clear consensus across donors and countries on the 'best resource tracking tool, and multiple options are used across different countries, making spending comparisons fairly difficult. Harmonization of existing resource tracking tools and development of innovative ones that link expenditures to performance will be an important next step

Actions for donors:

- **Beef up financing agreements -** add value by incorporating additional donor perspectives to the compact inventory mix, for example through reviewing other donors agreements with countries for smooth transitions.

- **Extra research –** find out what works and what doesn't. Draft country case studies by reviewing country experiences of donor transitions and the compacts used to guide these transitions. This will involve speaking with relevant stakeholders in these countries.

- **Share best practice -** review and publish reviews such as contained in this brief, and distribute them to countries and donors for comments and guidance. If endorsed by stakeholders it could help ensure smooth and sustain funding arrangements and transitions.

- **Action plan -** develop an action plan to actually implement compact guidance. Once finalized and endorsed by stakeholders, it will help bridge the gap between the information provided in a guidance document and the actual content of compacts and their operations going forward. A first step would be testing some of the recommendations contained in this document in a small selection of countries. UNAIDS could also use the Economics Reference Group or another interagency task force to ensure these findings are taken from policy to practice.

DONOR-COUNTRY COMPACTS FOR SUSTAINABLE FINANCING FOR THE HIV & AIDS RESPONSE

Produced by: Results for Development (R4D) - APW with UNAIDS 2013/359026

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Executive Summary

After a decade of increasing donor financing for HIV and AIDS, donor assistance is expected to plateau and in some places decrease. This changing financing situation is, in many cases, leading to a funding transition where low- and middle-income countries are providing, or could be providing, increased domestic funding for their HIV and AIDS programs. UNAIDS, Results for Development, and other key stakeholders have been examining tools to help make these donor-country funding transitions more smooth and sustainable. One promising tool is the country compact. We define country compacts as explicit agreements with the following properties:

- They are made between one or more country government departments or representatives and one or more donors;
- They include programmatic and financial commitments made by one or, ideally, all parties to the country's HIV and AIDS program; and
- They specify accountability mechanisms for donors, governments and other signatories.

A well-developed country compact can be used by countries and donors to clarify the financing situation in a country, ensure that all actors carry out their financial commitments that were used to develop this financing picture, and help lead to smooth and sustainable funding transitions towards increased country ownership.

The objective of this paper is to establish key guiding principles to create a compact that can achieve these goals. We reviewed a sample of country-donor financing agreements and compacts from PEPFAR, the Global Fund, the World Bank, the Millennium Challenge Corporation (MCC), the GAVI Alliance, and

the International Health Partnership (IHP) to inform the development of these principles. Although different donors have different names for these agreements, we will refer to them as compacts or compact agreements in this paper for consistency. We supplemented the information drawn from these compacts and donor websites with interviews with key persons at PEPFAR, the Global Fund, the World Bank, and the MCC. We focused on a selection of six features from the compact agreements we reviewed: duration of agreement; actors included; financing targets; inputs and tools for setting financing targets; monitoring and evaluation mechanisms; and consequences of not meeting the conditions of the agreement. For each feature, we analyzed current donor practice, tried to establish a standard to follow amongst the six donors, and developed a guiding principle that builds upon that standard. Feedback on initial findings was obtained from the Working Group on Sustainable Financing of the joint UNAIDS-World Bank Economics Reference Group and has been incorporated into this guidance.

I. Background

The HIV and AIDS community is entering a new era of financing in low- and middle-income countries. External donor assistance for HIV and AIDS is expected to plateau and in some cases decrease in coming years, while simultaneously, many low- and middle-income countries are experiencing rapid economic growth and are thus able to increase domestic resources for HIV and AIDS[1]. This changing financing situation is, in many cases, leading to a funding transition in which external donor assistance will no longer be the largest source of HIV and AIDS funding in low- and middle-income countries. Such a transition necessitates new thinking on the sustainability of HIV and AIDS financing, including the concepts of "fair share" – how much low- and middle-income countries can and should be expected to contribute to their HIV and AIDS programs – and "global solidarity" – the responsibility and capacity donors have to honor commitments and continue to contribute financially to the fight against HIV and AIDS. One way to help ensure that countries experience smooth and sustainable transitions, and that principles of fair share and global solidarity are respected in practice, is to use country compacts. A country compact is an explicit agreement between a country's government and one or more donors that outlines programmatic and financial commitments made by one or both parties to the country's HIV and AIDS program, and specifies mechanisms to hold parties accountable.

II. Objectives

Little guidance exists thus far on what a country compact should contain for fair share financing. Compacts should achieve the goal of stabilizing the changing HIV and AIDS financing situation in low- and middle-income countries by making explicit how much different funders are contributing and what that money supports. Compacts should also

[1] Results for Development Institute, "Financing of HIV Responses: Fair Share & Global Solidarity." 2013, Washington, DC.

include mechanisms for holding donors and country governments accountable for their commitments. Additionally, because many financing commitments will progressively reflect decreasing donor funding and increasing domestic funding, compacts should help to ensure that these funding transitions are smooth and sustainable. The goal is for service delivery to be un-interrupted during the transition, for specific programs (including those addressing key populations) to continue after the funding transition, and for the total level of funding to remain relatively stable over the transition period.

We seek to clarify how compacts may be optimally designed to achieve sustainable financing objectives. This analysis provides guiding principles for compact development by explaining why a particular compact feature is important for sustainable financing, highlighting an aspirational standard for that feature, and suggesting a guiding principle for that feature. We base our suggestions on an analysis of several HIV- and AIDS-specific country compacts from the three largest HIV and AIDS donors. We also draw on the experience of other non-HIV and AIDS development donors, with the objective of learning how these mechanisms have built sustainable financing into their compacts with countries. We highlight key features of their compact agreements to inform the future development of compacts for HIV and AIDS sustainable financing. We combine these analyses with previous thinking on country compacts, including a section on compacts from a UNAIDS policy brief on Fair Share and Global Solidarity.[2]

III. Methodology

Data Sources

Our initial analysis draws on twenty-one compacts from thirteen countries and four donors. First, we included all donors directly providing over US$1 billion globally for HIV and AIDS in 2012: PEPFAR, the Global Fund, and the World Bank.[3,4]. We also turned to other aid mechanisms, albeit not in HIV and AIDS or health, to understand how large country compacts were developed for sustainable development.

One mechanism, the Millennium Challenge Corporation (MCC)[5], stands out as an innovative U.S. foreign aid model that is helping to lead the fight against global poverty. The MCC forms strong partnerships through large grants and compacts with countries that are committed to good governance, economic growth, and investing in their people. Key features of this aid mechanism are: a strong commitment to designing for purpose, keeping the focus on long term development, providing incentives for country performance, prioritizing country ownership, learning through monitoring and measurement of results, insisting on transparency, and incorporating an appetite for experimentation and risk.[6] In addition, independent assessments of the quality

[2] Results for Development Institute, "Financing of HIV Responses: Fair Share & Global Solidarity." 2013, Washington, DC.
[3] Data on PEPFAR and Global Fund 2012 disbursements are from the KFF and UNAIDS report on Financing the Response to AIDS (http://kff.org/global-health-policy/report/financing-the-response-to-aids-in-low/). World Bank 2012 disbursement data for HIV are from the World Bank's website.
[4] Originally, we had used a cutoff of US$500 million, so that our analysis would have also included the U.K.'s Department for International Development (DfID). However, due to a lack of access to DfID's compacts, DfID was dropped from the analysis and the cutoff was raised to
[5] http://www.mcc.gov/pages/about
[6] http://www.modernizeaid.net/2010/08/12/guest-post-richard-morford-on-the-mcc-as-a-model-for-foreign-aid-reform/

of official development assistance (ODA) conclude that MCC is a top scoring aid agency.[7] Our review of country-donor compacts for sustainable development suggested that the MCC compact and its development process would provide an instructive model for us as we attempt to develop guiding principles for compact development for sustainable financing of the HIV and AIDS response.

We presented initial findings from this work at a meeting of a UNAIDS-World Bank working group on sustainable financing of HIV and AIDS. Based on feedback from participants, we added agreements from the GAVI Alliance and IHP to our analysis.

We selected compacts from each of the original four selected donors (Global Fund, PEPFAR, World Bank, MCC) with the objective of assembling a country compact inventory that achieves variability across country features. We tried to include a representative sample of countries by choosing countries of varying epidemic types, income brackets, and world regions. We also tried to analyze compacts for the same country across multiple donors whenever possible.[8] We selected six funding agreements each from PEPFAR, the Global Fund, and the World Bank, and three from the MCC (a smaller sample was adequate due to similarities across all MCC compacts). Table 1 shows the variation across countries in our inventory. Variability was sometimes difficult to achieve – for example, some of the donors (e.g. PEPFAR) operate mostly in a single region (e.g. Sub-Saharan Africa).

T.1

COUNTRY VARIATION IN COMPACT INVENTORY

	INCOME LEVEL	COUNTRIES	COMPACTS
INCOME BRACKET	Low Income (LIC)	5	8
	Lower-Middle-Income (LMIC)	4	8
	Upper-Middle-Income (UMIC)	4	5
REGION	Sub Saharan-Africa	7	12
	Asia & Middle East	4	5
	Europe & Central Asia	1	2
	Latin America & Caribbean	1	2
EPIDEMIC	Concentrated	6	9
	Generalized	7	12
TOTAL		**13**	**21**

[7] http://international.cgdev.org/sites/default/files/1424481_file_CGD_QuODA_web.pdf
[8] Due to time constraints and the late receipt of PEPFAR country compacts, we were unable in some cases to choose World Bank and Global Fund compacts for countries for which PEPFAR compacts were also available. To achieve greater consistency, future analysis could review additional World Bank and Global Fund compacts to match the countries for which PEPFAR compacts exist.

We also reviewed a selection of GAVI and International Health Partnership compacts. A smaller section of agreements from GAVI was adequate due to the fact that GAVI's agreements are fairly standardized and consistent across countries. The review of IHP compacts had limited applicability to the six identified compact dimensions (see Table 2), and thus a smaller section was included for the IHP as well (see Box 1 for more information).

BOX 1: LESSONS LEARNED FROM INTERNATIONAL HEALTH PARTNERSHIP COMPACTS

As suggested by the TWG on Sustainable Financing, we also reviewed the experience of the International Health Partnership (IHP) and their multilateral compacts in our analysis. While there are some valuable lessons to be learned from the IHP, their compacts tended to be much broader and higher level, and, the six dimensions of country compacts that we evaluated for the other donors were less applicable to the IHP's compacts. Therefore, rather than including information on the IHP under each dimension, we included a stand-alone box of lessons learned, taken from a 2012 review of IHP country compact experiences.[9]

One major lesson learned is that the process of compact development often resulted in more benefits than the actual compact document itself, including increased dialogue and trust among all actors involved, increased international legitimacy, more inclusiveness of CSOs, and increased coordination. The actual value added of a compact itself depended greatly on country context and what structures and processes already existed in a country. A main limitation of most country compacts was the "unrealistically large content and ambitious objectives and indicators" contained in the compact. Commitments from countries, donors, and other actors in IHP compacts were often not clearly defined, and indicators were usually not measurable and were often without clear targets. A few compacts, such as Ethiopia's and Nepal's, included more specific details, but for the most part, IHP compacts contain extremely broad language about increased alignment and coordination, with few specifics. Without clear targets and roles, it has been difficult for compact signees to follow through with specific actions, and even more difficult to monitor the compacts. In practice, most compacts have not actually led to increased predictability of funding and there is little evidence of more effective assistance for health coming from donors.

Still, compacts were seen as improving the quality of dialogue and donor-country partnerships in countries, and the key value of compacts was "an overarching guide that sets…high level objectives for the partnership to improve the efficient use of health resources". The IHP provides an important first step in moving from bilateral to multilateral country compacts. It shows that multiple donors are willing to work together in a country and commit to more coordinated financing arrangements and planning, at least in theory. A key next step for country compacts may be for individual donors to move away from separate agreements with countries and to coordinate targets, financing, and roles in a single overarching compact document. PEPFAR is moving a step in this direction with their new Country Health Partnerships. If this is a continuing trend, the IHP experience can provide some valuable examples of what has worked so far multilaterally and what needs improvement and strengthening.

[9] http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Key_Issues/Country_Compacts/Developing%20a%20Country%20Compact.What%20Does%20it%20Take.Dec2012.pdf

Analysis

Gathering relevant information from the original twenty-one country compacts, we organized our findings into a matrix for each country. These four matrices (one for each donor) helped us to systematically assess the twenty-one donor compacts against different features and criteria. We identified these features through an iterative process – by drafting initial ideas on what we thought should and would be included in compacts, and then adding to the list based on actual findings. Features assessed include the types of financing targets and arrangements specified, donor coordination mechanisms, processes and tools for monitoring and enforcement, and consequences of not meeting conditions specified in the compacts. All four matrices are shown in Annex 1. This approach allowed us to understand the key features of and types of content in each compact and their implications for fair share and global solidarity. It also allowed us to identify what was missing from a compact – by comparing against other compacts and against our existing ideas about what should be included in a compact. By analyzing these features, identifying how they help achieve the objectives specified earlier in this guidance, and singling out missing features that could also help achieve these goals, we were able to develop more generic evidence-based guiding principles for country compact development. We also analyzed GAVI and International Health Partnership compacts based on the structure of these matrices and the features identified. Review of the compacts themselves was supplemented by information from the six organizations' websites and from interviews with key persons at PEPFAR, the World Bank, the Global Fund, and the MCC.

IV. Guiding Principles for Compact Development

Each compact feature identified is discussed in detail below with reference to sustainable financing of the HIV and AIDS response, keeping in mind the concepts of fair share and global solidarity. For each compact feature, we specify why it matters for sustainable financing, describe current practice among the three HIV and AIDS donors, the MCC, and GAVI, identify any potential standards observed amongst the analyzed compacts, and suggest elements of a guiding principle going forward. Table 2 shows all of the compact features discussed in our analysis.

T.2 **KEY FEATURES OF COUNTRY COMPACTS**

NUMBER	FEATURE
1	Duration of a compact agreement
2	Actors included in agreement
3	Financing targets for donors and countries
4	Inputs & tools for setting financing targets
5	Monitoring & evaluation mechanisms
6	Consequences of not meeting conditions of compact

1. Duration of a Compact Agreement

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

Financing: *A compact agreement requires a long enough time period to allow countries and donors to visualize and plan for a financing trajectory that can align with the achievement of programmatic targets. An agreement that spans only one or two years would not provide enough time for substantial programmatic and financial targets to be reached. In addition, single year and shorter-term agreements result in higher transaction costs for all stakeholders and partners compared to multi-year agreements.*

Current Practice

In the sample of countries we analyzed (see attached inventory matrices) all donors sign agreements of varying lengths with countries, regardless of the type of epidemic (concentrated vs. generalized), income level (LIC, LMIC, UMIC), and region.

No consistent pattern of time period is observed for any particular country context. For example, for Nigeria (generalized epidemic, LMIC, SSA), the World Bank signed a three year agreement, the Global Fund, a two and a half year agreement, GAVI, a three year agreement, and PEPFAR, a six year agreement. There are some consistencies between compacts under the same donor. PEPFAR's Partnership Framework Implementation Plans (PFIPs) generally span five years (Nigeria appears to be an exception). Under their New Funding Model, the Global Fund will provide three year grant commitments in most cases (although these may be aligned with strategies covering a longer period of time, such as countries' HIV and AIDS National Strategic Plans [NSPs]). The World Bank's agreements are more variable, but generally last between three and four and a half years. GAVI's agreements have generally covered two to four years.

For many governments, understanding how much money is flowing into their countries is very difficult because each donor has a different fiscal year, different disbursement mechanisms, and different time horizons for providing money. Given these differences, tracking the money provided by the big three HIV and AIDS funders is a major challenge for recipient country governments. This is particularly difficult in cases where governments wish to accurately forecast the money that will be spent by the big three funders during an upcoming fiscal year, so that these forecasts can be used to make informed decisions on how to program their own public HIV and AIDS resources.[10]

[10] Bernstein, M & M. Sessions, "A Trickle or a Flood: Commitments and disbursement for HIV/AIDS from the Global Fund PEPFAR and the World Bank's Multi-Country AIDS Program (MAP)." Center for Global Development, 2007, Washington, D.C.

A Potential Standard?

The MCC always signs five year compact agreements with countries, and PEPFAR has moved towards a general standard of five year agreements through its PFIPs. This sets up a clear, predictable, and longer-term period in which advance programmatic and financial planning between countries and donors is possible, enabling all parties in a compact to realize their contributions and to produce programmatic results. In the MCC's case, this is a non-negotiable time period with clear rules and regulations for implementation.

Guiding Principle:

Set a standardized time period of five years for all compact agreements.

For sustainable HIV and AIDS financing, countries and donors should consider a standardized time period of five years for a compact agreement. This will allow a country government to take into account donor commitments when it plans its medium-term HIV and AIDS budget. This longer time period can help smooth the difficulties that arise from non-synchronous donor budget and country budget cycles, so that financing is more predictable every year.

For middle-income countries (MIC), this time period will facilitate the fair share transition, so that by the end of five years, a significant proportion of HIV and AIDS financing will be from domestic resources. LMIC countries with concentrated epidemics, like India and Vietnam, and UMIC countries with generalized epidemics, like South Africa, are countries that can begin to plan for and attain a greater proportion of fair share financing in the next five years because of their ability to draw on increased domestic resources as a result of stronger economic growth in the last decade. Such funding transitions are outlined in South Africa's and Vietnam's PFIP agreements with PEPFAR. Five year agreements will help ensure that these financial transitions can be gradual and are achieved smoothly and sustainably.

Unlike MICs, LICs like Kenya, Tanzania, and Mozambique, which have generalized epidemics and high HIV prevalence, will likely continue to depend on donor financing to a greater extent for the foreseeable future – until economic growth enables a significant increase in domestic resources for HIV and AIDS. However, developing a minimum fair share financing goal over a five year compact period allows LICs to adjust to the idea of contributing resources to their fight against HIV and AIDS, to reduce political resistance to this transition if and when they are ready to pay a greater share of HIV and AIDS financing in their countries, and to increase the sense of national ownership and control of the HIV and AIDS program, even if this does not yet include significantly greater financing control.

Five year compacts may not be possible for all donors, such as the Global Fund, whose funding model only calculates three-year resource envelopes for countries. Resource allocations from the Global Fund to countries could change drastically after a given three year period, due to changes in country income level and disease burden and depending on which countries apply for Global Fund resources. However, even providing three year Global Fund programmatic and financial information alongside five year agreements from other donors could signify significant progress.

2. Actors Involved

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

A compact agreement lays out important responsibilities and expectations for all parties. Signing partners should have a clear and substantial role(s) (whether financial or programmatic) for which they are held accountable under the compact. Key signatories for a compact agreement may include donors, country government ministries (Ministry of Finance, Ministry of Health), and non-governmental organizations (NGOs), but the specific combination and number of actors will depend on a specific country context and donor/government policy. The identification of a country government as a key actor in providing resources for the AIDS response provides an accountability mechanism for fair share financing. More actors mean higher transaction costs, but also more coherence. Even if compacts do not include multiple donors as signees, there should be some attempt to ensure donor coordination within a country.

Current Practice

The World Bank (IDA or IBRD, depending on the status of the country) signs a loan agreement or financing agreement with a country's Ministry of Finance (MoF). Other actors included in the agreements are main implementers (such as the Ministry of Health) and other implementing ministries.

Global Fund agreements have several signees: Principal Recipients (PR), the Global Fund, Country Coordinating Mechanism (CCM) Chairs, and CSO Representatives of the CCM. PRs and CCM chairs are generally branches of government or government representatives (PRs can also be NGOs or UN agencies). The Global Fund is the only donor analyzed whose compacts consistently include CSO representation. From a financing perspective, CSOs have no direct power, but could serve as advocacy organizations to ensure that the government PR provides the agreed-upon resources or spends them in the way specified. However, most compacts have (or should have) other mechanisms that make countries accountable to the donor or funder (see features five and six in this document), not to a third party such as a CSO.

PEPFAR's agreements only include PEPFAR and one government department as signees, often the MoF or head or treasury, but also National AIDS Councils (NAC) and Ministries of Health (MoH).[11] While not holding other donors accountable as signees, PEPFAR's PFIPs do incorporate planned activities and estimated financing from other major HIV and AIDS donors, especially the Global Fund.[12]

[11] This is based on conversations with PEPFAR and on the South Africa PFIP. The other PFIPs we received from PEPFAR did not contain the signature pages, so we cannot tell who the country signee was.
[12] PEPFAR and the country's government are also not "held accountable" for their funding commitments. In PEPFAR's case, funding is subject to Congressional approval and the availability of funds. We discuss this point further in later sections.

GAVI's agreements that were in the public domain (letters of support) did not contain signatures from both parties, but development of their country comprehensive Multi-Year Plans (cMYPs) involves both MoH and MoF. GAVI countries are also required to set up an Interagency Coordination Committee (ICC) which brings together immunization actors in the country, including WHO, UNICEF, CSOs, other donors, and the MoH.

Notably absent as a signee in some PEPFAR and most Global Fund compacts analyzed is a country's MoF: the country ministry that could be held accountable for its fair share contributions to HIV and AIDS financing, since it is generally responsible for allocating other government departments' budgets, such as the MoH. Exceptions include the Global Fund's grant agreements with Kenya and India, where the PRs are Kenya's MoF and India's Department of Economic Affairs, respectively. For the Global Fund, including the MoF may be difficult due to the CCM structure and the fact that the PR generally will be an implementing agency, not the MoF. Still, as the Global Fund begins to place greater importance on counterpart financing and domestic commitments in its New Funding Model, it will be important to obtain MoF involvement.

A Potential Standard?

The MCC has very clear rules for which actors are included in a country compact:

- MCC compacts are always between the U.S. and a recipient country. Compacts are direct treaties between the two governments,[13] because the MCC is a federal agency (this is probably not possible for most HIV and AIDS donors). Signees for the U.S. have been the MCC CEO or the President of the United States. Signees for the recipient country are generally high-level political leaders or other leaders with responsibility over financing, such as Prime Ministers and Presidents of Countries, MoFs, or Ministries of Planning & Development. In this respect, the World Bank could also be held as a standard, since it also makes agreements with countries' MoFs.

- The MCC compacts generally specify the formation of a country's Millennium Challenge Account (MCA), and designate the MCA as the accountable entity and program implementer (as in Moldova and Mozambique[14]). MCAs are part of the recipient country's government. In this respect, GAVI and the Global Fund could also be held as standards, as both require similar entities to be formed (the ICC and CCM, respectively, although these are not country government entitites).

Guiding Principle:

Select a key financing or high-level political authority in a country as a signee on compact agreements to ensure that fair share commitments are met.

The type and numbers of actors included in a compact will affect the implementation of a compact.

Type: In the case of most Global Fund and some PEPFAR compacts, excluding the MoF as a signee is a clear handicap to supporting fair share financing commitments from countries. The MoF

[13] Personal correspondence (interview) between the MCC (Chris Broughton, Margaret Dennis) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013

[14] The MCC compact with Tanzania specifies that while the MCA will implement the program, this does not relieve the government of its obligations. In this case, therefore, it appears that the MCA is the program implementer, but that the Government (external to the MCA) remains somewhat accountable.

has the power to allocate resources for sector-specific, and in this case, program-specific activities, so it should be included in the compact agreement along with the key implementing entity. This will ensure that each specific agency or ministry will have a clear role – financial or programmatic – for which it will be held accountable. In some cases, including a CSO or NGO may also be important. For example, if a very large NGO is implementing many ART delivery programs in a country and is indispensable to the compact's programmatic success (and if other signees do not have legal power to compel that NGO to act), it may be important to include the NGO itself as a signee. Additionally, in cases where country commitment has been questionable in the past, including a CSO signee may be wise for monitoring purposes.

Number: The number of signees should be kept to a minimum to keep the compact development process moving. South Africa's experience with PEPFAR's transition away from direct service delivery and toward decreased financing and technical assistance suggests that, while it is important to include major funders, bringing too many actors to the table could reduce speed and effectiveness of implementation. The South African government and PEPFAR have found that bilateral financial planning and monitoring can be time-intensive. These challenges could be exacerbated if too many different actors are involved. On the other hand, including more actors in a compact can lead to increased openness and transparency of the compact process and agreement, and the programs being implemented.

Form: GAVI, the MCC, and the Global Fund all set up structures in-country to manage donor-country activities (the ICC, MCA, and CCM, respectively). These structures usually include both donor and country actors and help donors and countries oversee donor-funded programs. They also allow for more constant and high-level dialogue between donors and countries. However, recommending that each donor set up such a structure for its HIV and AIDS activities would results in duplicative and parallel systems. Rather, going forward, it would be useful for compact signees (donors, MoH or NAC, MoF, and possibly CSOs and major implementing partners) to convene under one single structure. This is already done to a certain extent in the Global Fund's CCM, but such a structure could be improved by taking a more active coordination role and focusing less on a single donor's operations and more on all donors' finances and operations. This would help both countries and donors manage and track financing from donors as well as from governments, in an effort to monitor fair share financing and global solidarity of donors. Requiring that a country set up a structure like this could be a condition of a compact. While NACs were set up to conduct the task of coordinating donor activity in their countries, among other roles and responsibilities, they have rarely succeeded in being effective "on the ground" implementing and coordinating partners of HIV and AIDS donors. This could therefore also be an opportunity to redefine and reinvigorate one of the key roles of the NACs.

The right balance of necessary and accountable (financial and programmatic) actors must be struck when choosing signees on a particular compact. For fair share financing, the MoF, or a ministry that makes decisions about the allocation of resources must be a key actor, as well as

the prime implementing agency within the government (usually MoH or NAC). Thus a general guiding principle can be to always include three actors: the donor, the MoF or a similar agency, and the government implementing agency. In some situations, it may be important to include an NGO or CSO signee as well.

3. Financing Targets

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

Country compacts vary in the type of financing provided by the donor and in whether or not they contain domestic financing requirements for the recipient country. While different donors have different mechanisms for funding countries' HIV and AIDS programs that are unlikely to change, the presence of domestic funding commitments or requirements in a compact may be more flexible for donors. Including country financing targets in a compact is an important step in achieving one of the main objectives of country compacts: that they ensure smooth and sustainable funding transitions. Additionally, while donor predictability is important for country governments to plan and budget, domestic funding predictability will allow donors to coordinate better with the countries in which they operate.

Current Practice

Among the three HIV and AIDS donors we studied, none has a standard for holding countries accountable for specific domestic financing targets (including programmatic targets is much more common). Of the six Global Fund agreements reviewed, only Jamaica's (UMIC) included a counterpart financing requirement, despite the fact that the Global Fund's current policy requires counterpart financing for countries in all income brackets, starting at five percent for LICs. Although counterpart financing is required for all countries receiving Global Fund grants, these requirements are generally not spelled out in the Global Fund's grant agreements with countries, except when there are concerns about the country defaulting.[15] Under the Global Fund's New Funding Model, counterpart financing requirements will be more systematically implemented across all countries and will be included in grant agreements.[16]

Among the World Bank agreements, only two out of six (Nigeria, a LMIC and Kenya, a LIC) specified funding requirements

[15] Personal correspondence (interview) between the Global Fund (Michael Borowitz, George Korah) and R4D (Theresa Ryckman, Adeel Ishtiaq, Anit Mukherjee, Jennifer Weaver) on November 13, 2013
[16] Personal correspondence (interview) between the Global Fund (Michael Borowitz, George Korah) and R4D (Theresa Ryckman, Adeel Ishtiaq, Anit Mukherjee, Jennifer Weaver) on November 13, 2013

from the countries themselves. No funding requirements were specified for the two World Bank compacts with UMICs that we sampled (Botswana and Jamaica). The World Bank does not generally include legal clauses in its financing agreements regarding domestic funding requirements.[17]

PEPFAR takes a different approach. Five of the six PFIPs reviewed (Tanzania being the exception) included total predicted medium-term domestic funding (for between three and six years, depending on the agreement). However, this predicted funding is not a binding agreement with the country's government; nor is PEPFAR's funding trajectory, which is also provided in all of the PFIPs reviewed. Thus it may be more appropriate to view these funding projections as "intentions" rather than commitments.

The MCC does not provide explicit domestic funding commitments in its compacts. However, there is an expectation that governments will put forth some domestic funding to implement the programs specified in MCC compacts. These funding commitments may in some cases be part of MCC's quarterly requirements for funding disbursement. However, these requirements are included in Conditions Precedent Reports or Program Implementation Agreements, not in MCC compacts, and these reports are not made public and were not made available to R4D or UNAIDS. Thus, while we know that some MCC agreements do have explicit domestic funding requirements, the details of these requirements are not made public.

GAVI also requires co-financing for all of its New Vaccine Support (NVS) to countries. Co-financing requirements for the length of an agreement are generally included in GAVI's letters of support. GAVI's provisional budgets for all years of the agreement are also included, but typically only funding for the first year is actually "approved."

A Potential Standard?

Although no single donor's standards for financing targets achieve our objectives for country compacts (see Section II on Objectives), several best practices are observed. PEPFAR is the only donor to consistently include medium-term domestic funding projections in its compacts, but countries are not held accountable for meeting these projections. The Global Fund and GAVI are the only donors with explicit policies on counterpart financing for all recipient countries, but for the Global Fund, these financing requirements are not specified in agreements and do not always appear to be implemented in practice. The Global Fund is also notably moving toward a system of including more specific country commitments in its agreements (beyond the minimum counterpart financing requirements) and requiring that domestic funding increase over the medium term. GAVI does consistently apply its co-financing requirements in all countries. The best approach may be to further expand upon some combination of that taken by these three donors.

Guiding Principle:

Specify domestic and external financing commitments (not just estimates) and include projected financial plans for next five years in country compacts.

A first step is for donors to start including clear and binding domestic financing commitments in all of their agreements, which is not currently done by any of the three HIV and AIDS donors. It is also important that the trajectory of domestic funding over five

[17] Personal correspondence (interview) between the World Bank (Miriam Schneidman, Sheila Dutta) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013

years fits with the trajectory of donor funding, and that these projected financial plans are included in a compact in addition to a clear solid commitment goal from both the donor and recipient country. These plans allow all parties to move forward with a clear sense of financing contributions from each other.

An important caveat to this guiding principle is that these financing commitments will vary greatly across countries. Low-income countries with generalized epidemics are unlikely to be able to provide a significant portion of the total resources for their HIV and AIDS programs. Middle-income countries, especially those with concentrated epidemics, may be increasingly able to start taking more fiscal responsibility for HIV and AIDS, and their financing trajectories in compacts may show a bigger increase in domestic funding. To a certain extent, the Global Fund, GAVI, and PEPFAR are already observing these needs in their agreements. The Global Fund's counterpart financing policy specifies much larger counterpart financing for upper-middle-income countries (60%) than low-income countries (5%), but these requirements are also based on the total Global Fund grant amount, meaning that countries with larger disease burdens and countries where the Global Fund is the primary HIV and AIDS donor will have to pay more.[18] GAVI has a similar co-financing policy based for the most part on income level. The PEPFAR PFIPs that we analyzed contained rapidly increasing domestic funding estimates for middle-income countries such as South Africa, Vietnam, and Nigeria, while the scale-up in funding expected in low-income countries, such as Mozambique, was much more gradual. This point on financing ability is further discussed under feature four.

4. Inputs and Tools for Setting Financing Targets

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

While the financing targets discussed above will need to evolve through country and donor discussions, there are also ways to ensure that they are grounded in country context, such as financing ability and type and intensity of the epidemic, and in accordance with country strategies. Just as important is that a donor's standards and rules for setting financing targets are somewhat consistent across countries, although they may take into account country contexts as well. If countries do start providing their "fair share" of the resources for HIV and AIDS, it will be increasingly important for donors to achieve country buy-in for donor supported activities. Additionally, in a landscape of increasingly limited donor funds, it is important for donors to ensure that their resources are allocated strategically and that they are targeting funding where it is needed the most (i.e. to countries that have less capacity to provide more domestic financing themselves or to activities that countries are not already funding in their national response). Donors and countries therefore have a range of tools to choose from for setting financing targets, including country income and epidemic data and country strategies, such as National Strategic Plans.

[18] Personal correspondence (interview) between the Global Fund (Michael Borowitz, Korah George) and R4D (Theresa Ryckman, Adeel Ishtiaq, Anit Mukherjee, Jennifer Weaver) on November 13, 2013

Current Practice

The three HIV and AIDS donors studied vary in the degree to which they take into account country plans and strategies when setting financing targets. While the Global Fund uses country plans as a tool for developing programs, there is no evidence in the agreements reviewed that these plans were used to determine financing amounts. However, as part of their New Funding Model, gap analyses, coming from National Strategic Plans (NSPs) where possible, will be part of proposal development. A major pillar of the Global Fund's New Funding Model is to align Global Fund grants and activities better with country strategies. Global Fund templates show that country planning documents will be incorporated in a number of ways in developing funding requests (concept notes), including for financial and programmatic gap analyses, and main funders will be specified (by program) in these concept notes.[19]

PEPFAR uses NSPs and other country strategy documents to conduct a gap analysis, and PFIPs are almost always programmatically aligned with NSPs or similar documents. However, PEPFAR's financing targets do not appear to be determined by the NSPs or resulting gap analyses. In certain cases, domestic funding estimates are grounded in country budget documents, as was the case in Mozambique's and Vietnam's PFIPs. Moving forward, PEPFAR will also be attempting to ground compact development in existing processes involving other donors, such as Global Fund concept note development, the UNAIDS investment case process, and donor coordination units. PEPFAR's aim is to move from a bilateral to multilateral forum in its agreements with countries.[20]

The World Bank agreements reviewed do not specify the process of determining domestic funding requirements, in the rare cases that domestic funding requirements are specified. However, both the World Bank's IDA and IBRD and the Global Fund use resource allocation formulas to determine indicative amounts of funding that will be provided to each eligible country. These formulas take into account income level and, in the Global Fund's case, number of persons living with HIV (PLHIV) in order to ensure that resources are invested strategically. Including income as a factor to determine a country's funding level can help donors direct their resources towards low-income settings, since middle-income countries usually have more ability to provide some of these resources domestically. These indicative funding formulas help to keep external funding amounts consistent across countries, but are not used to set domestic contributions. For both the World Bank and the Global Fund, the resource envelopes determined by a formula are also combined with information on country strategies and priorities to determine specific projects and programs and the budgets that go with them.

The Global Fund is also the only one of the three HIV and AIDS donors reviewed that has an explicit "formula" to determine domestic financing commitments (as a percentage of total grant amount, based on GNI per capita). Under the New Funding Model, the Global Fund will also be working more closely with countries to set specific financing targets that

[19] The Global Fund to Fight AIDS, Tuberculosis, and Malaria "Concept Note for Early Applicants". Global Fund, 2013, Geneva: http://www.theglobalfund.org/documents/core/newfundingmodel/Core_NewFundingModelConceptNoteSingle_Template_en/.
[20] Personal correspondence (interview) between PEPFAR (Mamadi Yilla, Nalinee Sangrujee, Jeff Blander) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013

are most appropriate for countries, beyond the required counterpart financing.[21] The Global Fund will also set aside 15% of a country's indicative resource envelope to only be awarded to that country based on "willingness to pay" in this new model. Countries will receive additional funding if they make greater and more specific commitments, such as procuring a certain percentage of drugs or funding a certain programmatic component. These targets could be linked to planned domestic financing under an NSP, but also could be more realistic, given that NSP funding targets are often aspirational. In addition, the Global Fund also requires that countries progressively increase domestic funding over a five year period.[22]

The MCC also sets indicative country envelopes. However, these envelopes tend to change due to country eligibility changes, the number of countries applying for and approved for funding, and the programmatic needs of each country (e.g., cost of the programs to be implemented). Thus the approach used is a combination of top-down and bottom-up approaches. This is an in-depth but lengthy process (generally two to three years) that involves a data-based analysis of the country, a review of priority sectors and activities, and consultations with other donors, government branches, and the private sector. There are generally not any domestic funding requirements for LICs, but LMICs are required to contribute at least 15% of the total compact amount. [23]

The amount of GAVI's New Vaccine Support (NVS) to countries depends on need, which is fairly simple to calculate compared to HIV and AIDS need, as GAVI only funds vaccines and supplies through its NVS funding. This estimated need is grounded in country strategies and cMYPs. All countries receiving NVS funding are then required to co-finance a portion of most vaccines. Co-financing requirements depend on a country's income level and are gradually increased every year, until they reach 100% in the year that a country reaches "graduation" status and becomes ineligible for GAVI support. Required co-financing is generally included in GAVI's letters of support to countries. GAVI's Health Systems Strengthening (HSS) support is calculated through a resource allocation formula. After the first year of HSS funding, a certain percentage of a country's available envelope is awarded based on performance.

A Potential Standard?

None of the major HIV and AIDS donors currently have a standard approach for including explicit domestic financing targets in their compact agreements, but there are still lessons to be learned from these donors. A mix of approaches taken by a number of the donors, including MCC's preparatory work in understanding country contexts, the Global Fund's quantitative funding envelope and counterpart financing approaches, and GAVI's co-financing policy can stimulate the development of a standard approach for fair share financing.

UNAIDS has also developed an indicator known as the Domestic Investment Priority Index (DIPI). The DIPI uses data on countries' epidemic sizes and expenditures to measure the extent of investment priority given by governments to support their national HIV and AIDS response.[24,25] The DIPI is very

[21] Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
[22] Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
[23] Personal correspondence (interview) between the MCC (Chris Broughton, Margaret Dennis) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013
[24] UNAIDS, "2010 Global Report: HIV Investments". UNAIDS, 2010, Geneva: http://www.unaids.org/documents/20101123_GlobalReport_Chap6_em.pdf
[25] Mathematically, the DIPI is calculated using the following formula "(Public Expenditure on AIDS Response/Government Revenue)/HIV Prevalence"

useful as a tool for donors and countries to assess countries' levels of domestic commitment to funding HIV and AIDS programs against their peers. However, the DIPI is not a normative indicator, meaning that there is no single "DIPI score" that countries should aim to meet. Thus, at least for now, the DIPI is not a tool donors could use to compute indicative domestic funding levels. Other literature, including a study on HIV and AIDS financing in twelve PEPFAR countries[26], contains additional benchmarks for domestic financing and could be useful in developing a tool for these purposes.

In terms of donors setting their own funding levels for countries, a quantitative approach that can still be bottom-up and take into account country contexts, such as the approaches used by the MCC, the Global Fund, and GAVI is optimal.

Guiding Principle

Country and donor financing commitments found in compacts should be grounded in a combination of country strategies, quantitative approaches, and country dialogue.

When setting initial funding levels and domestic financing requirements, donors should consider the financing capacity of a country and its HIV context. Financing capacity can start with income level, but should also include information on a country's growth prospects, the size and flexibility of its ministerial budgets (in this case, the health budget is most relevant), and the amount of money the country is expecting to put towards HIV and AIDS programs (which can be found in NSPs and budget documents). The MCC considers many features when evaluating the fiscal capacity of a country, and supplements quantitative information (upon which it relies heavily) with conversations with key country stakeholders. PEPFAR and now the Global Fund also have a standard of basing some aspects of compacts in projections contained in NSPs and other country strategies.

Considering a countries' HIV context is equally important. Consider two identical countries with the same financing capacities, but one country has a small, concentrated epidemic, while the other has a large, generalized epidemic. The latter country will have more difficulty fully funding its HIV and AIDS program. In addition to epidemic size, current programmatic scale-up and the strength of health systems also matters. This information can also be taken from country plans and documents and through conversations with country stakeholders. The Global Fund considers numbers of PLHIV in its resource allocation formula and GAVI considers overall population as a proxy for immunization needs. All stakeholders consider country needs to a certain extent when setting programs, but it is unclear how this is translated into funding levels in most cases.

The DIPI takes into account information on epidemic size and financing capacity, but is not a normative indicator. In their study on twelve PEPFAR countries, Results for Development recommend several other standards for domestic funding levels be considered, including that countries attempt to meet at least one of two targets: the Abuja target (dedicating 15% of total government budgets to health) and the DALY Share target (equating the share of the health budget

[26] Results for Development Institute, "Financing National AIDS Responses for Impact, Fairness, and Sustainability: A Review of 12 PEPFAR Countries in Africa" [Final Draft], October 2013.

that goes to HIV and AIDS with the share of the country's disease burden, in DALYs, that is attributable to AIDS). However, standards for financing should also be realistic and take into account country specific contexts, and thus another approach may be to use as a starting point country-specific models used by MoFs to estimate health and other ministerial budgets, based on economic growth. UNAIDS' Economics Reference Group (ERG) Working Group on Sustainable Financing (WGSF) could help to advance thinking and tools in this area.

Incorporating information from country strategies and speaking with country stakeholders keeps HIV and AIDS responses and financing targets country-owned. Using a quantitative approach can help keep donor funding levels and domestic financing requirements fair, predictable, and consistent across countries. A balance between both strategies is optimal.

5. Monitoring & Evaluation

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

Without tools and processes for monitoring and evaluating the financing commitments made in a compact, it will be impossible to tell if these commitments are being met. Country compacts can provide mechanisms to promote greater transparency and trust between donors and countries, and to evaluate whether both are meeting their commitments. Compacts can identify specific tools and processes which can be used to monitor financing flows.

Current Practice

Most World Bank and Global Fund compacts reviewed specify that country recipients must provide regular, audited financial reports to donors as proof that they are using the funding as specified in their agreement with the donor. In World Bank agreements, country recipients are required to provide the World Bank with annual audited financing reports, and in many cases quarterly un-audited financial reports as well. The Global Fund requires PRs to provide annual audited financial statements, but so far has mainly used budget allocations (not actual expenditures) as proof of counterpart financing.[27] In both cases, these financial reports must show that the recipient is spending the money on the agreed program,

[27] This is partially due to the fact that the counterpart financing policy was only implemented in April 2012, so there has not been much time to review actual expenditures yet.

and that a structured budget (included in the agreements) is being followed, with line items for different activities. These audits generally apply to the projects specified in funding agreements only, not to overall national HIV and AIDS program spending. They are typically used to monitor donor money only, not domestic funding commitments.

The Global Fund is now moving toward supporting regular expenditure tracking exercises in its recipient countries. By trying to support the same types of exercises (mainly the System of Health Accounts[28]) across countries, data on expenditures will be more consistent across countries. Currently, the Global Fund has difficulty collating data on country spending and how countries are meeting their counterpart financing requirements because different expenditure tracking systems mean that such a database would have non-comparable inputs. Specifying how a country tracks and reports its domestic commitments will be part of Global Fund grant agreements going forward.[29]

PEPFAR's funding is provided mostly to NGOs operating in a country and is not "on-budget", thus audited financial statements from a government recipient are not required in PEPFAR's PFIPs. Several PEPFAR PFIPs specify expenditure reviews as a method for monitoring PEPFAR and country government spending commitments. Expenditure reviews that are being encouraged and in some cases funded by PEPFAR and the Global Fund are important for other donors, especially if donors move toward compacts that include both donor and domestic financing targets, and if the domestic financing targets apply to overall HIV and AIDS spending, not narrow project-related expenditures. In some cases, PFIPs state that these expenditure reviews will take place using existing expenditure tracking tools and processes, such as PEPFAR's Expenditure Analysis (EA), the South African Government's Basic Accounting Systems (BAS), the Government of Mozambique's biannual programmatic and financial review process, and the Tanzanian Government's biannual Public Expenditure Review (PER) process. Some of these expenditure tracking tools may be better than others for monitoring compact financing commitments, in terms of speed (how long it takes expenditure information to be available after the expenditures are made), their ability to be routinized, and accuracy. Some PEPFAR PFIPs also mandate regular committee meetings to assess programmatic, and in some cases financial, progress and future plans.

The MCC also requires that MCAs spend MCC funding using a specified budget, although this budget can be flexible. To monitor MCA spending, the MCC requires regular accounting and book-keeping by the country government and sub-recipients, and semi-annual audits of government spending.

GAVI is unique in that it tracks three indicators specific to financing for all of its recipient countries. These indicators measure both GAVI and domestic funding commitments and include: GAVI support tracked against GAVI pledges; country investments in vaccines per child; and fulfillment of domestic co-financing requirements. The first indicator comes from GAVI financials, the second from country's national health budgets, and the third uses expenditure data collected by the UNICEF Supply Division and PAHO. Because GAVI mainly provides funding to UNICEF or PAHO for vaccine procurement, there is less of a need to track GAVI resources in-country, but GAVI does also require financial statements and external audits for its cash-based support.

[28] This includes National Health Accounts and Sub-Accounts
[29] Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013

A Potential Standard?

Of the donors reviewed, PEPFAR is the one that currently comes closest to monitoring joint funding commitments. The Global Fund is also moving toward joint expenditure tracking, through its push for National Health Accounts in recipient countries. GAVI also provides a standard by consistently tracking standard financing-specific indicators across all countries. The World Bank and the MCC mainly track whether specified budgets are being followed by country recipients.[30] However, monitoring donor funding is much less necessary in the case of the these donors, since they are disbursing funding at regularly agreed intervals or upon request directly to the government recipient, and counterpart financing is rarely required in financing agreements. Since this guidance recommends that donors and countries move toward specifying domestic financing commitments in country compacts, following and improving upon PEPFAR's and GAVI's current approaches and the Global Fund's proposed approach to monitor joint expenditures and financing-specific indicators is likely the best course.

Guiding Principle

A combination of expenditure tracking tools and regular meetings should be identified in country compacts to be used to annually monitor country finances and, where applicable, donor funding commitments. Where possible, these should be aligned with existing financial monitoring processes.

A transition to more sustainable financing for HIV and AIDS with increased country ownership and joint funding commitments will require that donors and countries jointly monitor each other's spending. Thus joint expenditure tracking tools are important components of evaluating performance in meeting funding commitments. In many of its compacts (South Africa, Mozambique, Tanzania), PEPFAR achieves a three-way goal of tracking joint expenditures, using existing expenditure tracking tools and processes that are already occurring in a country, and supplementing these exercises with regular meetings to discuss financing. The Global Fund achieves the first of these goals, but may be setting up additional and less routinized tracking systems with its push for the System of Health Accounts (granted, such systems will probably be needed at first in many countries) and meetings regarding expenditure tracking are not specified. Immunization funding is somewhat simpler and thus GAVI does not stipulate specific expenditure tracking mechanisms, but rather collects expenditure information on co-financing through its partners. Still, other donors may want to follow GAVI's standard of tracking standard financing-specific indicators across recipient countries. GAVI also sets an example by tracking both country performance and its own performance against these financing indicators.

PEPFAR's approach to monitoring and evaluation is a model approach to follow, but there are definitely areas for improvement. Although the approach described in compacts is a good standard to follow, in practice, planned actions have not always been achieved. For example, in South Africa, whose PFIP began in 2012/13, results of joint expenditure tracking have not yet been shared and discussed between PEPFAR and the Government, and there have been obstacles on both sides to accessing the other's spending data. This experience highlights the importance of transparency

[30] However, monitoring donor funding is much less necessary in the case of the these donors, since they are disbursing funding at regularly agreed intervals or upon request directly to the government recipient, and counterpart financing is rarely required in financing agreements.

and trust when implementing a compact. Compacts could also specify that regular meetings should include financial tracking, and that future budgeting should be based on the results of that tracking, which few of PEPFAR's reviewed PFIPs do. Such meetings should also be streamlined with any existing financing meetings where possible (e.g. Global Fund CCM meetings or PEPFAR PFIP committee meetings that may already be happening in a country), to avoid over-burdening both countries and donors. In cases where a donor provides "on-budget" support to a government, rather than to NGOs operating in a country, expenditure tracking should focus more on tracking the government's spending, but should include monitoring both donor money spent by the government and domestic money committed by the government.

In cases where existing public financial tracking systems are not yet strong enough to produce robust expenditure data, further work is needed to determine what the best tools are to monitor the financing commitments made in a country compact. Such tools must be routinized and ensure quick turnaround in order for them to be useful for monitoring medium-term financing agreements. It will also be important for funding for other diseases and the health sector overall to be monitored regularly to ensure that increased domestic spending for HIV and AIDS does not come at the expense of other health priorities.

6. Consequences of Not Meeting Conditions

WHY IT MATTERS FOR SUSTAINABLE FINANCING:

The objectives of country compacts can only be realized if the commitments made in these compacts are binding, or at least heavily respected, for all parties involved. One way of ensuring that compacts have leverage is by including specific consequences for not meeting the conditions specified in a compact.

Current Practice:

While PEPFAR, the Global Fund, and the World Bank have numerous conditions on funding and can suspend or modify disbursements, their financing agreements with countries do not provide adequate information on what happens if these conditions are not met. PEPFAR's PFIP with Vietnam specifies that "USG funding is… based on performance", but more detail is not provided. The Global Fund's grant agreements are "enforceable against the PR in accordance with its terms", but specific consequences of not meeting certain conditions in the agreement are

not given. Generally the Global Fund will not delay funding based on a country's failure to produce its counterpart financing alone – it would also be based on program management, performance, and other criteria[31]. The World Bank's agreements do not describe specific penalties either. There is also no information available in these agreements regarding what happens if donors fail to follow through on their funding commitments.

GAVI has a zero tolerance policy for misuse of funds, but is more flexible regarding co-financing. If a country defaults on its co-financing requirements, GAVI will work closely with the country and decide what to do on a case-by-case basis.

A Potential Standard?

The MCC disburses funding quarterly, and funding may be delayed or decreased if quarterly disbursement requirements are not met, as specified in the Conditions Precedent Report created under each agreement (separate from the compact document). The MCC views these quarterly disbursements as part of its toolkit to manage compact resources responsibly. The MCC demands a lot from the countries it works with, and selects countries that are poised to take advantage of resources and have relatively high levels of capacity and commitment (this may be too much reporting burden for programs implemented under the other donors). If programs are not on track or are not likely to meet their goals, funding for those programs may be decreased or eliminated. However, this funding will generally be channeled toward a different program, as MCC compacts are structured so that the country is promised its total "funding envelope",[32] but that envelope may be flexibly distributed across priorities (subject to certain conditions). In rare cases, MCC has terminated agreements where countries have been non-cooperative. This has been mostly in force majeure situations, such as Mali and Madagascar, where political turmoil resulted in programmatic failures. Conditions in the Conditions Precedent Reports are generally respected by both the MCC and recipient countries, and MCC has made good on its promise to decrease or, if absolutely necessary, terminate MCC funds.

Guiding Principle:

Country compacts should specify clear consequences of not meeting various financing conditions in the compact.

Consequences should range from light to severe, depending on the condition that has not been met. Agreements should not be terminated for every compact breach – other consequences could include funding being delayed, or less funding being provided for a specific activity, if targets for that activity are behind or there is evidence that the activity-specific funding has been misused. Still, consequences need to be significant enough that they provide incentives for countries and donors to meet their commitments and carry out the conditions specified in compacts. The MCC strikes a good balance, by viewing disbursements as a funds management tool, delaying or reallocating funding where necessary, and only very rarely terminating agreements entirely.

[31] Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
[32] Although there is no information in these compacts about what happens if the MCC fails to follow through on its funding commitments

These tools also need not be "traditional" consequences that decrease or withhold donor funds. Other types of mechanisms that can hold donors and countries to their commitments should also be considered. For example, one could require that a high-level political figure widely publicize a country's domestic funding commitment for HIV and AIDS, such as through a speech, in order to increase awareness of the commitment by civil society and the general public. In South Africa, the signing of the PFIP coincided with a visit by then U.S. Secretary of State Hillary Clinton and was widely publicized in the media. Other mechanisms could include using CSOs to help pressure all parties in a compact to fulfill commitments or requiring that financial performance be transparently published. Another tool may be Results Based Financing. For GAVI's Health Systems Strengthening grants, countries are given additional funding after the first budget year if immunization coverage improves (or if high coverage is maintained). The Global Fund is doing something similar but more specific to sustainable financing under its New Funding Model by reserving 15% of countries' total resource envelopes for funding that will be allocated based on governments' willingness to pay for their own disease programs. Both the Global Fund and the MCC also cited the possibility of being awarded funding in the next "funding round" as a major incentive for countries to follow agreements and stick to their commitments.[33,34] Further analysis will likely reveal other tools that can increase the leverage of a country compact, although many of these are unlikely to be components of a compact themselves (rather, they would come before or after the compact is signed).

Compacts should also be flexible in allowing countries to "get back on track" for funding if a condition has not been met but the country is showing a meaningful attempt to fix its problems associated with meeting that condition. For example, if funding has been withheld because progress was not being made on an activity, and now that activity's targets are being reached, funding could again begin being disbursed. Or, if funding disbursements were reduced because a country was not providing promised co-financing, those funds could be replaced if the country later provides extra funding to make up for its previous nonfulfillment.

Finally, consequences should apply to both donors and recipient countries. It is hard to take a donor's funding commitments seriously if there are no conditions to ensure that the donor meets those commitments. For example, all of PEPFAR's PFIPs reviewed state that PEPFAR's funding levels are non-binding estimates that are subject to congressional appropriations and future availability of funds. MCC sets a useful standard in this regard, as its agreements are structured so that a country is eligible to receive its full MCC funding amount even as priorities shift and activities' scopes change, except in dire circumstances, and these agreements are binding treaties for both parties involved.9 GAVI also provides a good example in that it is the only donor to transparently report on an indicator that tracks its actual disbursed funding against commitments.

HIV and AIDS donors face a particular challenge since they are, in many cases, funding programs that are putting people on life-saving ART support. There is a major ethical dilemma when it comes to withholding or delaying funding, and

[33] Personal correspondence (interview) between the Global Fund (George Korah) and R4D (Nandini Oomman, Theresa Ryckman) on December 10, 2013
[34] Personal correspondence (interview) between the MCC (Chris Broughton, Margaret Dennis) and R4D (Nandini Oomman, Theresa Ryckman) on November 20, 2013

countries realize this and may take conditions and consequences less seriously as a result. This is likely one reason why most of the HIV and AIDS donors will not delay funding based on counterpart or domestic financing alone. In the end, donors have to be willing to draw lines and these lines have to be made clear to countries. A combination of clear consequences with clear trigger points and other incentives and methods of increasing leverage can help increase the weight of a compact.

V. Conclusions & Next Steps

The guiding principles discussed in this paper are a starting point for the development of country compacts for sustainable financing for HIV and AIDS. The compact is one tool that can ensure that countries experience smooth financing transitions when external donor funding decreases. These principles may be further developed through additional analysis, country experiences, and feedback from experts. Additional analysis of the agreements of other donors, such as DfID, were not included in this report, but would provide more information for compact development. Country compacts and other donor-country financing agreements that include domestic funding commitments are still in nascent stages for most donors (PEPFAR is only in the first few years of most of its PFIPs and the Global Fund is about to fully implement its New Funding Model), so it will be important to incorporate lessons learned from country experiences with these agreements as they occur.

Suggested next steps include:

- Reviewing more closely the programmatic targets in country compacts, in order to analyze the connection between programmatic goals and outputs, exercises to cost those programs, and the development of financing targets based on that costing.

- Additional research on "less traditional" incentives and consequences (other than withholding or delaying funding disbursements), such as CSO engagement, Results Based Financing, and using media or other forms of public engagement, could assist in producing guidance for developing compacts that, if not legally binding, at least have significant leverage.

- Adding DfID's financing agreements to the compact inventory mix, if available, could add value by incorporating additional donor perspectives in the analysis. Currently, the only bilateral donor considered is the United States.

- Drafting country case studies by reviewing specific country experiences with donor transitions and the compacts used to guide these transitions (and speaking with relevant stakeholders in these countries) could provide additional insight into what works and what does not.

- Additional work is also needed on expenditure tracking mechanisms. While there are many tools available, some are less routinize-able and require longer turnaround time, while others create additional burden for countries. There is not a clear consensus across donors and countries on the "best" resource tracking tool, and multiple options are used across different countries, making spending comparisons difficult. Furthermore, it may be the case that

none of the current expenditure tracking systems pushed by HIV and AIDS donors (National AIDS Spending Assessments, System of Health Accounts, and Public Expenditure Reviews) are appropriate for tracking financing commitments in country compacts, in which case development of such a tool would be an important next step.

Having this report reviewed and published, including distributing it to countries and donors for comment and as possible guidance, can help ensure that the information contained here is endorsed by stakeholders and can be used to ensure that smooth and sustainable funding arrangements and transitions occur in countries.

Development of an action plan to actually implement compact guidance, once finalized and endorsed by stakeholders, will help bridge the gap between the information provided in a guidance document and the actual content of compacts and their operationalization going forward. A first step in such an action plan could be to test out some of the recommendations contained in this document in a small selection of countries. UNAIDS could also use the Economics Reference Group or another interagency task force to ensure these findings are taken from policy to practice.

Annex Table 1: Global Fund Country Compacts Inventory Matrix

	STANDARD FEATURES	CAMBODIA	INDIA	JAMAICA	KENYA	MOLDOVA	NIGERIA
COUNTRY FEATURES							
Epidemic Type	These are standard features across all agreements	Concentrated	Concentrated	Concentrated	Generalized	Concentrated	Generalized
Income Bracket		LIC	LMIC	UMIC	LIC	LMIC	LMIC
Region		EAP	SA	LAC	SSA	ECA	SSA
COMPACT FINANCING FEATURES							
Time Period:		3 years (2011-13)	2 years (2010-12), with 3 more possible in Phase 2	2 years (2008-10), then 3 more approved in Phase 2	3 years (2011-14)	1.5 years (2010-12)	2.5 years (2010-12)
Actors Included	Signees: Principal Recipient, Global Fund, CCM Chair, CSO representative of CCM	National Centre for HIV/AIDS, Dermatology, and STDs (PR), GF, NAC (CCM chair), HIV Programme PACT Cambodia (CSO rep.)	Dep't. of Economic Affairs (PR), GF, MOH (CCM chair), Suraksha (CSO rep.)	MOH (PR), GF, MOH National HIV/STI (CCM chair), Jamaica Network of Seropositives (CSO rep.)	MOF (PR), GF, MOH (CCM chair), Kenya AIDS NGOs Consortium (CSO rep.)	Moldova Health Systems Restructuring Project (PR), GF, MOH (CCM chair), Soros Foundation (CSO rep.)	NACA (PR), GF, Nigeria Office of the Secretary (CCM chair), NEPWAN (CSO rep.)

	STANDARD FEATURES	CAMBODIA	INDIA	JAMAICA	KENYA	MOLDOVA	NIGERIA
Financing Targets (GF)	Made Between: PR and GF	Only "first disbursement" is committed	Funds only committed for Phase 1. 10% of Phase 1 funds set aside for disbursement after 12 months	Funds only committed for Phase 1.	Only "first commitment" is committed	Only "first commitment" is committed	Only "first disbursement" is committed
Financing Targets (country)		None	None	Counterpart financing requirements (10-20% of total)	None	None	None
Inputs to Financing Targets	Detailed budget provided by PR in application	Combined remaining funds from previous grant and funds requested in proposal	None other than Standard	None other than Standard	Combined remaining funds from previous grant and funds requested in proposal	Combined remaining funds from previous grant and funds requested in proposal	Combined remaining funds from previous grant and funds requested in proposal
Processes for Enforcement & Monitoring	LFA verification, auditing, competitive sub-recipient (SR) selection, SR performance monitoring, periodic reporting	Regular budget and expenditure reporting	Quarterly update of programmatic results, Steering Committee meetings	None other than Standard	None other than Standard	None other than Standard	M&E TWG quarterly meetings, periodic inventory management, annual reviewing
Are these processes new or existing?	New	New	New	New	New	New	New
Tools for Enforcement & Monitoring:	Annual audits; program reports;	Annual training plans, annually updated country profile, list of non-cash assets	Quarterly reports, annual training plans, PMIS data reports, SR reports	Counterpart financing	Financial reports, annual verification of fixed assets	None other than Standard	Quarterly reports, expenditure analysis, M&E progress reports, Internal Audit reports.
Are these tools new or existing?	New	New	New	New	New	New	New
Other Required Output Tools & Committees	Procurement, use, and supply management plans (PSM)	Financial management manual, HR manual, facility renovation workplans & budgets, procurement manual, sub-recipient management plan	M&E plan/ costed action plan, SR management plan, SR workplans & budgets, report on SR taxes and duties,	Small grants program plan	Back-up system and equipment, pharmaceutical & health product management profile, staff TORs, financial reporting, fixed asset register, delivery kits workplan & budget, past audited reports, updated ops manual, assess storage conditions	Establishment of a department for planning & interaction between NAC, ART Treatment Section, M&E Unit, MOH, and MOSPFC	Service mapping, national specifications for laboratory equipment

	STANDARD FEATURES	CAMBODIA	INDIA	JAMAICA	KENYA	MOLDOVA	NIGERIA
Types of Programmatic Content Included	Objectives, target groups, strategies or activities under each objective,	None other than standard	None other than standard	None other than standard	None other than standard	None other than standard	PR or NACA assigned to each activity (split in some cases)
Consequences of not meeting conditions	If any conditions are not met, the GF can terminate or suspend the agreement.	None other than standard	None other than standard	None other than standard	None other than standard	None other than standard	2nd disbursement may not be disbursed if conditions are not met. 1st is subject to terms & conditions
Terms & Conditions	See Standard Terms & Conditions below	None other than standard & tools/ outputs listed above	Bank account statement & request letter prior to first disbursement	Bank account statement & request letter prior to first disbursement	Bank account statement & request letter prior to first disbursement	None other than standard & tools/ outputs listed above	Bank account statement & request letter prior to first disbursement

Standard Terms & Conditions:

- Implementation in accordance with budget and approved program activities, changes must be authorized by GF
- GF may extend commitment period at its discretion
- "This agreement has been duly executed and delivered by the PR and is enforceable against the PR in accordance with its terms"
- PR not receiving funding from other sources that duplicates GF funding & informs GF of additional funding
- Cooperation with CCM & LFA, progress verification by LFA
- No disbursement unless: request for disbursement signed by PR, GF funds are available, special conditions met, previous progress reports submitted, demonstration of results consistent with performance framework targets, PR reports prices and supply information following procurement, LFA verification.
- If any conditions not met, GF can terminate or suspend the agreement
- Conditions on number and type of bank accounts (etc.), interest, revenues, taxes, duties
- Auditing: Accounting books and records maintained, PR annual financial audits using independent auditor. PR ensures audits of SRs. GF has right to audit.
- Sub-recipients: PR assesses capacity of SRs, SRs activities designed to facilitate PRs objectives/activities, copy of SR agreements to GF, PR monitors SR performance

- Progress Reports: periodic reports toward objectives and targets
- Conditions on procurement practices and policies, supply chain, products, PSM plan, adhere to WHO guidelines,
- Conditions on insurance, liabilities, conflict of interest, etc.
- PR receives unused grant funds upon termination, provides audited financial report, inventory of assets (and plan for use if requested)

Annex Table 2: PEPFAR Country Compacts Inventory Matrix

	ANGOLA	MOZAMBIQUE	NIGERIA	SOUTH AFRICA	TANZANIA	VIETNAM
COUNTRY FEATURES						
Epidemic Type	Generalized	Generalized	Generalized	Generalized	Generalized	Concentrated
Income Bracket	UMIC	LIC	LMIC	UMIC	LIC	LMIC
Region	SSA	SSA	SSA	SSA	SSA	EAP
COMPACT FINANCING FEATURES						
Time Period:	5 years	5 years	6 years	5 years	5 years	5 years
Actors Included	USG and GRA (National Commission to Fight HIV/ AIDS and Large Epidemics)	USG and GRM (multiple ministries, NAC)	USG and GON (leadership of NACA and FMOH)	USG and SAG. Signees: US Ambassador, SA Minister of Health	USG and URT (MOH, TACAIDS)	GVN and USG (Steering Committee)
Financing Targets (PEPFAR)	3 year budget projection. "PF funds for 2009 and 2010 are approved, the funds for 2011-13 are subject to Congressional appropriations and approval by the Global AIDS Coordinator"	5 year total projected contribution. "USG contributions in out-years are estimates and do not include binding funding levels. Levels are subject to congressional appropriations and based on the availability of funds"	6 year expected financing contribution. "All funding subject to annual Congressional appropriations process."	5 year Financing Plan. "Allocation is notational and subject to Congressional appropriation and approval by the Global AIDS Coordinator"	5 year funds by donor. "Availability of PEPFAR resources in 2011 and beyond is subject to Congressional appropriations and approval of the US Global AIDS Coordinator"	5 year projected financial contribution. "USG funding is anticipated over the full 5 year PF; actual annual allocations are subject to the availability of funds and based on performance"
Financing Targets (country)	5 year budget projection	3 year total projected contribution	6 Year Expected Financial Contribution; GON to finance 50% of the cost for Universal Access	5 Year Financing Plan	None included	5 Year Projected Financial Contribution
Financing Targets (other donors)	Expected contributions of other donors are included	Expected contributions of other donors	Expected contributions of other donors	Expected contributions of other donors are included	Expected contributions of other donors are included	Expected contributions of other donors

	ANGOLA	MOZAMBIQUE	NIGERIA	SOUTH AFRICA	TANZANIA	VIETNAM
Inputs & Tool for Setting Financing Targets	Current GRA funding extended forward, PEPFAR past COP allocations, gap based on NSP	GRM from budgets (3 years only), PEPFAR past COP allocations, current agreements with other donors (3 years only), Round 9 GF Proposal	NSP resource needs, current WB, GF, DFID, CHAI agreements, past PEPFAR COP allocations, NASA, HAPSAT; Assumes GON provides 50% of total HIV financing by 2015.	Past PEPFAR COP allocations, other expected donor funding (from current funding), NSP resource needs	Budget guidelines informed domestic spending estimates. PEPFAR based on past COP allocations. Donor funding projected forward from PER. NMSF, treatment costing exercises.	GVN from budget forecasts, GF from current grants, PEPFAR from past COP allocations. UNGASS 2010.
Processes for Enforcement & Monitoring	High Level: annual meetings; Strategic: INLS semi-annual workshop, PFIP management group meetings; Technical: quarterly TWG and multisectoral coordination and supervisory committee meetings	GRM bi-annual review will include a review of financing contributions, transition progress. Twice annual SC meetings, National Directors Meetings, GRM inclusion in PEPFAR annual review process	Semi-annual data reviews, in-depth state monitoring by lead IPs.	Twice yearly SC meetings, MC meetings every other month, monthly TTT meetings.	Biannual PER to track expenditures. Ongoing JTWG technical sub-committee reports, and quarterly progress statements. Annual convenings to inform budgets. Biannual stakeholder review.	SC annual progress reviews and semi-annual meetings. Twice yearly TWG reviews, SC co-chair monthly meetings and information exchanges.
Are these processes new or existing?	Some new, most existing	Some new, some existing	New	New structures, but aligned with existing SAG processes	Mostly existing	New
Do processes explicitly cover financing?	No	Yes	No	No	Yes	No
Tools for Enforcement & Monitoring:	Nothing financing specific	Bi-annual review	Nothing financing specific	Regular spending reviews, using PEPFAR Expenditure Analysis and SAG BAS, APT	Biannual PER. TACAIDS annual reviews of donor commitments and pledges	Financial commitments to be measured through the NASA
Are these tools new or existing?		Existing		Already being developed	Existing	Already being developed
Types of Programmatic Content Included	Goals and objectives, strategies and activities to achieve these, generally aligned with NSPs or other national HIV planning documents. General language on country ownership, transitioning certain services (all service delivery to TA in MICs), emphasis on joint planning, alignment, collaboration, information sharing, capacity building.					
Consequences of not meeting conditions	None	None	None	None	None	USG funding is subject to availability of funds and based on performance

Annex Table 3: World Bank Country Compacts Inventory Matrix

	AFGHANISTAN	BOTSWANA	INDIA	JAMAICA	KENYA	NIGERIA
COUNTRY FEATURES						
Epidemic Type	Concentrated	Generalized	Concentrated	Concentrated	Generalized	Generalized
Income Bracket	LIC	UMIC	LMIC	UMIC	LIC	LMIC
Region	Asia/Mid-East	SSA	Asia/Mid-East	LAC	SSA	SSA
COMPACT FINANCING FEATURES						
Time Period:	3.25 years; (Sept 2007 – Dec 2010)	4.5 years; (Jan 2009 – Sept 2013)	4.5 years; (June 2013 – Dec 2017)	4.25 years; (June 2008 – Nov 2012)	4.5 years; (July 2007 – Dec 2011)	3 years; (Nov 2010 – Dec 2013)
Actors Included	Financing Agreement: IDA & Afghanistan (MOF) Main Implementer: MOPH Other Implementers: MOF, other ministries	Loan Agreement: IBRD & Botswana (MOF) Implementer: NACA, DAC, CSOs/private sector, ministries	Financing Agreement: IDA & India (MOF) Implementers: DAC/NACO, SACs at state level	Loan Agreement: IBRD & Jamaica (MOF) Implementers: MOH, other line ministries, private sector, CSOs	Financing Agreement: Kenya (MOF) & IDA (IDA coordinates DFID grant – IDA and DFID have a separate agreement). Implementer: Kenya makes funds available to NACC on grant basis under subsidiary agreement that gets approved by IDA	Financing Agreement: Nigeria (MOF) & IDA Implementer: Nigeria makes funds available to NACA and SACAs through separate agreements
Financing Targets (WB)	Loan from IBRD to Botswana	Grant from IDA to Afghanistan	Credit from IDA to India	Loan from IBRD to Jamaica	Grant from DFID (IDA coordinates); Credit from IDA to Kenya	Credit from IDA to Nigeria
Financing Targets (country)	None	None	None	None	Commitment from Kenya to fund 20 M shillings.	Nigeria "causes states to ensure SACAs fund $100,000"
Financing Targets (other donors)	None	None	None	None	DFID grant (IDA administers)	None
Inputs & Tool for Setting Financing Targets	Not specified	Not specified	Not specified	Not specified	Not specified; DFID funding already determined by Kenya/DFID	Not specified

	AFGHANISTAN	BOTSWANA	INDIA	JAMAICA	KENYA	NIGERIA
Processes for Enforcement & Monitoring	Financing: Quarterly and annual financial reporting Non-Financing Specific: annual planning by Planning Committee, annual and semi-annual project reporting	Financing: Financial reporting Non-Financing Specific: twice yearly SC and technical sub-committee meetings, semi-annual reporting (Botswana), annual reporting (NACO, ministries, non state)	Financing: Semi-annual financial reporting (India, DAC/ NACO, SACs, subgrantees) Non-Financing Specific: Semi-annual project reporting	Financing: Quarterly financial reporting (Jamaica, MOH, line ministries, less frequently for CSOs and private sector), auditing Non-Financing Specific: Quarterly project reporting	Financing: Annual financial reporting, auditing Non-Financing Specific: annual project reporting, progress monitoring through Inter-Agency Coordinating Committee & Steering Committee	Financing: Financial reporting (by Nigeria, subgrantees, NACA, SACAs) & auditing. Periodic budgeting Non-Financing Specific: Annual project reporting
Are these processes new or existing?	New	New	New	New	New	New
Do processes explicitly cover financing?	Yes	Yes	Yes	Yes	Yes	Yes
Tools for Enforcement & Monitoring:	Financing: Quarterly financial reports (audited annually) Non-Financing Specific: semi-annual project reports, integrated annual reports	Financing: Quarterly financial reports, annual audited financial statements Non-Financing Specific: semi-annual project reports, annual progress reports (NACA, ministries, non-state actors); mid-term review	Financing: Quarterly financial statements, audited annually (Jamaica, SACs) Non-Financing Specific: Semi-annual progress reports (Jamaica, SACs, subgrantees) using program indicators	Financing: Quarterly financial reports (audited annually) Non-Financing Specific: Quarterly project reports	Financing: Annual audited financial statements (NACC) Non-Financing Specific: annual project reports on programmatic indicators (NACC), mid-term review with IDA (Kenya)	Financing: Annual audited financial statements from Nigeria, subgrantees Non-Financing Specific: quarterly project reports (NACA, states)
Are these tools new or existing?	New	New	New	New	New	New
Other Required Processes & Tools (related to financing)	Financial Management Manual; Annual workplans, including budgets	Annual workplans (budgets not specified) Backlogged audited reports	Annual workplans, including budgets	Annual workplans, including budgets	Annual consolidated workplan (budgets not specified)	Subsidiary agreement with one state; annual workplans & budgets
Types of Programmatic Content Included	High risk groups, knowledge, reducing stigma, advocacy, comms capacity building	NACA capacity building, prevention/ mitigation	Targeted prevention, BCC, institutional strengthening	Targeted prevention, access to treatment, management strengthening, capacity building	Prevention interventions, focus on target populations, grounded in KNASP	Scaling up prevention, access. Capacity building & TA for management
Consequences of not meeting conditions	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified

	AFGHANISTAN	BOTSWANA	INDIA	JAMAICA	KENYA	NIGERIA
Terms & Conditions	Afghanistan responsible for MOPH carrying out the project in accordance with other terms in the agreement. Afghanistan must follow the budget contained in the agreement (but only two line items for everything) Other specific terms of grant – payment dates, withdrawal etc.	Botswana responsible for ensuring the project is carried out under NACA, in accordance with Operational Manual, other terms in agreement. Botswana must follow the budget contained in the loan agreement Other specific terms of repayment, interest, schedule, etc.	India responsible for ensuring DAC/NACO carry out the project in accordance with Project Strategic Plan and other terms in agreement. India must follow the budget contained in the agreement (but only one line item for everything) Other specific terms of repayment, interest, schedule	Jamaica responsible for ensuring the project is implemented through MOH, ministries, CSOS, private sector – in accordance with operations manual & terms in agreement. Jamaica must follow the budget contained in the loan agreement Other specific terms of repayment, interest, schedule, etc.	Kenya responsible for ensuring NACC carries out the project in accordance with criteria and procedures in operations manual, including financing, & terms in agreement Kenya must spend the grant/ credit following an agreed upon budget Other specific terms of repayment, interest, schedule, etc.	Nigeria responsible for NACA and SACAs carrying out the project in accordance with project implementation manual, terms in agreement. Nigeria must spend the credit following an agreed upon budget Other specific terms of repayment, interest, schedule, etc.

Annex Table 4: MCC Country Compacts Inventory Matrix

	MOLDOVA	MOZAMBIQUE	TANZANIA
COUNTRY FEATURES			
Epidemic Type	Concentrated	Generalized	Generalized
Income Bracket	LMIC	LIC	LIC
Region	Eastern Europe/Central Asia	SSA	SSA
COMPACT FINANCING FEATURES			
Time Period:	5 years	5 years	5 years
Actors Included	Agreement Between: USA, Moldova Acting Through: MCC, Government of Moldova Signees: MCC CEO, Deputy Prime Minister of Foreign Affairs Other: Agreement gets ratified by the Moldovan Parliament Government designates MCA-Moldova as the accountable entity	Agreement Between: USG, GOM Acting Through: MCC Signees: MCC CEO, Minister of Planning & Development Government may designate an entity to implement, and MCA-Mozambique is the accountable entity (including financial control)	Agreement Between: USA and the Government of Tanzania Acting Through: MCC, T MOF Signees: President of US, President of Tanzania MCA-Tanzania carries out and implements the program, but this does not relieve the government of its obligations
Financing Targets (WB)	Grants with an upper limit and multiple disbursements (Program Funding & Implementation Funding), subject to terms of Compact.	Grants with an upper limit and multiple disbursements (MCC Funding & Implementation Funding), subject to terms of Compact	Grants with an upper limit and multiple disbursements (MCC Funding & Implementation Funding), subject to terms of Compact

	MOLDOVA	MOZAMBIQUE	TANZANIA
Financing Targets (country)	The Government will provide all funds and other resources necessary to carry out the Government's responsibilities and obligations under the Compact	The Government will provide all funds and other resources necessary to carry out the Government's responsibilities and obligations under the Compact	The Government will provide all funds and other resources necessary to carry out the Government's responsibilities and obligations under the Compact
Financing Targets (other donors)	Yes, mostly with USAID and World Bank, also OECD, UN, EU	Yes, through Working Groups – mostly the World Bank and also USAID and other donors (DFID, etc.)	Yes, through groups (e.g. Joint Technical Committee) of many donors, mostly with World Bank and USAID.
Inputs & Tool for Setting Financing Targets	Not specified, but a Multi-Year Financial Plan Summary (budget) with line items for each project and for M&E and Admin/Auditing is included in the compact.	Not specified, but a Multi-Year Financial Plan Summary (budget) with line items for each project and for M&E and Admin/Auditing is included in the compact.	Not specified, but a Multi-Year Financial Plan Summary (budget) with line items for each project and for M&E and Admin/Auditing is included in the compact.
Processes for Enforcement & Monitoring	Regular accounting and book-keeping by the Government and "Covered Providers" (anyone funded a certain amount by the Government using MCC Funds), semi-annual Government auditing.	Regular accounting and book-keeping by the Government and "Covered Providers" (anyone funded a certain amount by the Government using MCC Funds), semi-annual Government auditing.	Regular accounting and book-keeping by the Government and "Covered Providers" (anyone funded a certain amount by the Government using MCC Funds), semi-annual Government auditing.
Are these processes new or existing?	New	New	New
Types of Programmatic Content Included	Compact Goal, Program Objective, and Project Objectives (2 projects). Much more detailed programmatic information on what the MCC Funds should be spent on. Plans for sustainability are included (e.g. amended Road Fund Law to provide reliable mechanism for adequate road maintenance funding)	Compact Goal, Program Objective, and Project Objectives (4 projects). Much more detailed programmatic info on what the MCC funds should be spent on. There is a section under 1 of the projects on financial sustainability.	Compact Goal and Project Objectives (3 projects). Much more detailed programmatic info on what the MCC funds should be spent on. There is also an HIV component in this project (incorporating HIV awareness programs into implementation)
Consequences of not meeting conditions	MCC may terminate the agreement if the Government fails to comply. If terminated, all disbursements cease and funding not disbursed will be released from obligation, while unspent disbursed funds must be returned to MCC. The Government may also have to pay back any misspent funds.	MCC may terminate the agreement if the Government fails to comply. If terminated, all disbursements cease and funding not disbursed will be released from obligation, while unspent disbursed funds must be returned to MCC. The Government may also have to pay back any misspent funds.	MCC may terminate the agreement if the Government fails to comply. If terminated, all disbursements cease and funding not disbursed will be released from obligation, while unspent disbursed funds must be returned to MCC. The Government may also have to pay back any misspent funds.
Funding-Specific Conditions	The funds must be spent in line with the Multi-Year Financial Plan Summary included in the compact, and the Government must provide more detailed multi-year financial plans periodically.	The funds must be spent in line with the Multi-Year Financial Plan Summary included in the compact, and the Government must provide more detailed multi-year financial plans periodically.	The funds must be spent in line with the Multi-Year Financial Plan Summary included in the compact, and the Government must provide more detailed multi-year financial plans periodically.

JAMAICA HIV/AIDS PROGRAM TRANSITION FROM DONOR SUPPORT TRANSITION PREPAREDNESS ASSESSMENT

Produced by: Results for Development (R4D) - APW with UNAIDS 2013/359026

Country report

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Disclaimer

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
CARPHA	Caribbean Public Health Agency (CARPHA)
CCM	Country Coordination Mechanism
CHAI	Clinton Health Access Initiative
CIF	Curatio International Foundation
CSO	Civil Society Organizations
EEI	Enabling Environment Index
EMCTC	Elimination of mother-to-child transmission
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GDP	Gross Domestic Product
GF	Global Fund
GNI	Gross National Income
HDI	Human Development Index
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
IMF	International Monetary Fund
HRH	Human Resources in Health
JASL	Jamaica AIDS Support for Life
J-FLAG	The Jamaica Forum of Lesbians, All-Sexual and Gays
KAP	Key Affected Populations
LGBT	Lesbian, Gay, Bisexual and Transgender
LMIS	Logistics management Information System
MERG	Jamaica Monitoring and Evaluation Reference Group

MOH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NHDRRS	National HIV-related Discrimination Reporting and Redress System
NHF	National Health Fund
NHP	National HIV/STI Programme
NFPB-SHA	National Family Planning Board and Sexual Health Agency
NGO	Non-Governmental Organization
NSEP	Needle and Syringe Exchange Programs
OST	Opioid Substitution Therapy
PAHO/WHO	Pan American Health Organization/World Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PIOJ	Planning Institute of Jamaica
PLACE	Priority for Local AIDS Control Effort
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infections
SW	Sex Worker
TG	Transgender People
TGF	The Global Fund
TPA	Transition Preparedness Assessment
UMIC	Upper-middle income country
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Executive Summary

The Jamaica country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program that examines the country's disease program readiness for transition from external support. The research intends to understand the factors affecting HIV program sustainability and aims at informing a smooth and effective transition planning process from the Global Fund support in Jamaica. The assessment has utilized mixed methods of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees included government officials, donor representatives, staff from international organizations, and civil society members, among others.

Transition preparedness assessment singles out system wide and programme level bottlenecks that may impede sustainability of the national HIV response in Jamaica. A summary score of transition risk (26.92%) indicates that the country is exposed to high to moderate transition risk. Carefully designed transition planning is needed to ensure that public health gains achieved through the concerted efforts from the Government of Jamaica and donor-funded programs are sustained after the GF funding ends. Findings presented in the report follows the TPA framework and are organized around two overarching domains: external environment and internal environment, and various sub-components under each major domain.

External Environment

Political Environment: GoJ declares its commitment to its population's health, however state investments in health have not been steadily increasing over the last five years. The share of government spending on health out of General Government Expenditure in 2014 remained below the mean of that for upper-middle income countries. Per capita health expenditure (current US$) by the State, as well as the Total Health Expenditure as a percentage of GDP declined in 2014.

Existence of numbers of discriminatory laws in Jamaica also poses high risk to program transition and sustainability of progresses achieved in terms of reversing HIV epidemic, especially among KAPs. The laws criminalizing anal sex contacts, transactional sex and drug use create substantial service barriers and drive at-risk populations underground. Furthermore, such laws may impose limitation on the government to fund CSOs for providing HIV services that specifically target persons engaged in criminalized behaviors.

Economic environment: Jamaica's GDP has been increasing over the last few years but at a very low rate averaging less than 1 percent a year. The country's debt to GDP ratio was estimated at 146.2 percent of GDP in March 2013, making the country one of the most indebted middle income nations in the world.[1]. Less conducive macro-economic environment along with huge debt burden may limit government's ability to assume full financial responsibility for the HIV program interventions currently funded through the GF. The World Bank classification of Jamaica as an upper middle-income country has resulted curtailed funding to the country. In addition, Jamaica as a small island and developing state is susceptible to external shocks that further exacerbates the country's vulnerability.

[1] Jamaica's National Integrated Strategic Plan for Sexual and Reproductive Health & HIV 204-2019, p. 42

Internal Environment

Financial resources: while AIDS spending data for recent years is not available, latest NASA data indicates that in FY 2012/2013, the GoJ covered only one fifth of the AIDS total spending, largely using borrowed funding from IBRD. There are numbers of HIV interventions that remain largely or solely dependent on the GF funding that poses significant risk to financial sustainability of HIV national response.

Human resources: There is a severe shortage of HR in health sector in general, including HIV field with the highest gap in non-medical/ support staff. In addition, HR costs for HIV remain largely dependent on external support and after transitioning, staff shortage might become even worse if the GoJ is unable to absorb the costs of human resources currently paid by donors. Development of a HR policy for medical and non-medical personnel involved in HIV field will be needed to mitigate HR-related risks. Institutionalization of donor-supported training programs into formal educational system should be ensured to ensure sustainability.

Information Systems: Substantial efforts have been made in the country to refine treatment and prevention databases in Jamaica in recent years, but there are still weaknesses in data collection and analysis that need to be addressed during transition period. Second generation surveillance studies have been regularly conducted in the country among different KAPs that have been largely financed by the external donors. Advocacy should be intensified to ensure that the Government starts allocating adequate financial resources to HIV surveillance and research studies to ensure sustainability. Furthermore, using more robust methodologies for surveillance studies needs to be institutionalized to improve the validity and reliability of epidemiological data that should inform HIV programming and budget allocation decisions.

Governance: HIV/AIDS has been declared as a priority by the Government, but to assure adequate transition towards sustainability of HIV national response, the declaration is to be substantiated with credible funding allocation from the State and with legislative amendments. The National Integrated Strategic Plan (2014-2019) that is costed and is accompanied with M&E plan needs to be approved by the Government resolution to ensure that NISP has more legal power to drive adequate allocations within the national budget.

Integration of HIV national response into the National Family Planning Board has been a positive signal that the GoJ strives to increase coordination and optimize country response that is key to sustainability. However, coordination functions and modes of operation of NFPBM/CCM should be further defined and strengthened during transition period through national level consultations involving civil society organizations among others.

Accountability: National surveillance system of MoH produces epidemiological profiles and Global AIDS Response Progress (GARP) reports annually, and the NASA reports biannually and make them publicly accessible. However, the quality and timeliness of reporting, particularly that for spending data should be improved.

Programme

Service delivery: Jamaica has ensured unrestricted equal access to HIV testing and treatment services for all groups of the society. Integration of HIV treatment services into primary health care and availability of free-of-charge ARV treatment services at private clinics is also positive factor towards program

sustainability. However, ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention and survival rates also need to be improved. PMTCT has been very successful in terms of sharp reduction in AIDS pediatric cases and the country currently moves towards elimination of MTCT. Despite program achievements, structural barriers, stigma and discrimination, and weak HIS are limiting country's ability to better track service coverage and treatment outcome indicators, and these challenges need to be addressed during transition.

CSO engagement: Jamaica Government has supported engagement of civil society organizations in HIV service provision, including ARV treatment services. There are no laws that would restrict the state to contract CSOs for health service delivery. Thorough assessment of social contracting mechanisms should be conducted to identify and address potential barriers. A national dialogue between the Government and civil society should be initiated to find out most feasible ways for sustainability of CSOs engagement in service provision under the public funds.

Organizational Capacity: There is a strong national programme management capacity within the MoH that serves as TGF PR and manages the national HIV programme. Recent decision of the GoJ to integrate HIV national programme into the National Family Planning Board has emerged a new player into the HIV response management scene. Therefore, significant technical assistance and capacity building interventions will be warranted to expand program management skills to both, existing and newly recruited staff of the NFPB-SHA. CSOs capacity should be strengthened in managing programs under the public funds as well as in fundraising.

The GF procurement and supply chain management is integrated into the national system that is positive factor to make transition smoother. However, Jamaica experiences frequent stock-out of ARV drugs and reasons should be explored and addressed within the transition plan. In 2015, the mean price of ARV drugs in Jamaica was substantially higher than the mean price for upper-middle income countries. The procurement and supply chain management system in Jamaica should be thoroughly assessed to identify system challenges and overhaul the national PSM system.

Transition planning: Jamaica has been privileged to be one of those countries where Transition Preparedness Assessment started well in advance before the transitioning from the Global Fund Funding occurs. The GoJ has demonstrated strong political will to ensure smooth and full transition of HIV national response from external support to country ownership. Country major donors - the Global Fund and USAID are committed to support the country during the transition period. All above mentioned provide solid ground for optimism that Jamaica in collaboration with the GF and other development partners will make concerted efforts to address major challenges identified through the assessment, and will design and implement a well-conceptualized transition plan to ensure HIV program sustainability after the GF funding ends.

The Table 1 present the summary of transition preparedness assessment for HIV national response in Jamaica. For better visualization, risk zones for each domain and subdomain are color-coded. Detailed description of the assessment's findings, and a list of major recommendations can be found in the main body of the report below.

T.1 TRANSITION PREPAREDNESS ASSESSMENT FOR HIV/AIDS - SUMMARY TABLE

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
EXTERNAL ENVIRONMENT					
	PG1	Existence of political will to prioritize health investments	Share of government spending on health out of General Government Expenditure in 2014 was 8.1%. Over the last 5 years this indicator has varied from its lowest in 2011 (6.5%) to the highest in 2013 (9.7%), that is below the mean for UMIC (12% in 2013). Total Health Expenditure has been fluctuating over the last 5 years reaching its peak in 2013 (57.9%). In 2014, the share of government spending out of THE was 52.38% which has been the lowest since 2011. There are no regulations/ laws that would prevent the Government from CSO contracting. According to the stakeholders, the ministry of Education, Ministry of Social Security, as well as Ministry of Health have practiced CSO contracting under the public funds.	High Risk	High Risk
	PH2; PH3	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases & Rule of Law		High Risk	
	PG4; PG5	Government ability to contract with CSOs; CSO contracting practices		Low Risk	
	EG1	Favourable economic indicators	GDP has been increasing over the last four years, however the growth averaged less than 1 percent a year. The country still faces substantial debt-burden and according to the World Bank, Jamaica's debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014. The share of General Government Revenues as % of GDP has been stably high over the last 5 years ranging from 30.4% in 2011 to 32.4% in 2013. This indicator is above the mean for the same income group countries - 28.9% in 2012.	Low Risk	Low Risk
INTERNAL ENVIRONMENT					
INPUTS					
Financial Resources	FH1	Budgetary commitment to disease	HIV budget lines are included in the Jamaica multi-year national budget. The latest NASA report provides AIDS spending data by various program areas, however cross-tabulation of spending by prevention priorities, by beneficiary groups and by financial sources is not available. Goals Model impact	High Risk	High risk
	FH2	Prevention priority		High Risk	

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
	FH3	Allocative efficiency	assessment study, & Modes of Transmission study were conducted in Jamaica. HIV program financial sustainability study was also completed. Unit costs of comprehensive package of HIV prevention targeting KAPs has been conducted for the USAID/PEPFAR project; established unit costs can be applied for planning and projection purposes. Budget allocations have been informed by these studies. HIV screening tests, ARV drugs are partially funded from public sources. The Government's share in financing treatment adherence costs is minimal. The exact share of public funding in financing these services is not known. The assumption is based on the stakeholders' opinion.	Low Risk	
	FH4	Treatment / input financing from public sources		Moderate Risk	
	FH5	Prevention financing from public sources		High Risk	
Human Resources	HRH1	Sufficient human resources for disease (quantities, geographic distribution and aging)	The full time equivalent of currently deployed health care workers (HCWs) in HIV response is 62% of the optimal level required with the largest gap in non-medical, support staff. The number HCWs providing HIV treatment services has not kept the pace with the increased number of patients. Substantial portion of staff training remains heavily relied on donor-supported grants. Only some training, mostly training about HIV/AIDS clinical management have been institutionalized into formal curricula of medical schools. Majority training for non-medical staff has not been institutionalized into formal education system. A policy for production of CSO personnel/ non-medical, social and support services does not exist. Stakeholders confirm that donor-funded HR salaries in most cases are aligned with national pay-scale. However, substantial portion of HR costs still is covered by external support.	High Risk	High Risk
	HRH2; HRH3; HRH4	Institutionalization of donor supported programs; Existence of policy for production/training of CSO personnel (non medical, social service); Donor funded HR salaries aligned with national pay-scale		High Risk	
Information Systems	HISH1	Routine statistical reporting - Integration in the national system	HIV Program data is integrated into the national system; however, the quality of reporting is suboptimal. ARV and PMTCT data from private providers is not integrated; pediatric treatment data is not completely integrated. AIDS treatment database is operational with limited capacity for data disaggregation by KAPs, age, gender, regions, etc. Prevention database does not exclude double-counting of beneficiaries; data about transgender, or homeless drug users, out-of-school youth, adolescents at risk of HIV- are either limited or unavailable. Under the PEPFAR funding	High Risk	High Risk
	HISH2	Routine statistical reporting - Level of advancement		High Risk	

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
	HISH3	HIV Second generation surveillance - Methodologies, Timeliness	being developed but has not yet been implemented at the national level. KABP among general population is based on solid research methodology. PLACE studies (Bio-BSS) among KAPs used convenience sampling and therefore, study findings lack robustness. In 2016, through USAID support RDS methodology will be introduced for Bio-BSS among MSM. PSE studies have not been conducted. Upcoming BBSS (USAID/PEPFAR) among MSM will be combined with PSE study. Bio-BSS studies have been financed through external funds. Only some research staff salaries are covered by the Government. Population Size Estimation studies have never been conducted and most estimates for KAPs are based on experts' opinion.	High Risk	
	HISH4	HIV Second generation surveillance - Funding from public sources		High Risk	
GOVERNANCE					
Governance	GovH1	Strong political commitment to diseases	The National Integrated Strategic Plan (2014-2019) was developed through participatory process; costing of the NISP was completed in 2016. NISP is not approved by the Cabinet, or by any Government resolution. HIV is identified as a priority in the National Agenda of 2030 Sustainable Development Goals. Stakeholders found it difficult to name legally empowered leading organization, which contributes to effective functioning of HIV response. CSOs named individual champions from civil society organization - Jamaica AIDS Support for Life, who has been most prominent leader in advocating for sustainable funding for HIV response, and protecting vulnerable populations' rights. While, CCM and NFPB-SHA, both are expected to serve as an effective mechanism to strengthen HIV coordination in the country, none of these two structures is placed adequately within the government hierarchy, and is legally empowered to assure strong coordination across the sectors. 40% of seats in the CCM is allocated to civil society. Stakeholders believe that CCM functions effectively.	High Risk	High risk
	GovH2	Strong leadership		Moderate Risk	
	GovG3	Strong coordination mechanisms		Moderate Risk	

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
Accountability	AH1	Programme performance results are available and accessible through public domain	HIV Epidemiological Profile is being prepared by HIV/STI National Programme. Reports are available publicly. Data for some KAPs is not available; data disaggregation and analytical part remain weak. Global AIDS Response Progress (GARP) reports are produced and available on the UNAIDS website. Funding matrix files can be obtained upon request. As of September 2016, last AIDS spending data submitted to UNAIDS was from FY 2012/2013. NASA reports up to FY2012/2013 are available. However, cross-tabulation of spending by beneficiary populations all program areas by financial sources is not available. Program evaluation specific reports are not available. Only GARP report and GF PUDR provides some outcome indicators. Enabling Environment Index for civil society organizations - EEI= 0.55 There are no laws or policies that restrict civil society from playing an oversight role, and civil society is actively engaged in providing oversight.	Low Risk	Low Risk
	AG2	Enabling Environment for Civil Society engagement		Low Risk	
PROGRAMME					
Service Delivery	SH1	Treatment	Percentage of adults and children receiving ARV out of total number of PLHIV though has been increasing over the last three years, did not exceed 33% in 2015. ART coverage remains far below the Fast-Track treatment targets. Treatment cascade is suboptimal. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV is declining over the last three years- from 90% in 2013 to 60% in 2015. PMTCT is integrated with PHC/Maternity care. PMTCT services are available for pregnant women attending antenatal services in both, public and private clinics; though data from private sector is not collected. HIV and TB services are integrated within the PHC system. Family nurse practitioners are legally empowered to manage diseases in primary care facilities inclusive of HIV. The coverage of general population with testing has been on rise since 2004. Data based on rigorous Bio-BSSs regarding the two indicators - coverage of MSM and sex workers with prevention services is missing; therefore the indicators were qualified as "worsening" the coverage. The MoH has practiced social contracting mechanism in health sector.	High Risk	Moderate Risk
	SH2	Integrated services		Low Risk	
	SH3	Key populations reach with preventive services		High Risk	
	SG4	CSOs contracting in health		Low Risk	

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
Organizational Capacity	OH1	Strong management of the National Disease Programme Management Entity	There is strong national programme management capacity within the MoH that serves as TGF PR and also manages the national HIV programme. TGF funded	Low Risk	Moderate Risk
	OH2	Procurement & Supply Management	Procurement is conducted using national system in compliance with state procurement regulations. Supply chain management is integrated into the national system. Stock outs for ARV drugs, including for 1st line ARV drugs, happens few times a year. Emergency procurements of drugs become necessary due to frequent stock outs. ARV drugs price from 2011 through 2014 followed similar trend of that for UMICs. However, in 2015, the price in Jamaica skyrocketed. Analytical capacity at MoH is adequate to produce reports, such as GARP, NASA. However, the quality of the reports is not optimal. Reports are more descriptive and analytical part is weak. TGF Concept Notes and National strategic Plans are based on the evidences generated from program data or researches.	Moderate Risk	
	OH3	Monitoring & Evaluation		Moderate Risk	
Transition Planning	TH1	Legally binding and actionable Transition plan / Transition elements	Jamaica initiated working on its transition process in 2016. There are some plans from the GoJ to start absorption of certain portion of HIV/AIDS costs starting from 2016, and they are included in the NISP. However, the NISP has not yet approved by Government resolutions and, thus has limited legal power. Transition plan in Jamaica has not yet been developed. Once the plan is developed and approved, the data in the TPA tool can be updated and the risk will be recalculated.	High Risk	High Risk
	TH2	Transition plan / Transition elements characteristics		High Risk	
TRANSITION RISK SCORE FOR HIV/AIDS				**26.92%**	High to moderate risk

1. Introduction

The country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program. The assessment examines the country's disease program readiness for transition from external support. The TPA identifies areas of high, moderate or low risk for successful transition and outlines necessary steps towards programming for sustainable transition. The assessment follows the TPA Framework for data collection, analyses and transition risk assignment. The TPA Framework was developed by Curatio International Foundation with The Global Fund financial support. Details of the TPA Framework are provided in the Error: Reference source not found.

The Global Fund definitions of transition and sustainability are used in the report:[2]

Transition is *"as the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate".*

Sustainability - *"the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after the removal of external funding by the Global Fund and other major external donors".*

The TPA findings provide valuable information primarily to the national stakeholders for the transition plan development / update. In addition, the assessment findings will be useful for the donors to guide the country in the transition process.

2. Methodology

The assessment has utilised mixed methods for data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders: government officials, donor representatives, staff from international organizations, and civil society members, and those directly working with the donor supported programs. They were identified based on their relationship with these grants as well as through the snowball technique. The quantitative and qualitative data were triangulated in line with the TPA framework domains, sub-domains and components.

During the country mission on September 5-13, 2016, the CIF consultant met and interviewed more than 50 individuals including representatives from the Planning Institute of Jamaica; Ministry of Health; Ministry of Education; Ministry of Finance; Ministry of Labor and Social Security and other government agencies; UNAIDS local and regional team; representatives from USAID and numbers of local civil society organizations targeting PLHIV, MSM, sex workers and other vulnerable populations (see Annex 5). No site visits were conducted; instead,

[2] The Global Fund Sustainability, Transition and Co-financing Policy. Board Decision. GF/B35/04 – Revision 1. 35th Board Meeting. 26-27 April, 2016

skype conference calls were organized with Regional Health Authorities.

More than 60 documents and online sources were reviewed that included national level documents about national budgets, health sector development, HIV/STI strategic plans, the Global Fund concept notes and progress reports, National AIDS Spending Assessment reports, Global AIDS Response Progress (GARP) reports, HIV related surveys, USAID assessment report, biological-behavioral surveillance surveys, other operational researches and publications. (Annex #4)

3. Setting the Stage

3.1 The Context

Jamaica, is the largest English-speaking island in the Caribbean region. Jamaica gained independence from British colonial rule half a century ago in 1962. In 2010, Jamaica was classified as an upper middle-income country. In 2015 the Gross National Income (Atlas Method, current US$) reached US$ 5,010 in per capita terms. Jamaica is ranked in the "high human development" category (with HDI 0.719) of the UN's 2014 Human Development index.[3]

Total population of Jamaica has been slowly but steadily increasing over the last decade and reached 2,725,941 in 2014.[3] Low population growth and slightly increasing life expectancy at birth have resulted in aging the population, and the share of youth aged 0-14 years has decreased from 27.1% in 2010 to 23.6% in 2015.[3]

- Population - 2.8 million[3]
- GDP per capita (current US$) – 5,138 in 2015[3]
- HIV epidemic type – Generalized and concentrated epidemic[6]
- Number of PLHIV - 29,364[6]
- HIV prevalence:[6]
  - Adults – 1.62%
  - MSM – 33%
  - Sex workers – 2.9
  - ANC attendees -0.35%

T.2 **JAMAICA- COUNTRY KEY INDICATORS (WORLD BANK DATA BASE)[4]**

	2010	2011	2012	2013	2014	2015
Population, total	2,690,824	2,699,838	2,707,805	2,714,734	2,721,252	2,725,941
Population growth (annual %)	0.35	0.33	0.29	0.26	0.24	0.20
Life expectancy at birth, total (years)	74.8	75.1	75.3	75.5	75.7	

[3] Human Development Report 2014 Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience
[4] World Bank. Country overview. Last updated on September 20, 2016. http://www.worldbank.org/en/country/jamaica/overview accessed on September 27, 2016

GDP per capita (current US$)	4902	5332	5446	5254	5119	5138
GNI per capita, Atlas method (current US$)	4570	4810	5240	5300	5200	5010
Health expenditure, total (% of GDP)	5.3	5.2	5.7	5.9	5.4	
Health expenditure per capita (current US$)	255.7	273.3	302.9	305.9	266.2	

Jamaica is still ~~struggled~~ struggling with high levels of crime, poverty and unemployment.[4] General unemployment rate though slightly declining from 14.3% (2012) to 13,2% in 2014, increased to 13.7% as of April 2016.[4] Unemployment among youth is even higher at double the national average – 29.2%; the average unemployment rate for women is almost double that for men: 18.6% versus 9.6 percent.[5] High levels of unemployment, particularly among youth and young girls have contributed to the development of transactional sexual relationships, and encouraged intergenerational sexual activity between younger women to achieve economic security.[6]

Over the last few years, the burden of communicable diseases in Jamaica is declining and burden of non-communicable diseases is on rise. Recent national surveys among adults 15-74 years of age[7] show an upward trend in the prevalence of overweight and obesity, hypertension and diabetes. The ageing of the Jamaican population leads to increasing trend in prevalence of chronic diseases. Nonetheless, HIV/AIDS still ranks among the top 10 causes of premature death in Jamaica.[6]

Health System brief overview

The Jamaican health sector is comprised of both public and private entities. The Ministry of Health is responsible for ensuring that quality health services are delivered to the population effectively and efficiently in accordance with established standards and regulations.[8] Healthcare system was decentralized in 1998 when a law was passed to establish four regional health authorities to deliver health services to the populations in specific geographic locations in all 14 parishes[9]. Ministry of Health Headquarter performs steering function by developing policy, standards and regulations, monitoring and evaluation, and proposing relevant legislation to Parliament.[10]

The healthcare system is divided into tiers: primary, secondary and tertiary. Health services are provided by both, public and private entities. NGOs also provide health services to the public. There are 384 primary health care centers that refer patients to secondary and tertiary care as appropriate.[11] The MOH public health sector has 24 secondary-level hospitals providing hospitalization and surgery, and 5 Tertiary care hospitals providing

[5] Source: World Development Indicators. http://data.worldbank.org/indicator
[6] Modes of Transmission study.
[7] GARPR Narrative Report. Jamaica. 2016
[8] Ministry of Health Strategic Business Plan 2015-2018. Ministry of Health of Jamaica
[9] PAHO Jamaica Health System
[10] PAHO/WHO Health in the Americas 2012, p.23
[11] Sustainable financing and reform of the Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica; p.24

specialized care.[11] PAHO/WHO reports that the Jamaican population does not suffer serious geographic barriers in accessing basic health care services. [8]

Health in Jamaica is largely financed from taxation in the form of general taxes and sin taxes. In 2003, the National Health Fund (NHF) was established that collects revenues from three sources:[12] twenty percent of the Special Consumption Tax charged on Tobacco Products (1); 5% of Special Consumption Tax collected (2) and 0.5% of annual earnings up to $500,000 paid by employee and employer.

There are two health insurance models in Jamaica. The public sector is based on the British National Health Service financed by the Government; and the second model is the private health insurance model, which covers about 10% of the population. Private health insurance is not strictly regulated.[13]

In April, 2008, the Jamaican government abolished user fees for health in public sector in an effort to improve access and ensure universal coverage. The policy led to increased use of the public health services. The health services found it difficult to respond to the increased demand particularly due to funding challenge that could not compensate for the loss of user fees. The efficiency and effectiveness of introducing comprehensive package became ongoing concern of the Government of Jamaica. The projected increases in future burdens on health care system indicate that critical analysis of the system should take place to ensure long-term stability.[14]

HIV/AIDS epidemiology overview

Jamaica has features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.6%; however, surveys show higher HIV prevalence in at-risk groups.[15] Based on modeled estimates, around 29,690 persons are currently living with HIV; but approximately 19% are unaware of their status.

The Modes of Transmission Study (2012) identifies the following key affected populations:[16]

- Men engaging in casual heterosexual sex and their female partners
- Men who have sex with men and their female partners
- Sex workers and their clients and partners.

In 2011, the National Strategic Plan on HIV also identified at risk youth, particularly out-of-school youth as one of the key affected populations. These key populations overlap considerably that calls for a holistic approach to provide comprehensive prevention package addressing diversified needs of different populations.

Between January 1982 and December 2014, 33.193 cases of HIV were reported to the Ministry of Health. Of these, 9,278 (28.0%) are known to be deceased. HIV related death rate declined from 25 deaths/100,000 population in 2004 to around 8 deaths/100,000 population in 2014.[16] This 67% reduction in death rate is

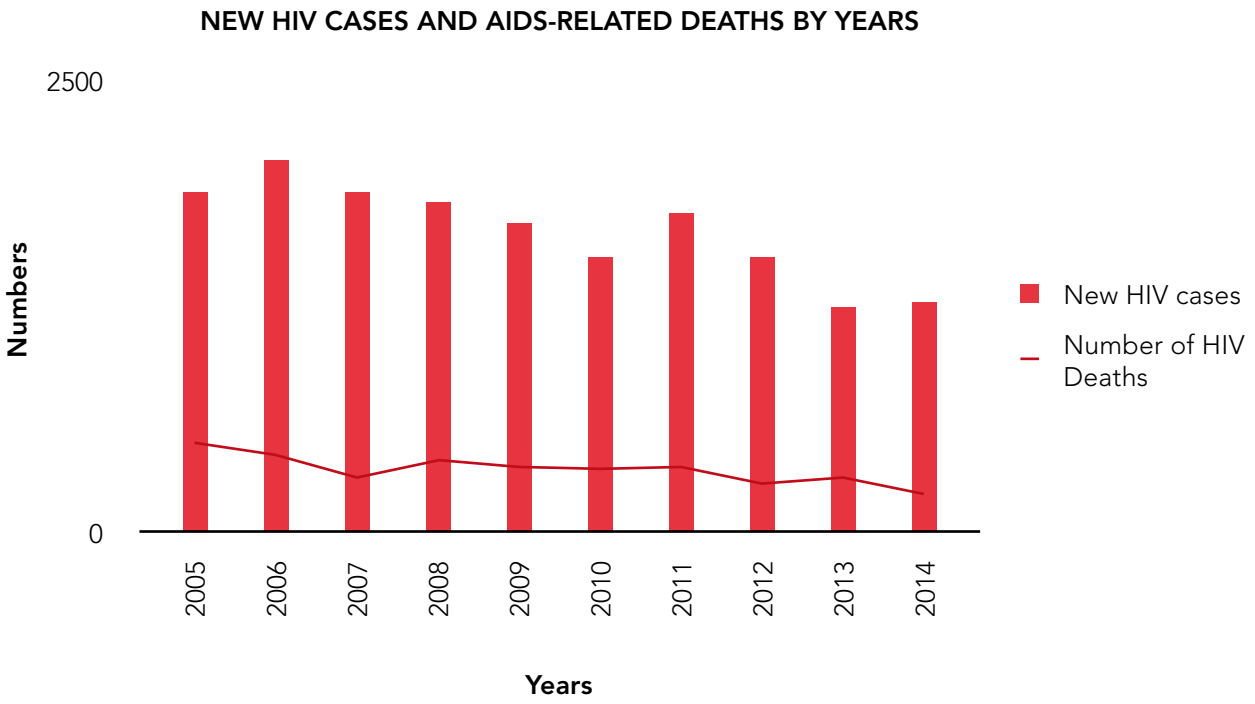
[12] Sustainable financing and reform of the Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica; p.30
[13] PAHO Jamaica Health System
[14] Sustainable financing and reform of the Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica
[15] HIV Epidemiological Profile; MOH of Jamaica. www.moh.gov.ge
[16] Global AIDS Progress Reporting. Jamaica Country Report. 2016

attributed to introducing accessible ARV treatment since 2004. However, Spectrum modeling estimates suggest that AIDS related deaths might be underreported as registered number of deaths account only for 20% of the estimated number of AIDS-related deaths.[17]

HIV prevalence varies substantially by geographic regions: the highest cumulative numbers of reported HIV cases are found in Kingston & St. Andrew – 1,017.9/per 100,000 persons, and St. James – 1,498.9 /per 100,000 persons followed by the parishes with significant tourism-based economies.[6]

F.1

NEW HIV CASES AND AIDS-RELATED DEATHS[18]



While adult males account for a larger proportion of all HIV reported cases in the 30 and older age groups, young females represent significantly larger portion of HIV positive persons in the 10-29 age groups.[16]

Analyzing HIV prevalence data among adolescent shows that HIV prevalence increases in the older cohorts (from 10-14 to 15-19 and from 15-19 t 20-24).[19] This increase is more pronounced for boys rather than for

[17] Global AIDS Progress Reporting. Jamaica Country Report. 2016
[18] Source: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx
[19] UNICEF, Synthesis Report of the Rapid Assessment of Adolescent and HIV Programme Context in Five Countries: Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe.

girls in Jamaica. On the other hand, 21 per cent of girls in Jamaica experience sexual violence, which is significant and greater than the percentage of boys experiencing such violence (5%).[18]

Statistics about major transmission routes are scarce and existing data may not be reliable. Due to restrictive legislation banning sex work and anal sex among consented adults, it is highly likely that many PLHIV do not self-identify themselves as MSM or sex workers, and avoid disclosing their risk behaviors with service providers. It is also possible that people use false names due to fear of criminal sanctions or stigmatizing and discriminatory attitudes from the society. Obviously, these factors drive key populations underground, and create fertile ground for false reporting. This eventually is likely to lead to distortion of most epidemiological data in the country, which should inform policy makers and guide HIV programming to mitigate the burdens of HIV epidemics in Jamaica.

The GARP report submitted in 2016, states that in 2014, the sexual practice of 44% of men reported with HIV (and 41% of men reported with AIDS) was unknown. Furthermore, of the total number of men reported with HIV, only 4% (669) were identified as bisexual and 4% (618) identified as men having homosexual contacts.

HIV prevalence among key affected population is also established through the surveys; however the study methodologies (e.g., using convenience sampling) lack robustness and, therefore, the figures presented below represent best available data in the country, though the numbers may not be accurate.

T.3 JAMAICA- COUNTRY KEY INDICATORS (WORLD BANK DATA BASE)[4]

HIV PREVALENCE (TREND)	2008/2009	2011-14
ANC attendees (15 – 24 years)	1.1%	0.35%
Sex workers	4.9%	2.90%
STI clinic attendees	2.4%	1.96%
Men who have sex with men	32.0%	32.90%
Inmates	3.3%	2.46%
Homeless persons/Drug users	8.8%	8.17%
Adults 15-49 years (Spectrum est.)	1.6%	1.62%
Provider initiated testing - 2014		4.00%

Jamaica's achievement in terms of reducing mother-to-child HIV transmission is substantial: in 2014, HIV incidence rate was the lowest – 0.15 per 1000 live birth, which is lower than the country target (0.3 per 1000 live births) towards Elimination of MTCT (EMTCT).[77] The success of the PMTCT is reflected in declining paediatric AIDS cases among 0-9 years of old from 78 in 2005 to 10 in 2014; AIDS related death among paediatric cases also dropped to 8 in 2014 from 34 in 2004. HIV prevalence among HIV+ pregnant women attending antenatal services in public sector has also declined to 0.35%.

Injection drug use: Official HIV data in Jamaica suggest that injecting drug users do not constitute a significant proportion of PLHIV. During the interviews with key stakeholders, including key professionals from the National Council on Drug Abuse (NCDA) declared that injection drug use is not common practice among Jamaican population in general. That explains the fact that people who inject drugs are not identified as a target population for HIV program. Harm reduction, low threshold services and opioid substitution programs are completely absent in the country. The data about drug abuse is contradictory: some sources state that 27% of homeless men and women reported crack/cocaine use;[20] the Caribbean Regional Operational Plan indicates that the Ministry of Defence estimates the size of PWID population is 5,000 (of them 250 female injecting drug users).[21] The report of KABP survey among general population[22] indicates having a section about substance abuse in the survey instrument; however, while analysing survey results, questions on use of illicit drug have been overlooked, and not presented in the final report. Most recent national survey on drug use among schoolchildren[23] reports that some 87 schoolchildren (3% of the total survey population) admitted use of injecting drugs before. Of them 45% reported cleaning the needle, they were given to use; 10% re-used it, and 9% gave used needle to someone else. For comparison: according to the 2011 European School Survey Project on Alcohol and Drugs (ESPAD) conducted among over 100,000 students in 36 countries in Europe (including eastern European countries with HIV epidemics largely driven by injection drug use), between 0% and 3% stated that they had injected drugs on at least one occasion.[24] Therefore, the Jamaica school survey findings (if data validity is satisfactory) should be flagged, and thoroughly examined by stakeholders to ensure that possible signs of changes in drug use behaviour among Jamaican population are detected as early as possible to avoid escalation of HIV epidemic in the country.

3.2 International Funding Overview

Jamaica has been benefiting from technical and financial support from key development partners to enhance its multi-sectoral response to the HIV epidemic, and attain the targets under the UNAIDS Fast Track strategy: achieving the 90-90-90 targets by 2020 and the 95-95-95

[20] Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development; UNAIDS, UNDP, National HIV/STI Programme; 2015; p 138
[21] Caribbean Regional Operational Plan 2016 Strategic Direction Summary. July 6, 2016. .p. 8
[22] 2012 Knowledge, attitudes and Behaviour Survey in Jamaica, 2012. Prepared by HOPE Caribbean Co. Ltd 2012; p. 61
[23] National secondary school drug prevalence survey in Jamaica. NCDA & Inter-American Drug Abuse Commission (CICAD), 2014. P. 47
[24] Damon Barrett, Neil Hunt, Claudia Stoicescu Injecting Drug Use Among Under 18s. A Snapshot of Available Data| Harm Reduction International; ISBN 978-0-9927609-1-5 December 2013 https://www.hri.global/files/2014/08/06/injecting_among_under_18s_snapshot_WEB.pdf

targets by 2030. The GARP Report[25] states that the contribution of international donors and partners have been substantial in all major components of HIV national response: prevention, treatment, care and support, creation of enabling environment and advancing human rights, monitoring and Evaluation and HIV research. The Global Fund support started in 2004 and currently active grant will be implemented through 2018. Total amount Jamaica has already received or will receive from the GF exceeds US$ 84 million. The Global Fund is the largest donor supporting HIV national response in Jamaica, and significant portion of interventions remains to be largely or solely dependent on the availability of the GF funds.

T.4 HIV/AIDS GRANTS[26]

GLOBAL FUND GRANT	PRINCIPAL RECIPIENT	BUDGET	LATEST RATING
JAM-H-MOH (2016-2018)	MoH of Jamaika	$ 15,242,178	NA
JAM-708-G02-H (2008-2015)	MoH of Jamaika	$ 46,310,113	B1
JAM-304-G02-H (2004-2010)	MoH of Jamaika	$ 22,855,059	A1
Total funding for HIV programme		$ 84,407,350	

In 2013, the Global Fund allocated US$8.3 million to support HIV national response in Jamaica. Jamaica receives substantial support from the US government. PEPFAR funds in 2013 amounted to US$ 4.5 million, which was higher than the total public spending for HIV/AIDS in the same year (US$3.8 million).[27] Technical and financial assistance from UNAIDS with close collaboration with Pan Caribbean Partnership against HIV/AIDS, as well as contribution of key development partners, such as UNAIDS, UNICEF, UNDP, UNESCO, UNFPA, IOM, ILO and UN Women in terms of health system strengthening, capacity building, HIV policy development and advocacy has been considerable to Strengthening HIV national response in the country.[6]

[25] Global AIDS Response Program Report. Jamaica country report. 2016. p. 94
[26] The Global Fund. http://www.theglobalfund.org/en/portfolio/country/grant/?k=70d9be67-cff2-43c4-a3aa-0e48c3de6b81&grant=JAM-304-G01-H Accessed on August 18, 2016
[27] Sustainability Index and Dashboard. Jamaica. PEPFAR. 2016

4. Assessment Findings

4.1 External Environment

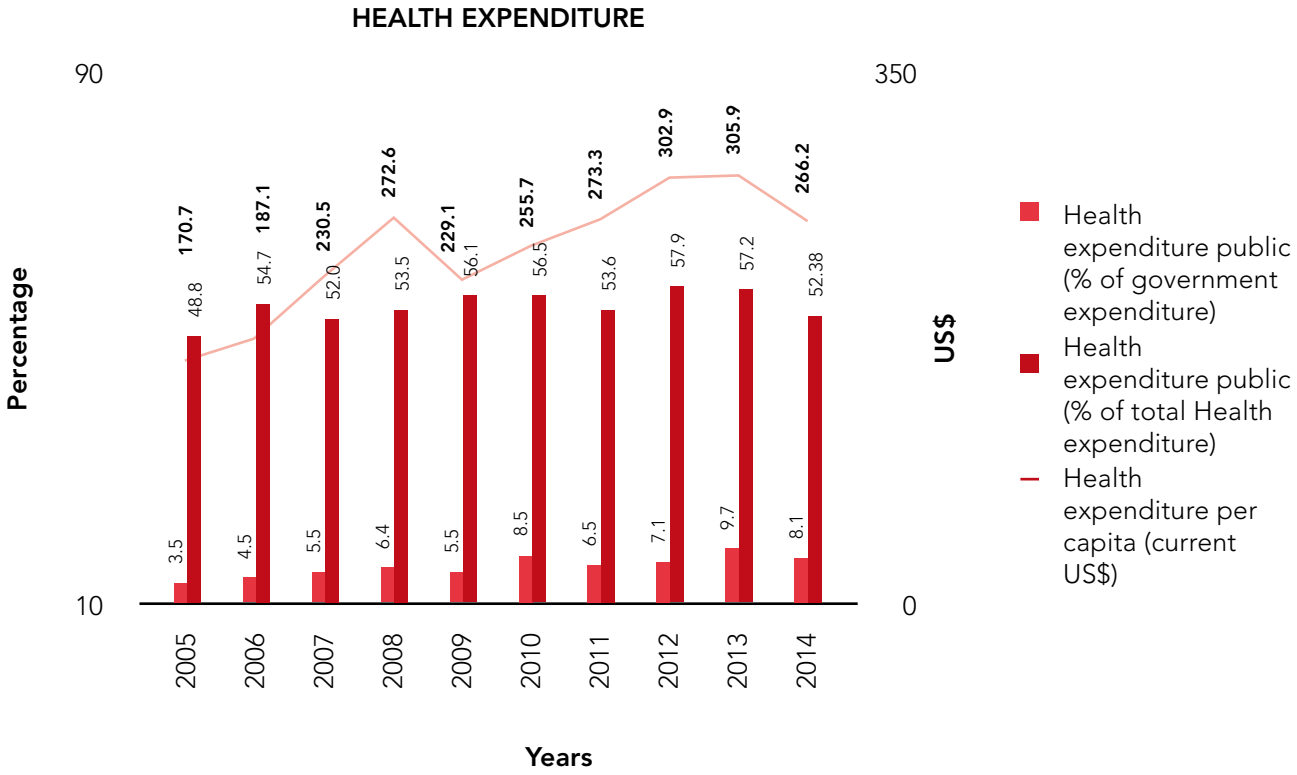
4.1.1 Political Environment

4.1.1.1 Prioritization of Health Investments

The share of government spending on health out of General Government Expenditure in 2014 was 8.1%. Over the last 5 years this indicator has varied from its lowest in 2011 (6.5%) to the highest in 2013 (9.7%), that have stayed below the mean for UMIC (12% in 2013). The share of government spending on health out of Total Health Expenditure has been fluctuating over the last 5 years reaching its peak in 2013 (57.9%). In 2014, the share of government spending out of THE was 52.38% which has been the lowest since 2011. Health expenditure per capita (current US$) by the State was rising steadily since 2009 through 2013, but declined in 2014. Total Health expenditure as a percentage of GDP also declined in 2014 to 5.4% that is the lower than the average for Caribbean region - 6.1%.[28]

F.2

GOVERNMENT SPENDING ON HEALTH



[28] Caribbean Regional Operational Plan 2016 Strategic Direction Summary. July 6, 2016. .p. 21

The GoJ is committed to improving population health, which has been proved by the Government's decision to abolish user's fee for health services in public sector. However, declared political will has not been translated into adequate and stable increase in investment in health due to fiscal challenges in the country.

4.1.1.2 The Legal and Social Context

There are a numbers of legislation in the country that create barriers to HIV services and pose substantial risk to sustainability of HIV interventions that have been implemented through rigorous advocacy and financing from the GF and other international development partners for more than a decade.

Offences Against the Person Act, which criminalizes anal sex (and therefore same sex relations between males) operates as a barrier for access to HIV prevention, treatment, care and support services. This law limits the country's ability to provide comprehensive quality services to MSM due to fear of stigma and discrimination as a result of disclosure of their sexual practices. The law refers to male same-sex intimacy as "gross indecency"[29, 30] and fuels stigmatizing and judgmental attitudes towards MSM population from the society, including health care workers. Despite many years of advocacy and awareness campaigns implemented in Jamaica through the donor-funded programs, little or no success has been achieved to change population's attitudes: 82% of respondents of National Survey on Homophobia in 2012, believed that the act between two males was immoral. Similar views prevailed among respondents participating in the KAPB survey among general population[31]: 89% of respondents (N=1800) believed that anal sex between males should remain illegal; and 82% reported that anal sex should remain illegal between man and a woman.

Due to the same law, condom distribution is banned in all prisons and the topic has been tabooed for two decades. This might be an implication of the incident that took place as far back as late 1990s. Dr. Raymoth Notice, former prison doctor and former mayor of Spanish Town responded to the growing HIV epidemic in prisons by providing strong recommendation to distribute condoms to inmates. The approach was supported by then Commissioner of Corrections, Colonel John Prescod, who in 1997 ordered issuing condoms to prisoners. This decision humiliated prison staff, and it resulted in prison riot in which 17 persons were killed including warders.[32] A research about HIV and homophobia among prisoners reports that some prisons began a policy of separating persons labeled as homosexuals after the 1997 prison riot.[33]

Sexual Offences Act prohibits prostitution in Jamaica, which has negative impact on health seeking behaviors among those engaged in transactional sex. Existence of restrictive law only creates barriers to services and heightens sex workers' risk for contracting and spreading HIV. Fear of punishment does not deter people to get engaged in sex in exchange money or gifts. The KAPB survey 2012 states that *"transactional sex practice is inching upwards and is particularly so among the youth (15-24 years)."*[34] Stakeholders and policy makers should start communicating the message to the society that annulling prohibition of sex work will be beneficial to

[29] Legal Reforms, Social Change HIVAIDS, Human Rights and National Development in Jamaica. UNDP 2015
[30] Global AIDS Response Progress Report. Jamaica Country Report, 2014
[31] 2012 Knowledge, attitudes and Behaviour Survey in Jamaica, 2012. Prepared by HOPE Caribbean Co. Ltd 2012; p. 61
[32] Jamaica Observer. Review condom policy for prisoners. February 22, 2011[33]
[34] 2012 Knowledge, attitudes and Behaviour Survey in Jamaica, 2012. Prepared by HOPE Caribbean Co. Ltd 2012; p. 17

increase access to services by sex workers and prevent spread of HIV, while having no effect about the scale of transactional sex in the country.

Based on the **Age of Majority Act**, there is a dissonance between the age of consent (16 years) and the age a person can access health care without parental consent -18 years[35], which makes it difficult to provide HIV testing or treatment services to HIV positive and at-risk youth. Furthermore, under the Child Care and Protection Act distribution of condoms to adolescents without parental consent is also prohibited.[36] Having access to reproductive health and HIV services for adolescents is critical taking into account early sexual debut among Jamaican youth - 33% of people aged 15-24 report having sex before the age of 15.[32]

Vulnerability of young girls is further exacerbated by the **Anti-abortion legislation (Sections 72 and 73 of the Offences Against the Person Act of 1864)** that restricts access to safe abortion services. A 1975 ministerial order allows health services to terminate a pregnancy only based on medical indication if it is determined that the continuation of the pregnancy will put the mental and physical health of the woman at risk.[33] The National Family Planning Board-Sexual Health Agency (NFPB-SHA) has drafted a policy position paper for proposed amendment.

Section 8(B) of the **Dangerous Drug Act of 1948** makes the possession and use of illicit drugs criminal offence in Jamaica. The Bill passed in February 2015 by Senate and House of Representatives decriminalized marijuana possession of "ganja" up to two ounces for personal consumption and religious/medical use. The Drug Court Act provides the option to non-violent drug offenders being prosecuted to be admitted to a treatment program instead of a prison sentence. [17]

Urgent needs to change punitive legislation has been documented in all major reports on HIV in Jamaica. Even though that advocacy work to change restrictive legislations in the country has been in progress for more than a decade,[37] no tangible results have been achieved thus far. Several agencies and projects have implemented policy advocacy initiatives, and elaborated critical amendments to legislation that are currently under consideration. Adolescent Health Unit of the MoH, with the support of a multi-sectoral Adolescent Policy Working Group has led the process of reviewing policies related to adolescent access to Sexual and Reproductive Health Services, and these recommendations are currently under review.[38]

Civil society organizations serving key vulnerable groups recently made a submission to the joint select committee reviewing the Sexual Offenses Act. The recommendations list 21 recommended amendments, including the strengthening legislation "to address sexual violence against men and boys and non-consensual penetrative acts - all key issues that the LGBT individuals have been advocating."[27]

There is no law safeguarding non-discrimination of PLHIV in Jamaica. HIV testing is mandatory as a pre-requisite for accessing some life-insurance policy. AIDS patients complained about undignified treatment from medical staff at some treatment sites in public sector. To mitigate negative influence of stigmatizing

[35] Global AIDS Response Progress Report, Jamaica Country Report. 2014
[36] Transition Preparedness Assessment mission in Jamaica. Interview with NFPB-SHA. Meeting transcripts. September 6, 2016
[37] David A Grimes, Janie Benson, at al. Unsafe abortion: the preventable pandemic. The Lancet Sexual and Reproductive Health Series, October 2006
[38] Global AIDS Response Progress Report, Jamaica Country Report. 2014

and discriminatory attitudes, a National HIV Discrimination and Reporting and Redress System was established, however utilization of this service and resolution of cases is limited.35 CSOs believed that one of the reasons for the system being ineffective was the lack of enforceable power and legislative framework for the redress system.[39]

4.1.1.3 CSO landscape

Civil society activism in Jamaica emerged back in the 18th century.[40] Since then, Jamaica has had strong civil society organizations, mostly NGOs, community based organizations, and community development committees (CDCs) working in different sectors.[37] Enabling Environment Index for Jamaica is 0.551[41] indicating that the conditions within which civil society operates in Jamaica is conducive, and there are no laws or policies that restrict civil society playing an oversight role.

Jamaica enjoys having a strong, vibrant and vocal civil society actively engaged in the national HIV response.[42] There are no laws that would restrict the GoJ to contract CSO for service delivery. CSO assessment in Jamaica conducted in 2011[43] states that the Government has provided funds to CSOs through its Social Development Commission (www.sdc.gov.jm). The social contracting has been practiced by various ministries in Jamaica including Ministry of Education, Ministry of Social Security, and Ministry of Health.

4.1.2. Economic Environment

Jamaica is classified as an Upper Middle Income Country with a per capita GDP of US$ 5,119 in 2014 and US$ 5,138 in 2015, reaching the same level of GDP as in 2008 prior to the global economic crisis. GDP has been increasing over the last four years, however the growth averaged less than 1 percent a year making the country one of the slowest growing developing countries in the world. The share of General Government Revenues as % of GDP has been stable high over the last 5 years ranging from 30.4% in 2011 to 32.4% in 2013.

T.5 GDP PER CAPITA GROWTH & PUBLIC REVENUE EXCLUDING GRANTS

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
GDPper capita growth (annual %)	0.5	2.5	1.1	-1.1	-4.8	-.1.8	1.4	-0.9	0.3	0.5
Public revenue, excluding grants (% of GDP)	30.7	31.6	32.3	31.7	32.5	31.3	30.4	31.4	32.4	31.1

[39] Interviews with CSO at the NFPB office. September 11, 2016. Meeting transcripts. Unpublished
[40] ASSESSMENT OF THE CIVIL SOCIETY IN JAMAICA Prepared for: The British Council Rochelle James Project Manager in Society. June 2014
[41] http://www.civicus.org/
[42] GARP Report, Jamaica. NCPI 2013
[43] ASSESSMENT OF THE CIVIL SOCIETY IN JAMAICA. Prepared for: The British Council. June 2014

While the economy is growing slowly at a very low rate, the country still faces substantial debt-burden and according to the World Bank, Jamaica's debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014.[44]

After national elections in February 2016, new administration has launched institutional reforms to improve the business environment for the private sector. The reform program started bearing its fruit: in the 2016 Doing Business report, Jamaica for a second year in a row is ranked among the top ten improvers worldwide. "Prudent macroeconomic policies and careful liability management reduced total government debt to 128 percent of GDP by the end of fiscal year 2015/16." The World Bank forecasts GDP growth accelerating to 1.7% in 2016 over 2% in 2017[45] that provides a promising signal that if the positive trend is maintained, the Government's ability to increase investments in health will improve.

Punitive legislative environment for MSM, sex-work and drug use presents challenges to sustainability of HIV national response in the country. Despite concerted efforts with funding from donors, legal barriers in the country have not been reduced that raises concerns whether the conducive legal environment in Jamaica can be created during the transition of thereafter. While CSOs are strong and government CSO partnership has longstanding and durable history, existing legal environment may not permit the Government to fund the services targeting MSM or sex workers. Furthermore, less conducive macro-economic environment along with huge debt burden, although improving after the election in 2016, may limit government's ability to assume full financial responsibility for the HIV program currently funded through the GF.

4.2 Internal Environment

4.2.1 Inputs - Financial Resources

4.2.1.1 Budgetary commitment to HIV program

The budget for HIV national response is integrated into the country's multiyear budget plans[46]. The Jamaica two-year Budget for 2015-2016 states: "The National HIV/STI programme has led the Government's response to the HIV epidemic since 1986 and its aim is to maintain an effective response when international support for this Programme ceases." However, achieving sustainability of national HIV program interventions at adequate scope and scale will require substantial increase in financial commitment from the Government of Jamaica for HIV response in upcoming years.

The national HIV program in Jamaica has been primarily financed through the Government of Jamaica, a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), and grants from the Global Fund and the United States Agency for International Development and President Emergency Plan for AIDS Relief (USAID/PEPFAR).[47] Two NASA reports were accessible to analyse AIDS spending data in Jamaica for 4 fiscal years from 2009/2010 through 2012/2013. Unfortunately, more

[44] World Bank. Jamaica. Country overview. http://www.worldbank.org/en/country/jamaica/overview
[45] Doing Business 2016. Full Report. http://www.doingbusiness.org/~/media/GIAWB/Doing%20Business/Documents/Annual-Reports/English/DB16-Full-Report.pdf accessed on Sept 30,2016
[46] Jamaica Budget 2015-2016; HEAD 4200 – Ministry of Health. P.542
[47] NASA 2014, p.17

recent data about AIDS spending was not available that substantially limited our ability to assess financial sustainability risk for HIV program in Jamaica.

The Table 6 : AIDS Spending by financial sources (NASA 2012; NASA 2014) summarizes AIDS spending by three financial sources: public, international and private. Public spending was the highest in 2010/11. In 2013, funds provided by the GoJ increased by around US$100,000 compared with the previous year, however it still remained lower than that in FY 2011.

T.6 AIDS SPENDING BY FINANCIAL SOURCES (NASA 2012; NASA 2014)

	2009/10	2010/11	2011/12	2012/13
Total spending	$ 16,912,222	$ 16,196,112	$ 16,851,445	$ 20,392,493
Public	$ 3,486,421	$ 4,066,063	$ 3,706,165	$ 3,807,538
International	$ 13,379,224	$ 12,083,472	$ 10,941,612	$ 14,193,526
Private	$ 46,577	$ 46,577	$ 2,203,668	$ 2,391,429

As shown in the Table 7, public funds to support the National HIV Response represented only 21.99% and 18.67% of the overall AIDS spending in FY 2011/12 and 2012/13, respectively. [44]

T.7 AIDS SPENDING BY FINANCIAL SOURCES (%)

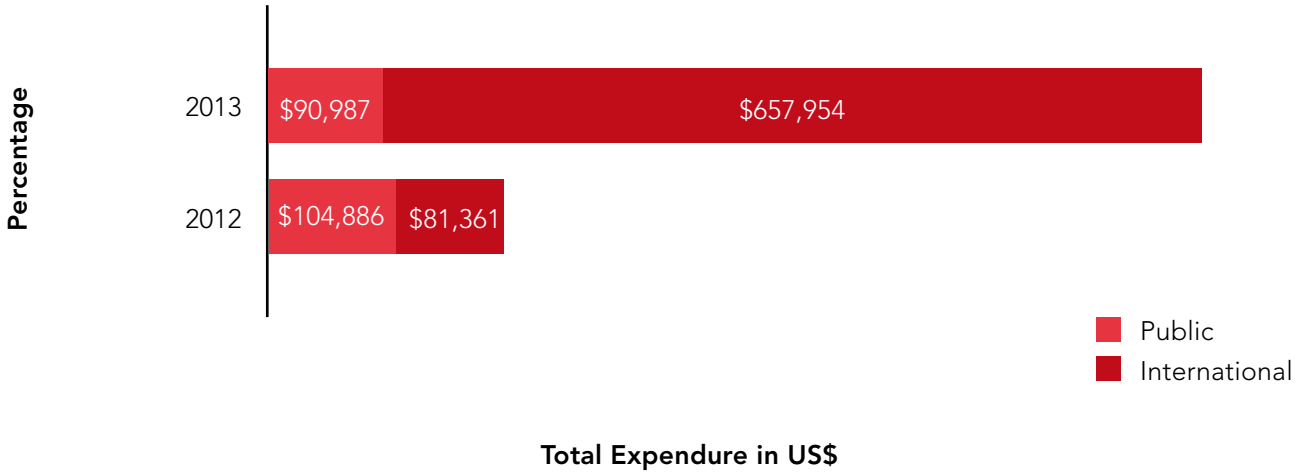
	2009/10	2010/11	2011/12	2012/13
Public [48]	21%	25%	22%	19%
International	79%	75%	65%	70%
Private	0.3%	0.3%	13%	12%

[48] NASA reports clarify that the Public Funds was calculated as a combination of GoJ contribution to projects supported by the World Bank loan and United States Agency for International Development (USAID), central government funding from the Ministry of Youth and Culture and the World Bank loan resources. The classification of World Bank Loan resources as public funds was applied in the NASA as it is in accordance with the Global Fund classification of loans funds. Main rationale for this classification is the nature of the WB loans, which represents an obligation of the GoJ to be paid in future. NASA Report, Jamaica 2014, p.24.

The largest shares of public spending on AIDS in 2012 and 2013 fiscal periods have come from World Bank loans (69% and 72% respectively).

Obviously, HIV National response is largely dependent on external support. The share of the Government funds to cover cost of human resources for HIV response, became minimal in 2013 not exceeding 13.8% of the total HR costs, that also poses serious risk to program sustainability.

F.3 EXPENDITURE ON HUMAN RESOURCES BY MAIN FUNDING SOURCES FOR 2011/12 & 2012/13 FISCAL YEARS



According to the TGF CN, the GoJ will be required to continue leveraging more financial resources from potential partners, such as PEPFAR as well as to identify innovative financing mechanisms such as Debt2Health Programmes to meet the anticipated funding gaps in HR.[49]

4.2.1.2 Prevention Priority

HIV Prevention in Jamaica has had several financial sources; however, the main source has been the funds from GF and USAID/PEPFAR. The share of the GoJ in HIV prevention financing in recent years is unknown. The latest NASA report provides AIDS spending data by various spending categories that shows that prevention spending accounted for the largest share compared with other spending categories, including that for treatment and care services. The prevention expenditure out of total AIDS spending in FY 2011/2012 reached 36%, which slightly decreased to 33.7% in FY 2012/2013.

[49] TGF Standard Concept Note. HIV program. Jamaica. 2014

T.8

HIV/AIDS SPENDING BY SPENDING CATEGORIES[50]

	2011/2012	%	2012/2013	%
Prevention	$ 6,063,711	35.98	6,865,831	33.67
Care and Treatment	$ 3,068,996	18.21	$ 5,865,810	28.76
Programme Management and Administration	$ 6,599,214	39.16	$ 6,195,537	30.38
Human Resources	$ 186,517	1.11	$ 748,941	3.67
Social Protection and Social Services (Including Orphans and Vulnerable Children)	$ 480,264	2.85	$ 388,222	1.9
Enabling Environmen	$ 325,347	1.93	$ 313,574	54
HIV Related Research	$ 127,396	0.76	$ 14,578	0.07
GRAND TOTAL	**$16,851,445**	**100**	**$ 20,392,492**	**100**

The NASA report indicates that in 2009, 8% of prevention spending came from the GOJ/WB that increased to 16% in 2010.[51]

Stakeholders during the interviews expressed concerns that HIV prevention targeting vulnerable populations has been traditionally financed by external donors with little involvement from the State. PEPFAR Sustainability Assessment Index[52] states that according to stakeholders' opinion, approximately 10-49% of funding for HIV/AIDS related civil society organizations comes from domestic sources (excluding TGF funds). The same source says that supplies provided to CSO are partly government funded. In addition, the GoJ provides in kind floor space/accommodations, technical assistance and HR to CSOs. All available information indicate that the share of public funds in prevention interventions is suboptimal, but we were unable to document if public spending on HIV prevention for key populations was increasing over the last five years.

4.2.1.3 Prevention, Treatment financing from Public Sources

In general, up-to-date data about AIDS spending is not readily available in Jamaica. Latest NASA reports present limited data through FY2012/2013. Furthermore, some stakeholders expressed dissatisfaction because of using the NASA data for financial sustainability assessment saying that the data were incomplete and inaccurate. No other data sources about financing HIV prevention, treatment, care and support services from public sources are available.

4.2.1.4 Allocative Efficiency

Modes of Transmission study estimates that approximately 60% of all new infections may be

[50] National AIDS Spending Assessment report. Jamaica. 2014
[51] National AIDS Spending Assessment. Jamaica April 2009-March 2010.
[52] Sustainability Index and Dashboard. Jamaica. PEPFAR. 2016. Indicator 3.4.

attributed collectively to MSM, SW and those who have casual heterosexual sex (CHS); and 40% of incident infections will occur among persons who are considered to be engaging in low risk sex.[53] Based on this finding, the study provides the recommendation that while continued attention needs to be focused on high-risk groups to scale up testing, prevention and treatment services among KAPs, HIV national program in Jamaica should maintain focusing on low risk groups as well.

The NASA report provides AIDS spending data by key population groups, which shows that the greatest portions of the AIDS spending were directed to the general population (with 41% of the total spending in FY 2013), and PLHIV (with 29% in FY 2013). AIDS spending targeting most-at-risk populations slightly increased from FY2012 to FY2013 accounting 10.5% of the total AIDS spending in 2013 year. Disaggregation of AIDS spending by KAPs (see the Error: Reference source not found) shows that the spending on MSM population has doubled in FY 2013 compared with FY 2012, and the spending for sex workers also increased substantially that seems to follow the epidemiological characteristics of HIV epidemics in the country.

T.9 AIDS SPENDING BY MAIN BENEFICIARY POPULATIONS[54]

BENEFICIARY POPULATION	TOTAL SPENDING (US$)	
	2011/2012	2012/2013
PWIDs and partners	$ 56,669	$ 27,267
Female sex workers and their clients	$ 5,305	$ 15,876
Male non-transvestite sex workers	$ 2,382	$ -
Sex workers, not disaggregated by gender and their clients	$ 195,813	$ 262,641
Men who have sex with men (MSM)	$ 612,645	$ 1,226,959
"Most at risk populations"not disaggregated by type	$ 554,324	$ 607,680

Few economic studies were conducted in Jamaica that can serve as practical tools for HIV budget projection: Goals Model impact assessment for treatment program, Modes of transmission study; HIV Program Financial Sustainability study; and estimation of unit costs for HIV prevention package for MSM (for USAID/PEPFAR funded project). Through these studies, important information have been generated that will help national stakeholders

[53] Sustainability Index and Dashboard. Jamaica. PEPFAR. 2016. Indicator 3.4.
[54] NASA Report. Jamaica, 2014. P.49

and policy makers better understand HIV disease burden. Strengthened surveillance data and analysing AIDS spending data on a regular basis will help the Government of Jamaica to make evidence-based allocation decision while taking over financial responsibility for its National HIV response.

While AIDS spending data for recent years is not available, latest NASA data indicates that in FY 2012/2013, the GoJ covered only one fifth of the AIDS total spending, largely using borrowed funding from IBRD. There are numbers of HIV interventions that remain largely or solely dependent on the GF funding. While the Government continues to be committed to co-financing treatment, care and support (TCS) services,[55] prevention services provided to KAPs through civil society organizations have been financed through the external donors, that poses significant risk to financial sustainability of HIV national response.

4.2.2 Inputs – Human Resources

4.2.2.1 HR Sufficiency/availability

There is a severe shortage of Human Resources for health, as the official cadre for health care workers has not increased since 1970s.[56] The challenge is recognized in Jamaica's vision 2030. The shortages of HR for health is aggravated by high staff turnover, and attrition. Introducing "no-user fee" policy resulted in increased demand for health in public sector, which further exacerbated the challenge. Relatively low pay, poor working conditions and the lack of professional development opportunities forced many health professionals to leave the public service, to change the profession or migrate to developed countries.

A 2014 Human Resource Analysis for HIV services revealed that overall the full time equivalent (FTE) of currently deployed health care workers in the field is 62% of the optimal level required with the largest gap in the number of "support" staff.[57] However, the HR patient ratios for the HIV response are still above the average ratio for that within the general health care system.

Between 2004 and 2012, over 18,000 PLHIV were linked to care, and healthcare work force has not increased proportionately.[58] This problem is most severe for non-medical professions, as patients in addition to regular medical visits, also need laboratory monitoring, pharmacy, nutritional counselling, psychological counselling, etc. Staff shortage continues to be a challenge at treatment sites as well causing long waiting time at clinics.[59]

Severe shortage of psychologists is named as major reason for low coverage of PLHIV with psycho-social support services in the GF PUDR in 2015, and an amendment was proposed by the GF project management team to change the data source for this indicator from the psychologists reports to the social workers reports.5 During the meeting with the MoH representatives, respondents said that there was only one staff member providing counselling to inmates in all prisons of the country.

4.2.2.2 HR Development & trainings

The Ministry of Education should play a major role in the training of human resources for health[60] which should be guided by the MOH

[55] The Global Fund HIV program in Jamaica. PUDR #13
[56] Tomblin Murphy, G., MacKenzie, A., Guy-Walker, J., & Walker, C. (2014). Needs-based human resources for health planning in Jamaica: using simulation modelling to inform policy options for pharmacists in the public sector. Human Resources for Health, 12, 67. http://doi.org/10.1186/1478-4491-12-67
[57] The Global Fund Concept Note, HIV program. Jamaica. 2016
[58] Global AIDS Response Progress Report. Jamaica country report. 2014
[59] TGF PUDR #16
[60] Health System and Services profile of Jamaica Jam health system; PAHO 2001

policy for human resources for Health. Over the last decade, on-job training in HIV field has been provided through the financial support from TGF and PEPFAR as well as from GoJ. Within the integration of the National HIV program into National Family Planning Board (NFPB), cross training of staff for both, HIV and family planning/reproductive sexual health has been implemented that increased the pool of persons available to offer services in more cost-efficient manner.[53]

Most clinical training programs have been institutionalized into formal education curricula at medical schools at undergraduate and postgraduate levels.[61] The annual HIV/AIDS Clinical Management workshop has been institutionalized through the Caribbean HIV/ADS Regional Training Network (CHART).[62] Currently, the MOH is responsible for training HCWs in HIV management. However, there is no policy for production of CSO personnel/ non-medical, social and support services in HIV response. In addition, there are considerable numbers of training programs that have been developed for non-medical staff which have not been institutionalized into formal education institutions, and thus, their sustainability is at risk after the donor funding declines or ends.

4.2.2.3 Alignment of salaries

Stakeholders believe the salary scales in the public sector and for the staff employed by donor-funded programs are well aligned. Despite the challenges, in the past years the GoJ has incrementally subsumed the HIV service delivery HR costs that were previously supported with grant resources from GF and PEPFAR. As part of the absorption process, the MOH has agreed to provide additional US$ 500,000 per annum for HR costs beginning in 2016.[64]

The severe shortage of HR in health sector is further exacerbated by the fact that Jamaica is under IMF restrictions and cannot hire more health care workers.[25] The challenges in terms HRH is a larger problem of the national health care system that goes far beyond HIV programme. While HR shortage will certainly affect HIV program sustainability, this problem may not be resolved during the transition period.

4.2.3 Inputs – Health Information System

4.2.3.1 Routine HIS

A national Health Information System Strengthening and e-Health Strategic Plan 2014/2018 was developed to modernize health information system in Jamaica. The plan includes implementation of an inventory management and pharmacy information system as well as logistics information system for public laboratories.[63] The GoJ introduced a national health card to track the utilization of health services in the public sector. There is a plan to link the health card to the National e-Health system, which will further strengthen the health information system in Jamaica.[59]

An HIV Electronic Register system operational in Jamaica, includes HIV/AIDS Treatment Database and PMTCT Database. The electronic treatment information system is operational within all treatment sites. The paediatric treatment sites have not yet utilized the database. However, treatment databases are not linked that undermines

[61] TPA Assessment mission. Interview with Dr. Pete, PAHO. September 9, 2016. Meeting transcripts
[62] NSP 2008
[63] The Global Fund Standard Concept Note. HIV program. Jamaica. 2016
[64] Global AIDS Response Progress Report. Jamaica 2014

accuracy of treatment data.10 Disaggregation of routine programme data on PLHIV within the clinical setting by key populations is limited. 60;62Therefore, the data about loss to follow up, treatment adherence, or treatment outcome/survival rates specific to each KAP is not available, that limits the ability of surveillance system to explore potential reasons and/or social determinants for unfavorable treatment outcomes.

Treatment data from private sector providing ARV treatment to AIDS patients is not currently captured by the national treatment database. During the discussions with Private Treater's (doctors) group, doctors declared full readiness to comply with the national reporting requirements if institutionalized/ enforced. Information about HIV+ pregnant women receiving ARV in private clinics for PMTCT is not available.[65]

Electronic monitoring system for ARV drugs does not involve all public and private pharmacies across parishes. During interviews with PLHIV, it was revealed that in response to drug stock-outs many patients are registering at different pharmacies in different parishes using same identities, and receive prescribed drugs. Majority of respondents said this is a common practice among patients with the intention to compensate for frequent stock-outs of ARV drugs. Thus getting drugs from different pharmacies help them create personal "buffer stock" and assure treatment continuity with same regimen of drugs.

Double counting of beneficiaries receiving prevention services remains to be a challenge that can be addressed if prevention database is linked with all service provider organizations and uses standardized client unique identification codes.

HIV surveillance may benefit from capturing all available data on HIV testing. While blood donors are routinely tested for HIV and other blood borne diseases, data are not analysed by national HIV program to complement existing HIV surveillance data. Testing data generated through other projects providing VCT to certain population groups also may have an added value for understanding HIV diseases burden. For instance, local CSO FAMPLAN provides HIV testing at the community level that involves family counselling allowing them to test adolescent girls for HIV. The FAMPLAN testing data can be unique for HIV surveillance system given that prevalence data about this group is largely missing from official data due to restrictive legislation.

Weaknesses of HIV information system and unreliability of data has been well-acknowledged challenge in Jamaica. The GF program placed emphasis to improve the data quality to drive evidence-based programmatic decisions. With the support, collaboration and technical guidance of the Clinton Health Access Initiative (CHAI) partnership, major data cleaning exercise was carried out that detected substantial data inaccuracies, and stakeholders concluded that intended targets (TGF PUDR #13) had to be revised downwards.[66] Strengthening the HIS and building technical capacity of HR involved in HIV surveillance should intensify to have better understanding about the burden and characteristics of HIV epidemics in Jamaica. This will require substantial financial investments and technical assistance during the transition period.

[65] Global AIDS Response Progress Report. Jamaica 2016
[66] TGF PUDR #13; Jamaica

4.2.3.2 Second Generation Surveillance

According to the PEPFAR Sustainability Index and Dashboard, there is a strong local ownership for HIV research; however, most surveillance studies are funded by donors[67] and are conducted through the technical support from international development partners.

Jamaica has completed several rounds of Integrated Bio-behavioural surveillance surveys among FSWs and MSM since 2004. The Priority for Local Control Efforts (PLACE) methodology was introduced in Jamaica in 2003 as a rapid assessment tool to monitor and improve HIV prevention programme coverage in areas where HIV transmission is most likely to occur.[68] Several rounds of PLACE surveys were completed in 2005, 2008, 2011 and 2014. The use of convenience sampling for recruiting respondents for PLACE surveys undermines the validity as well as generalizability of research data. In addition, more robust methodology for Bio-BSSs is needed to achieve relatively more representative sample of hidden populations with criminalized behaviors.

Starting from 2015, through the support of USAID, efforts have been made to introduce a Respondent Driven Sampling methodology for conducting Bio-BSS among MSM.[69] An approval from Institutional Review Board is now pending, and in early 2017 first-ever in Jamaica, Bio-BSS among MSM will be conducted that will have the potential to generate reliable statistics about this most-adversely affected population group. This support is critical to strengthen the country's second-generation surveillance system and establish in country research capacity.

Several rounds of Knowledge, Attitudes and Behaviour Survey among general population (KABP) using robust methodology were conducted in Jamaica with the last study taken place in 2012.[28] Unfortunately, none of these KABP surveys involved biomarker component that could have been added at marginal cost. During interviews, researchers stated that offering HIV testing would deter respondents from participation. BBSS studies among homeless drug users, transgender population, and among youth focusing out-of-school youth have not been conducted in recent years.

Population Size Estimation (PSE): national estimates for the size of KAPs are established based on experts' opinion except that for Out of School Youth for which data is provided by the Ministry of Education.

T.10 ESTIMATES FOR KEY POPULATION SIZE

KEY POPULATION	LATEST SIZE ESTIMATION ESTABLISHED	SIZE ESTIMATION
Men who have sex with men	2014	(4.5% of male population) 33,000

[67] 2016 Sustainability Index and Dashboard Summary; Jamaica PEPFAR
[68] Measure Evaluation. https://www.measureevaluation.org/resources/tools/hiv-aids/place
[69] Global AIDS Response Progress. Jamaica Country Report 2016

Female sex workers	2014	(2.5% of female population) 18,696
Homeless drug users	2012	1,600
Inmates	2013	5,000
Out of School Youth	2012	141,744

Most data provided throughout the TPA report about the trends in HIV prevalence, program coverage and behaviour changes are based on the studies and PSE that lack robustness (e.g. using convenience sampling for selection of survey respondents; absence of population size estimation studies); therefore, some performance indicators may not be accurately reflecting the real characteristics of HIV epidemics in the given time.

Substantial efforts have been made in the country to refine treatment and prevention databases in Jamaica in recent years, but there are still weaknesses in data collection and analysis that need to be addressed during transition period. Second generation surveillance studies have been regularly conducted in the country among different KAPs that have been largely financed by the external donors. Advocacy should be intensified to ensure that the Government starts allocating adequate financial resources to HIV surveillance and research studies to ensure sustainability. Using more robust methodologies for surveillance studies needs to be institutionalized to improve the validity and reliability of epidemiological data that inform HIV programming and budget allocation decisions.

4.2.4 Governance – Governance

4.2.4.1 Political commitment

Since 1988 Jamaica has had national plans to guide National HIV/STI control programme. The HIV/AIDS Policy was developed in 2005, which is currently being revised. The UNAIDS "Three Ones" key principles for the coordination of national responses to HIV and AIDS which includes one national multi-sectoral strategy, one national coordination platform with a multi-sectoral mandate; and, one monitoring and evaluation framework is being applied in the Jamaica's response to HIV/AIDS.[70] Jamaica declares its commitment to achieve the UNAIDS 90-90-90 targets, and to adopt 'Test and Start' policy starting from FY 2017[71] that will require substantial increase in HIV financing from the Government.

In 2013, GoJ took considerable efforts to reorganize its HIV and family planning programmes and integrate coordination of the two programs into the new integrated entity, the National Family Planning Board-Sexual Health Agency.[72] Following this integration, in 2014 Jamaica initiated revision of the NSP to develop a new, National Integrated Strategic Plan (NISP) for Sexual and Reproductive Health and HIV for 2014-2019 years. The Plan provides

[70] Global AIDS Response Progress Report. Jamaica Country report. 2014
[71] Caribbean Regional Operational Plan 2016.
[72] Carr, Dara, and Kathy McClure. 2014. National Family Planning-HIV Programme Integration in Jamaica: Creating a New Sexual Health Agency. Washington, DC: Futures Group, Health Policy Project.

a blue print for achieving the vision of an integrated programme while supporting the achievement of the Millennium Development Goals and the emerging themes in the 2030 Jamaica sustainable development goals agenda.[73] The NISP was created through highly consultation process involving all key stakeholders including government, civil society, private sector, HIV affected communities, youth, faith-based organizations and international development partners.

4.2.4.2 Leadership

The TPA tool tried to identify if there were legally empowered leading organization or individual leader who were actively engaged in advocacy and were making public announcements about greater public investments for sustainable HIV response. During the interviews, key stakeholders involved in HIV national response found it difficult to identify any prominent, legally empowered organization that could be considered as a leader organization. Some of them recognized the role of the CCM that provides a platform for CSOs' engagement; however they also believed that CCM had no legal power to influence policy decision. CSOs organizations named individual champion- the head of civil society organizations- Jamaica AIDS Support for Life who pushes HIV agenda forward and has been a leader in advocating for sustainable funding for HIV response and protecting vulnerable populations rights.

4.2.4.3 Coordination Mechanism

Shortly after launching its first National STI/HIV programme, the Government of Jamaica in 1988 established a civil society-led partnership group, the National AIDS Committee (NAC) with its National Executive Committee, 5 sub-committees and 13 Parish-based AIDS associations. However, through interviews with stakeholders it became clear that NACs have never played assigned role and there was no clarity about the NAC function and operation.

After the GF funding became available in Jamaica, the role of the NAC was fully assumed by the Country Coordinating Mechanism (CCM) that currently represents the main body with the function to coordinate HIV national response under the Global Fund. CCM enjoys high-level representation from various ministries, government institutions as well as representatives of international partners and local CSOs. CSOs presently hold 40% seats on the CCM. Civil society groups unanimously stated that the CCM is the only mechanism that brings together high officials and HIV vulnerable populations to discuss HIV/AIDS response in Jamaica on a regular basis.

Following the integration of HIV and family planning program management function into the National Family Planning Board, some stakeholders think that the latter body is likely to replace the CCM after the assistance from the GF declines or ends.

The NFPB-SHA serves as a hub for coordination, guidance, research, monitoring and the facilitation of policy development and programming implemented through government ministries, departments and agencies.[74]

[73] Global AIDS Response Progress Report. Jamaica Country Report -2016
[74] National Family Planning – HIV Programme Integration in Jamaica. Creating a New Sexual Health Agency. USAID/PEPFAR Health Policy Project. August 2014.

During the interviews with the NFPB-SHA, the Executive Director and key staff members have demonstrated their readiness to strengthen coordination and expand the role of the Board that can be considered as a positive signal. Sixteen new positions were added to the Board staffing; the board plans to develop its three-year corporate and strategic plan in September/October 2016. The NFPB-SHA carries about 70% of the Government HIV response in relation to care and prevention.[75] However, AIDS related treatment and clinical services remain integrated into treatment programme of communicable diseases.

National Family Planning Board's legal status and powers are defined by the National Family Planning Act of 1970. The NFPB-SHA will retain strong ties to the government with at least 51% of members from the public sector. Currently the Board has 9 members, but there are plans to amend the Act to expand its membership and ensure CSO representation on the Board.

During interviews, civil society organizations seemed concerned fearing that NFPB-SHA, being a structure under the MoH, will not have adequate power to sustain concerted multi-sectoral response, and the policy dialogues among government agencies and civil society might be undermined. They lack clear understanding of the perspectives of civil society within the Board. Some mentioned that the membership of the Board is defined by law and "it may not be flexible enough to involve new players into the response".[76]

According to the Ministry of Health, the integration will not affect the function of the CCM, which will continue managing the GF project related activities, and the NFPB-SHA will be coordinating HIV response at a broader, national scale. It is likely, that the functions of these entities may evolve over time, and close monitoring of the process will be required. Policy dialogue among government institutions, NFPB, civil society organizations and development partners will be needed to define the functions and operation modes of the coordination body to have clear understanding about how the coordination of HIV national response continues after transitioning from the GF funding.

While the integration of HIV and SRH programs seems to be a positive step towards sustainability and strengthened coordination, stakeholders need to make sure that the focus on HIV and particularly on vulnerable populations is not diluted within a broader scope of SRH and HIV. Special emphasis should be placed to ensure that spending figures specific to HIV/AIDS by program areas, key population groups and financial sources can be differentiated from the spending figures on integrated SRH and HIV services to enable proper monitoring of National AIDS Spending Assessment.

During the transition, efforts should be undertaken to ensure that the NISP 2014-2019 is costed, has corresponding M&E plan and is formally approved by government resolution or by the Cabinet.

[75] TPA Assessment mission meeting transcripts. Meeting with NFPB-SHA, September 6, 2106.
[76] TPA Assessment mission meeting transcripts. Meeting with CSOs, September 7, 2016.

4.2.5 Governance – Accountability

4.2.5.1 Access to program performance results

HIV Epidemiological Profile is being prepared by HIV/STI National Programme every year and reports are available publicly on the Ministry of Health website. Data disaggregation by populations, gender, age groups, and regions, as well as analytical part of the report can be further strengthened. HIV Survey results are disseminated during meetings involving national stakeholders. HIV Program evaluation study has not been conducted in recent years. TGF grant performance results are available on the GF website. Data dissemination and sharing is seen as an area of weakness, as data is not reaching civil society to guide their programming efforts.[77]

In addition, Jamaica develops Global AIDS Response Progress reports and submits them to UNAIDS. The reports are elaborated through national consultation with stakeholders from various sectors. These reports are available on the UNAIDS website. However, funding matrix that should provide AIDS spending disaggregation by established priority areas as well as financial sources are not available for recent years. The funding matrix files from previous years can only be obtained upon request. Reporting, particularly of financial data lag far behind: as of September 2016, last AIDS spending data submitted to UNAIDS was from FY 2012/2013.

CCM does not have the website that might serve as a hub and online resource for interested audiences. Stakeholders confirmed that CCM meetings are conducted on a regular basis, however CCM meeting minutes are not publicly accessible.

4.2.5.2 Enabling environment for CSO engagement

The environment in Jamaica enables active engagement of civil society in the national HIV response. CSOs implement substantial portion of national HIV response, particularly prevention activities targeting key affected populations. Currently, 10 local CSOs are implementing the GF supported interventions with three of them serving as sub-recipients. Only one CSO –Jamaica AIDS Support for Life (JASL) currently provides ARV treatment service covering 5% of PLHIV enrolled in treatment. Most CSOs are based in Kingston, the capital city, and the network of civil society organizations in regions is relatively underdeveloped.

Civil society organizations participate in national policy development and are members of various technical working groups that represent multi-sectoral partnership and collaboration between and among governmental, civil society (CSOs) and non-governmental organizations (NGOs), HIV constituencies as well as international development partners. CSOs as members of a National Enabling Environment and Human Rights Technical working Group established in 2014, participated in the development and revision of the National Integrated Strategic Plan (NISP) 2014-2019, the Global Fund Concept Note: 2015 - 2018, the 2030 Sustainable Development Goals Agenda, etc. While civil society had strong presence in planning HIV national Strategic Plan,

[77] Global AIDS Response Progress Report. Jamaica Country Report. 2014.

NGO representatives complained that their involvement in the NISP budgeting process was substantially limited.[78]

Civil Society was part of the Youth and Adolescents Technical working group that worked on the revision of the legislation restricting reproductive and sexual health rights of young people. The group provided platform for civil society for advocating for a conducive environment guided by human rights principles.[79] Non-governmental organizations are also invited in the HIV M&E Reference Group (MERG). The MERG presently have five seats allocated to CSOs.[39]

During the interviews with civil society organizations, most NGOs serving MSM/LGBT communities or sex workers complained they were forced to disguise their organization's genuine mission and target groups in the Charter to avoid legal barriers while registering organizations as legal entities. Some NGOs had to change their names to hide their connection with the groups with criminalized behaviour.

Representatives of government institutions, as well as civil society organizations believe that there is no law or regulation that would limit the Government's ability to contract CSOs for health service delivery. Interviewees from the MoH, and Planning Institute of Jamaica (PIOJ) also confirmed that social contracting has been practiced in many sectors, including health sector. The Ministry of Health has contracted professional associations and foundations under the public funds. For instance, the MoH contracted National Cancer Society to develop national Cancer Registry in Jamaica.

Government representatives also stated that due to some state regulations exchanging patients data between the Government and CSOs may become challenging, and encouraged CSOs to change their organizations' legal status to foundations or society to be able to get funding.[80] Obviously, there is a certain level of ambiguity in existing regulations for social contracting, and more in-depth assessment is needed to find out not only potential legal barriers, but also the Government's willingness, readiness and practices to contract CSOs for health service delivery, especially for those groups that are marginalized and illegal under existing national legislation.

4.2.6 Program – Service Delivery

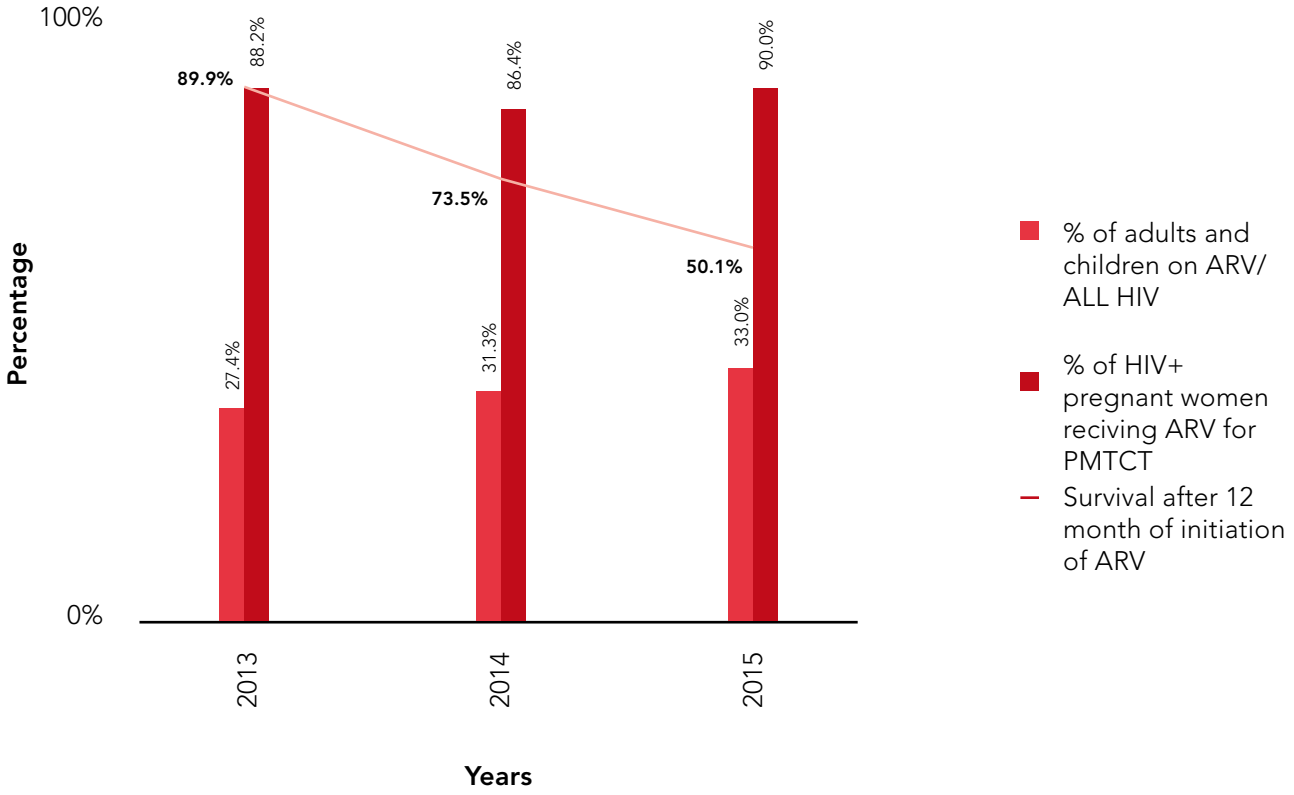
4.2.6.1 Treatment Coverage and outcomes

Persons living with HIV have access to 38 treatment sites and geographic access is balanced. Antiretroviral drugs are distributed free of charge through public pharmacies, and for a nominal fee through private pharmacies across Jamaica. Long waiting times at public pharmacies remain to be challenging for PLHIV, especially for those who are employed.

Free ARV treatment is offered in both, public and private sectors. While treatment data from private clinics are not routinely collected, stakeholders believe that the number of patients receiving ARV in private sector is insignificant. ARV treatment is accessible for inmates in correctional setting.

[78] TGF Concept Note. 2014
[79] GARP Report, 2016
[80] This suggestion was uttered during the national consultation meeting with stakeholders on September 11, 2016 at the PIOJ. The format of the meeting did not allow to explore the issue further and find out what are the barriers for contracting CSOs without changing their legal status, or what is the rationale behind the practice of contracting only foundations/societies.

F.4 ARV COVERAGE AND SURVIVAL AFTER 12 MONTHS OF INITIATION OF ARV



The percentage of adults and children receiving ARV out of total number of PLHIV has been increasing over the last three years though at a very low pace. The percentage of HIV-positive pregnant women who receive antiretroviral therapy to reduce the risk of mother-to-child transmission remains stable over 85% reaching its peak (90%) in 2015.[81]

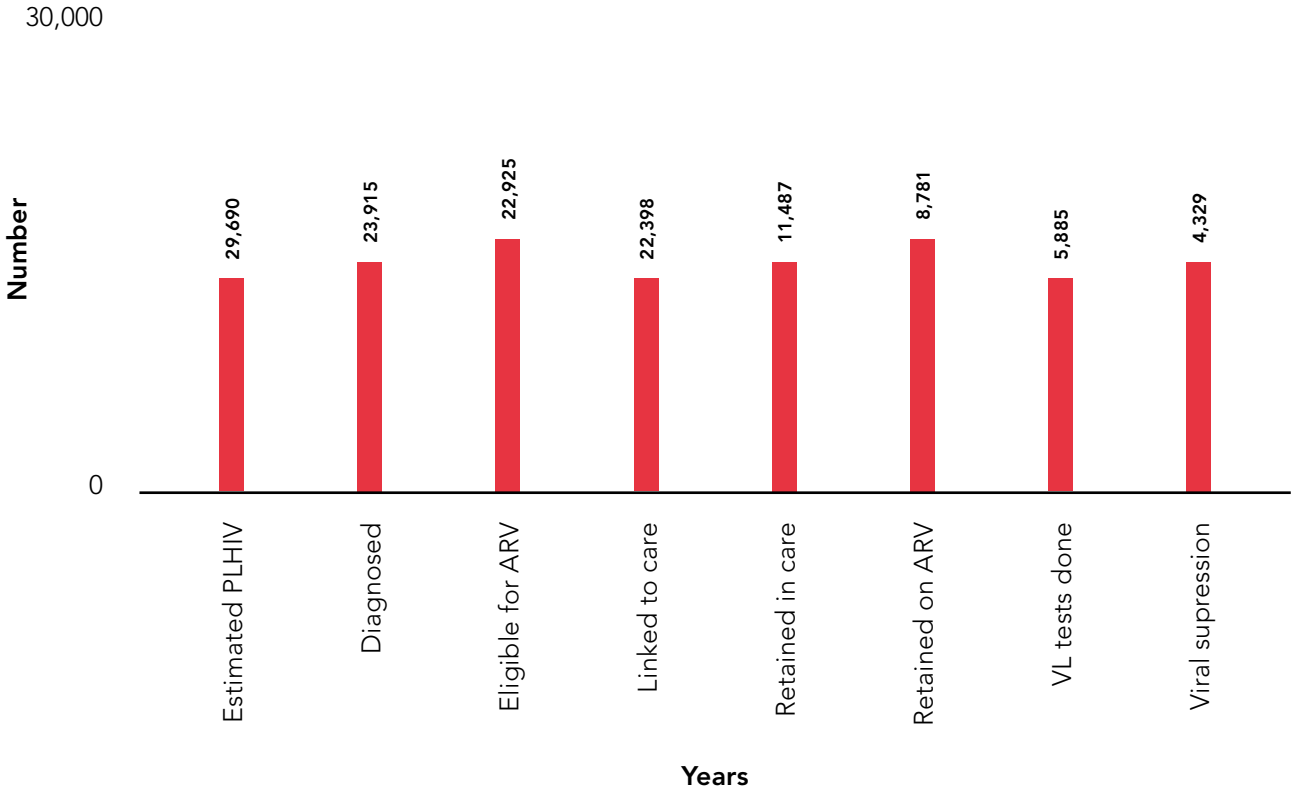
In 2015, Jamaica officially adopted CD4<500 treatment policy, and has committed to adopt 'Test and Start' strategy starting from FY2017.[18] These strategies, if implemented, will have substantial cost implications on the HIV national response. In addition, country should carefully assess the unknown needs in HRH, laboratory capacity, supply chain and other system components to successfully realize 'Test and Start' policy in Jamaica.

Based on the Treatment Cascade shown in the Figure 5, of the estimated (22,925) persons in need of ART only 38% (8,781) were on ART by the end of 2014. Only half of patients on ART have achieved viral suppression.[64] Survival after 12 months of initiation of ARV is also demonstrating unfavorable trend (Figure 5).

[81] Global AIDS Response Progress Report. Jamaica 2016

F.5

JAMAICA TREATMENT CASCADE - 2014[82]



Treatment cascade, as well as ARV coverage and treatment outcome indicators demonstrate that Jamaica is facing challenges that need to be explored and addressed during the transition period.

Treatment cascade and outcome indicators are contradictory with the reported sharp reduction in AIDS-related death: low coverage and retention in care, unfavorable treatment outcome translated into low survival rates presumably should lead to increased AIDS related mortality. It is possible that vital registration in Jamaica fails to capture all death cases and/or primary reasons of mortality, and therefore, the AIDS–related death cases might be underreported.

4.2.6.2 Integration of services

Following the integration of HIV program into the NFPB-SHA, the Ministry of Health has retained aspects for HIV treatment, care and support of former National HIV/ STI Programme. Furthermore, to sustain and further strengthen integration of both diseases, a unit under the Ministry of Health,

[82] Global AIDS Response Progress Report. Jamaica Country Report. 2016

now known as HIV/STI/TB Unit, is functional, which is responsible for both diseases focusing on HIV/TB policy, treatment, surveillance, and quality and standard setting.

HIV, TB and PMTCT services in Jamaica are fully integrated into the primary health care. HIV testing for pregnant women is accessible in antenatal healthcare centers in both, public and private sectors. ARV treatment is also offered to HIV positive pregnant women and HIV exposed infants in public or private clinics. The data about HIV testing and treatment of pregnant women in private sector is not collected. However, stakeholders state that vast majority of pregnant women attend services in public sector, rather than in private, especially for delivery services.

Family nurse practitioners are legally empowered to manage diseases in primary care facilities inclusive of HIV/TB. TB patients with intensive phase receive treatment in two main treatment sites across the island.[77] In 2014, eighteen and in 2015, fifteen HIV positive incident TB cases were detected and all patients received ARV therapy.

4.2.6.3 Coverage of KP with Preventive services

One of the risks for sustainability is restricted capacity of the HIV program to reach increasing number of KAPs. Weak surveillance data on coverage of key populations with prevention services and unreliable population size estimates make it difficult to assess the coverage levels of affected communities with comprehensive packages of HIV prevention.

The 2013 Medium Term Review of the UN High level Targets – Jamaica Report shows progress in several indicators: increased condom use among sex workers; youth having sex later; increase in HIV testing; increased outreach among sex workers; decreased HIV prevalence among sex workers.[83]

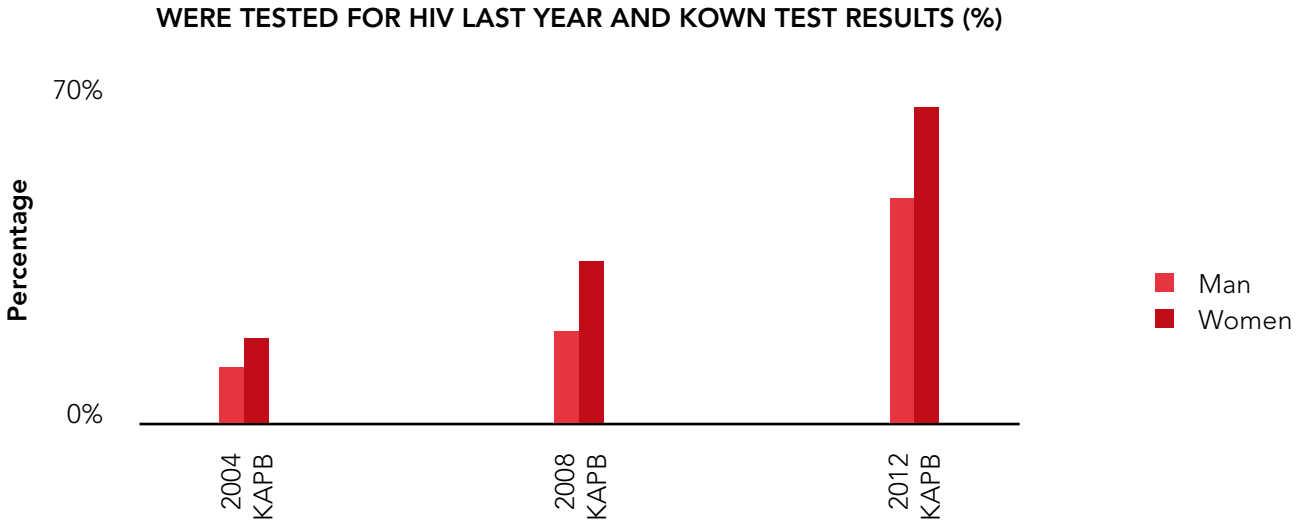
A Peer navigation strategy[84] has been utilized to increase coverage of MSM population with HIV testing and provide necessary linkage to care. Program data show that in 2015, the number of MSM reached with prevention interventions slightly increased (6, 502) compared with 2014 data (6,088); HIV testing uptake among MSM reached with the program remains relatively stable (33% in 2015 & 36% in 2014).86 Based on the 2011 Bio-BSS among MSM survey results, HIV testing uptake reached 68.3% in 2011 that was higher than that from 2007 BBSS – 53%. However, due to the methodological weakness of the studies, the indicators are less likely to be valid. This statement is also supported by the program monitoring data provided above that indicates that the percentage of MSM reached during a year remains under 20% (6502/33,000 in 2015).[85]

Only 30% of sexually active adolescent girls aged 15 – 19 years, and 18% of adolescent boys have been tested for HIV during last 12 months that is far below the national target of 75%.[77]

Introducing provider initiated testing among hospital attendees in public sector resulted in increasing the proportion of population who were tested for HIV and know their test results.

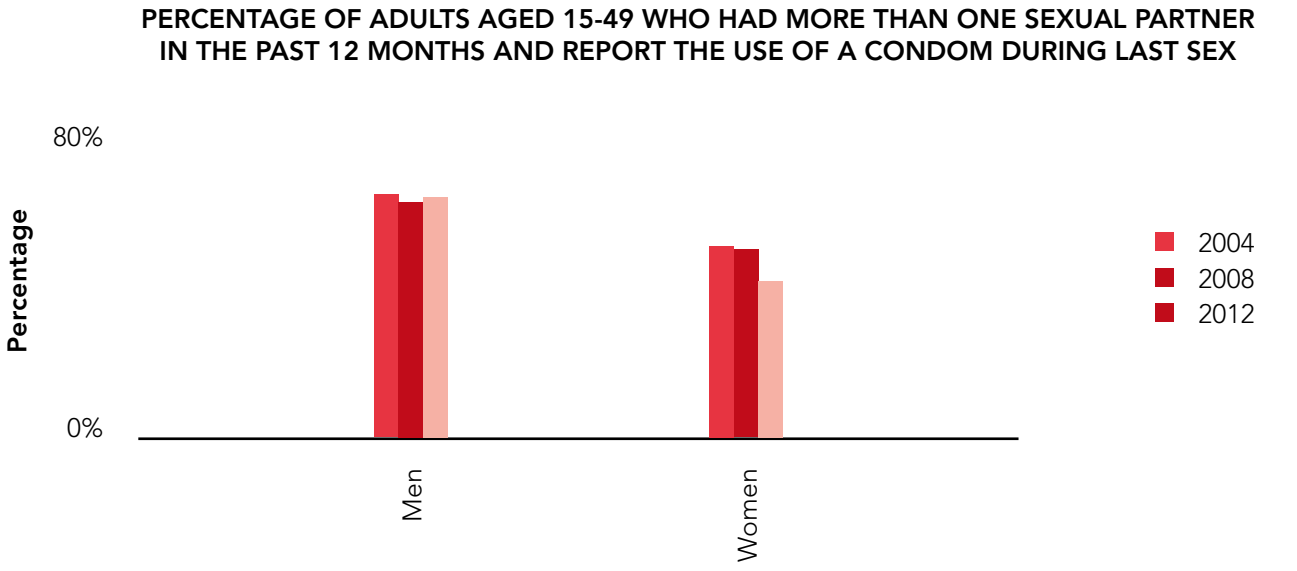
[83] Jamaica's National Integrated Strategic Plan for Sexual and Reproductive Health and HIV, 2014-2019
[84] PEPFAR/Jamaica Country Work Plan. October 2015-September 2016.
[85] It should be also noted that ccommonly programme data tends to overestimate the coverage indicator due to potential double-counting of beneficiaries; thus the coverage indicator may be even lower than 20%.

F.6 HIV TESTING UPTAKE AMONG GENERAL POPULATION IN JAMAICA.



Behavioural change trends do not show improvement when assessing the condom use among the population aged 15-49 who had more than one sexual partner in the last 12 months.

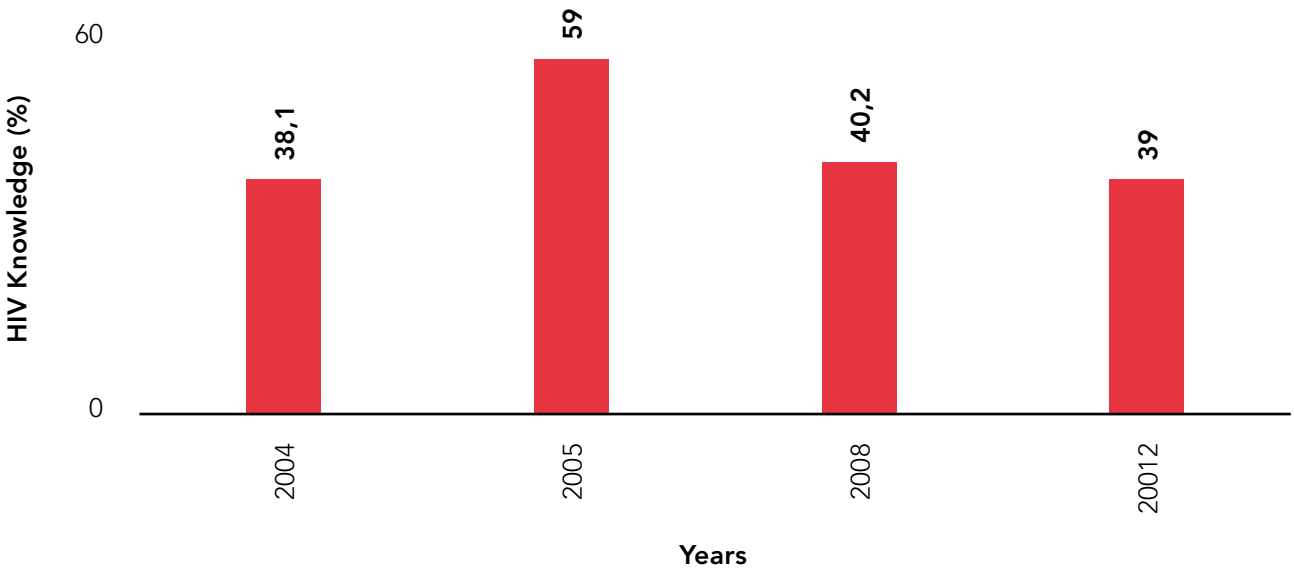
F.7 CONDOM USE AMONG MALES AND FEMALES AGED 15-49 YEARS WHO HAD MORE THAN ONE SEX PARTNER IN THE PAST 12 MONTHS AND USED CONDOM DURING LAST SEX



Unfavorable trend was also observed in terms of HIV awareness among youth 15-24 participating in the KABP surveys.

F.5

HIV KNOWLEDGE AMONG YOUTH AGED 15-24 YEARS



Data on coverage of transgender population is missing. Information about the coverage of out-of-school youth with HIV prevention services as well as the data about homeless/ drug users are not available for recent years.

Despite non-conducive legal environment, Jamaica has ensured unrestricted equal access to HIV testing and treatment services for all groups of the society. Integration of HIV treatment services into primary health care and availability of free-of-charge ARV treatment services at private clinics is also positive factor towards program sustainability. However, ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention and survival rates also need to be improved. PMTCT has been very successful in terms of sharp reduction in AIDS paediatric cases as the country moves towards elimination of MTCT. Despite program achievements, structural barriers, stigma and discrimination, and weak HIS are limiting country's ability to better track service coverage and treatment outcome indicators, and these challenges need to be addressed during transition.

4.2.7 Program – Organizational Capacity

4.2.7.1 Program Management Capacity

Ministry of Health of Jamaica has served as PR of the Global Fund project for years and service integration within formal healthcare system has taken place for many years. Program management team has

benefited from number of capacity building interventions that have been supported by donor-funded projects. In general, HIV program management capacity within government structures is adequate to plan, implement, and monitor HIV response during the transition and after the GF funding ends.

Recent decision of the GoJ to integrate HIV national programme within already well-established structure National Family Planning Board also seems a step towards sustainability. The integration process involved reorganization of units and divisions into the NFPB-SHA with expanding, rather than losing any functions or services; a new division for enabling environment and human rights was also added to the NFPB-SHA.[86]

Emerging the new player into the HIV response management scene requires substantial technical assistance and capacity building to expand program management skills to both, existing and newly recruited staff of NFPB-SHA. The Board has strong procurement and chain management skills as it participates in procurement and distribution of condoms, diagnostic test kits through both, the GoJ state procurement, and donor funding. Furthermore the NFPB-SHA management team stated they achieve economies of scale by purchasing large stocks of male condoms costing $JMD 5 (US$0.34) per condom.[87]

4.2.7.2 Procurement and Supply

The GF procurement is integrated into the national procurement system guided by the State Procurement procedures. Supply chain management is a major function of Treatment, Care and Support unit of the Ministry of health.[88] ARV drugs and other HIV programme commodities are procured by the National Health Fund (NHF) procurement system. Purchases of ARV using domestic resources is done through the Clinton Health Access Initiative.[89] The Central NHF warehouse is linked to majority of pharmacies and are able to view and generate reports on stock balances and ARV consumption in real time.[90] Paper-based LMIS is maintained in remaining sites. Under the management of NHF, restructuring of the public sector pharmacies took place to streamline procurement and distribution process, however patients still continue to wait long hours for prescriptions in public pharmacies.

There are frequent stock-outs of ARVs, including for 1st line drugs. During interviews with MoH and stakeholders, they confirmed that there is a buffer stock of ARVs for extra three months; however they admit experiencing stock-outs once or twice per year. MoH representatives do not think that forecasting of ARV needs should be blamed; they believe that procurement process/lead time is too long taking up to 6 months.

The Jamaica HIV CN 2016 states that the country, with financing from NHF, developed an electronic stock management and Logistics Management Information System (LMIS) reporting tool. The electronic LMIS was piloted and then rolled out to 43 ARV dispensing sites (dispensing 33% of all ARV stocks). However, it is obvious that the absence of linkages among different

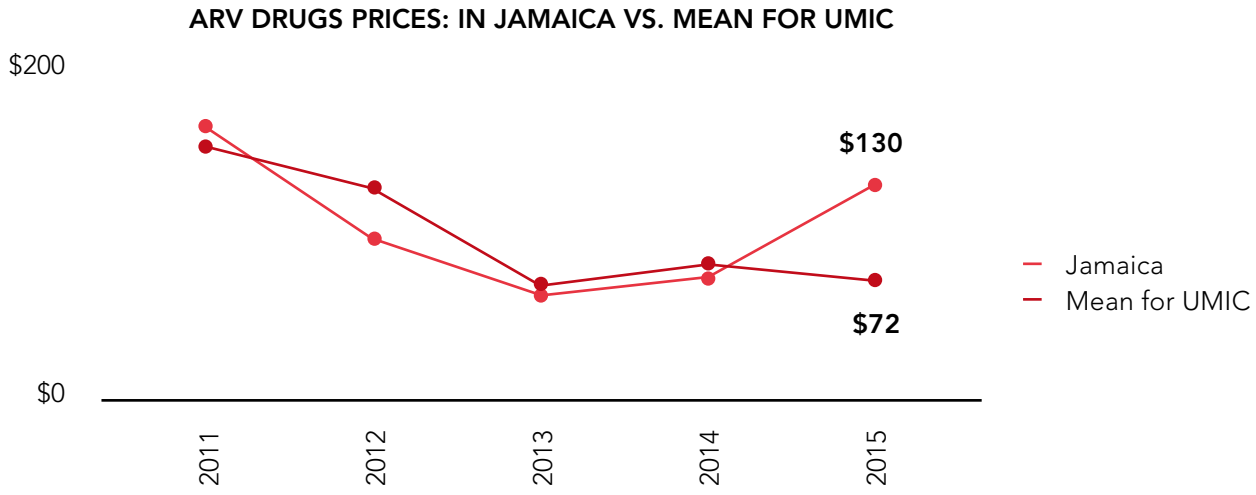
[86] ATIONAL FAMILY PLANNING-HIV PROGRAMME INTEGRATION IN JAMAICA. Case study. 2014. PEPFAR/USAID/HPP
[87] TPA mission. Interviews with the NFPB-SHA management team; September 6, 2016. Interview transcripts.
[88] Ministry of Health of Jamaica. http://moh.gov.jm/national-hiv-sti-tb-programme/nhp-components/treatment-care-support-tcs/ accessed on September 12, 2016
[89] Sustainability index and dashboard report. Jamaica. PEPFAR. 2016
[90] The Global Fund Concept Note. HIV. Jamaica. 2016

pharmacies in different parishes as well as potential weaknesses in procurement planning and implementation have encouraged ARV patients to register at different pharmacies under the same identity. Through this practices, PLHIV manage to get their prescriptions filled from multiple ARV dispensing sites and create personal stocks of prescribed drugs in case of stock outs.

ARV drugs' price is considered key factor posing sustainability risk in resource-constrained countries, particularly with generalized HIV epidemics where ARV drugs costs account for considerable portion of AIDS spending. The TPA tool looks at drug prices and compares country prices against the median price of ARV drugs for the same income classification countries. The graph below presents the ARV prices in Jamaica[91] over the last five years. As demonstrated, ARV price from 2011 through 2014 followed similar trend of that for upper middle-income countries. However, in 2015, the price skyrocketed that might be due to Jamaica's weak purchasing power with suppliers that can be addressed through using TGF procurement service agent. Another reason might be frequent stock-outs leading to frequent emergency procurements of drugs.

F.9

ARV DRUGS PRICES IN JAMAICA [78]



The procurement and supply chain management system in Jamaica should be thoroughly assessed to identify bottlenecks of the system. On August 22-September 2, 2016 USAID mission conducted Jamaica National Supply Chain Management assessment, which will lay the groundwork for subsequent assessment to overhaul the national PSM system. Jamaica should also adopt a strategy that will reduce the costs of

[91] ARV Drugs Global Price Mechanism. WHO. http://apps.who.int/hiv/amds/price/hdd/ accessed on August 28, 2016

ARV drugs. This is particularly critical as the country moves to 'Test and Start' policy that is expected to increase the number of patients on ARV, and will require substantially more financial investments from the Government.

4.2.7.3 Monitoring and Evaluation Capacity

The National HIV Response is guided by newly developed National Integrated Strategic Plan accompanied by the 12-component M&E framework. M&E function lies within the Jamaican Monitoring and Evaluation Reference Group (MERG-J) which is composed of a Chair, Vice Chair, seven permanent members and eighteen invited members representing key stakeholder and population groups.

Local staff capacity was strengthened through technical assistance and formal training to plan, implement and analyse data for HIV surveillance surveys being conducted among KAPs using various methodologies. Currently, through the CDC support, team will be trained in advanced survey methodologies, like respondent-driven sampling for BSSs among MSM. Having in-country research capacity will be key for sustainability of HIV researches after external funding declines/ends. Following the integration of the HIV and SRH data, M&E system was advanced through capacity building of senior health care professionals and community intervention personnel in record keeping, data collection, data quality, etc.

With the introduction of District Health Information System (DHIS2), the Ministry of Health in 2015, facilitated training on the software to accelerate implementation of a national web-based platform for ARV patients accessing care within the public sector.[92] On-site coaching on the use of treatment database is currently in progress for medical staff at treatment sites. Training in the use of Geographic Information System for mapping HIV prevention services were provided to community service provider organizations.[86]

While substantial efforts have been made by HIV national programme to strengthen the national M&E system, capacity building of program staff should continue; service provider organizations, including CSOs and organizations at subnational level should be supported to develop site-specific M&E plans. The NISP M&E plan with SMART[93] indicators specific to each target population groups should be an integral part of the NISP, and the latter with its M&E plan should be approved by Government resolution.

4.2.8 Transition Planning

Jamaica has not yet developed transition sustainability plan, but the GoJ has started absorption of HIV/AIDS costs incrementally. The Jamaica HIV program Concept Note spells out Government willingness to pay for a larger share of treatment and laboratory costs starting from 2016:

In transitioning the ARV drugs costs to the GOJ Budget, the costs will be absorbed as follows:[94]

- 30% of the 2016 costs equivalent to US$ 380,000 will be absorbed
- 50% of the 2017/2018 costs will be absorbed equivalent to US$ 740,000
- 70% of the 2018/2019 costs in the amount of US$ 1,270,000

[92] Global AIDS Response Progress Report Jamaica Country Report, 2016
[93] SMART indicators should be Specific, Measurable, Attainable and action-oriented, Relevant, and Time-bound
[94] The Global Fund Standard Concept Note, HIV program. Jamaica 2016

- Full absorption of ARV costs in 2019/2020

In transitioning laboratory reagents and supplies for viral load and CD4 testing to the GoJ Budget, the costs will be absorbed as follows:

- 50% of the 2017 costs amounting to US$ 340,000 will be absorbed
- 50% of the 2018 costs amounting to US$ 470,000 will be absorbed
- Full absorption by 2019/2020

Jamaica has been privileged to be one of those countries where Transition Preparedness Assessment started well in advance before the transitioning from the Global Fund Funding. To ensure smooth and full transition of HIV national response from external support to country ownership, MoH and PIoJ addressed UNAIDS to support transition preparedness process in Jamaica. GoJ assigned the Planning Institute of Jamaica in close partnership with the Ministry of Health to lead and coordinate transition and sustainability response in the country. Transition Steering Committee with high-level multi-sectoral representation was established. Exceptional commitment from the GoJ has been demonstrated during the TPA mission, however this commitment has to be realised through concrete steps from the GoJ to gradually reduce dependency on external funding.

Another advantage for the country was a joint initiative of major donors – the Global Fund and USAID to get engaged in the transition preparedness process from its very initial phase. A team of TGF Transition and Sustainability and health financing specialists, a team from local and regional UNAIDS, as well as local and US experts from USAID were involved in the TPA mission. Through these engagement, economies of scope were achieved as donor communities, at no extra costs, benefited from learning opinions and concerns from wide variety of stakeholders mobilized for interviews through the help of UNAIDS Jamaica team. The information collected during the TPA mission and discussions during national consultation and Steering Committee meetings, encouraged donors to start exploring their potential roles in the transition immediately. Donors have declared commitment to pool financial and technical resources in a coordinated manner, and support implementation of interventions in most critical areas identified through the TPA. Strong ownership of GoJ coupled with exceptional cooperation of country's stakeholders and donor communities provide solid foundations for optimism that HIV national response will be sustained in Jamaica.

5. Findings and Recommendations

5.1 Brief summary findings of transition preparedness assessment

Through the Transition Preparedness Assessment exercise achievements and remaining challenges of the National HIV response were outlined. Factors supporting or hindering program implementation and posing sustainability risk were identified and validated through consultation with key stakeholders.

The TPA tool final score indicates that Jamaica has been facing high to moderate

risk of HIV program sustainability with the score of 26.92%.

Brief summary findings presented below follow the TPA framework structure:

External Environment

Political Environment

GoJ declares its commitment to population health, however this commitment has not been translated into the adequate investments in health: the share of government spending on health out of General Government Expenditure in 2014 remains below the mean for UMICs, and the share of public spending out of total health expenditure in 2014 has been the lowest since 2011. Health expenditure per capita (current US$) by the State was rising steadily since 2009 through 2013, but declined in 2014. Total Health expenditure as a percentage of GDP also declined in 2014 to 5.4% that is the lower than the average for Caribbean region - 6.1%.[95]

Existence of numbers of discriminatory laws in Jamaica also poses very high risk to program transition and sustainability of progresses achieved in terms of reversing HIV epidemic, especially among KAPs. These laws include:

- Offences Against the Person Act (Buggery Law) – criminalizes private, consensual same-sex sexual acts;
- Sexual Offenses Act – makes the act of solicitation of women and girls for sex and the operation of brothels illegal in Jamaica;
- The Age of Majority Act – creates barriers for adolescents under the age of 16 years without parental consent;
- Dangerous Drug Act: Criminalizes drug use;
- Ban on condom distribution in correctional settings is a consequence of the Offences Against the Person Act that criminalizes anal sex;
- Anti-abortion legislation - Sections 72 and 73 of the Offences Against the Person Act of 1864 restricts access of women and girls to safe abortion services.

It is necessary to acknowledge strong linkages between criminalization, marginalization and discrimination of key affected populations on one hand, and the threats to HIV epidemics in the country. Having discriminatory laws drive key vulnerable populations underground; reduces HIV testing uptake and early detection; due to fear of stigma and discrimination, people do not seek testing and prefer not to know their status that heightens their individual risk for HIV as well as spread the infection to their sexual partners and the population in general. Furthermore, those who test positive for HIV in a fear of not being criminalized or marginalized by the society, most likely will not self-identify themselves as MSM, TG, or sex worker, or drug users and therefore surveillance data becomes incomplete and inadequate to properly diagnose the problem and design appropriate interventions. As a result of all the above mentioned, the data that is being routinely collected through the surveillance system, is likely to be misleading. This will substantially limit country's ability to plan well-targeted and focused HIV national response. Furthermore, such laws most likely will impose limitation on the government to budget for KAPs and to use national funding for service provision with the help of contracted CSOs.

[95] Caribbean Regional Operational Plan 2016 Strategic Direction Summary. July 6, 2016. .p. 21

There is no law safeguarding non-discrimination of PLHIV in Jamaica. Permanent fear of being discriminated and marginalized by the society, makes PLHIV even more vulnerable and susceptible to mental health problems; all these intertwined with side effects associated with ARV treatment, may greatly discourage AIDS patients to retain in treatment that might be one plausible explanation of the unfavorable treatment cascade in Jamaica. All these factors may result in fast-growing HIV epidemic with its negative consequences on human's lives and economic development of country as a whole.

Based on the indicators measuring the level of health investments by the GoJ, and assessing the legal environment in the country, the TPA tool calculated that in overall, the political environment in Jamaica poses very high risk to HIV program sustainability.

Economic environment

Jamaica's GDP has been increasing over the last few years but at a very low rate averaging less than 1 percent a year. The country's debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014 and potentially limiting fiscal space for adequate health investments. Less conducive macro-economic environment along with huge debt burden, although improving after the election in 2016, may limit government's ability to assume full financial responsibility for the HIV program currently funded through the GF.

Internal Environment

Inputs/Financial resources

HIV/AIDS budget lines are included in the Jamaica multi-year national budget. However, latest spending data shows that in FY 2013, the GoJ covered only one fifth of the AIDS total spending, using borrowed funding from IBRD. AIDS spending data did not allow assessing the share of the public funds out of total spending by program areas, and the TPA indicators that look at GoJ's budgetary commitment to case detection and treatment services are based on the stakeholders' opinion, that may not be accurate. Few economic studies were conducted in Jamaica that may serve as practical tools for HIV budget projection: Goals Model impact assessment for treatment program; Modes of transmission study; HIV Program Financial Sustainability study; and estimation of unit costs for HIV prevention package for MSM (for PEPFAR funded project). Appropriate monitoring of public spending on HIV program is warranted in order to generate necessary financial data and adequately inform the transition planning and implementation processes.

Inputs/Human resources

There is a severe shortage of HR in health sector in general, including HIV field with the highest gap in non-medical/ support staff. The situation is exacerbated by the IMF restrictions under which the Government of Jamaica cannot hire more health care workers.[25] Therefore, it should be acknowledged that the challenges in terms HRH is a structural challenge of the sector that goes far beyond HIV programme, and is doubtful to be adequately addressed within the limits of HIV program.

On the other hand, the HR costs for HIV remain largely dependent on external support and after transitioning, staff shortage might become even worse if the GoJ is unable to absorb the costs of human resources currently paid by donors.

Institutionalization of training programs previously supported and developed through the GF and other donors will mitigate the sustainability risk posed by the shortage of qualified professionals engaged in HIV national response. Given that most HIV clinical management trainings have already been integrated into formal education system, during the transition period, the GoJ should focus on accreditation of life-long education as well as on institutionalization of trainings for non-medical staff in HIV prevention, program management, adherence counselling, peer navigation, motivational interviewing, HIV-related research, PSM, M&E, stigma and discrimination, etc.

Inputs/ Information Systems

In recent years, significant efforts have been done by the GoJ to strengthen HIV health information system and major program data cleaning was carried out through the guidance and technical support from the CHAI partnership. Despite this, challenges still remain in terms of reliability of data about treatment and prevention services, especially for KAPs. Second generation surveillance studies have been conducted among MSM and sex workers periodically, but these studies need to use more robust methodologies to produce more reliable findings about marginalized population groups that have been driven underground due to existing legislation. Bio-BSS studies have been mainly financed through external funds and unless adequate national funding is secured during transition process, critical epidemiological and program related data, necessary to plan national response, may not be available. Most population size estimates for KAPs are based on experts' opinion rather than derived from research findings. Weak HIV information system and full reliance on donors' funds for surveillance studies poses high risk to program sustainability.

Governance

HIV/AIDS has been declared as a priority by the Government, but to assure adequate transition towards sustainability of HIV national response, the declaration is to be substantiated with credible funding allocation from the State and legislative amendments. Jamaica has had national plans to guide National HIV/STI programme since 1988. The National Integrated Strategic Plan (2014-2019) was developed through participatory process involving stakeholders from government, civil society, development partners, and private sectors. According to national stakeholders, the NISP is costed and is accompanied with the monitoring and evaluation framework. For smooth transition, it is critical to submit costed NISP and its M&E plan to the government for formal approval. The NISP approved from the Cabinet/or by the Government resolution will have more legal power to drive adequate allocations within the national budget.

CCM has been considered as an effective platform for stakeholders, particularly for civil society organizations to discuss HIV national response with high-level government officials, and wider representation of other sectors. Forty per cent of seats in the Jamaican CCM is allocated to civil society. CSOs believe that CCM should continue functioning beyond the GF funding.

GoJ has integrated HIV national program to National Family Planning Board to improve coordination and optimize country response to both, HIV, and reproductive health/ family planning services. While, CCM and NFPB-SHA, both are expected to serve as an effective mechanism to strengthen HIV coordination in the country, none of these two structures is placed adequately within the government hierarchy, and is legally empowered to assure strong coordination across the sectors. Consequently, it becomes

important during transition planning process to undertake consultations, and decide how and where the coordination function will be sustained and further strengthened.

Accountability

Jamaica develops HIV program reports annually, such as Global AIDS Response Progress (GARP) report, and HIV epidemiological Profile. These reports are publicly available on the UNAIDS and the MoH websites, respectively. The National AIDS Spending Assessment reports and GARP funding matrix files can be obtained upon request. Reporting on program financial data lag far behind in time: as of September 2016, last AIDS spending data submitted to UNAIDS was from FY2012/2013. Data dissemination and sharing is seen as an area of weakness as data is not reaching civil society to guide their programming and/or advocacy efforts. Program performance reports and survey findings have been used for planning purposes in Jamaica.

Programme

Service delivery

Recent integration of HIV program with reproductive and sexual health services seems to be sensible decision of the Government as the focus of services has become broader and less stigmatizing that may improve health seeking behaviour of most-at-risk population. Despite non-conducive legal environment, Jamaica has ensured unrestricted equal access to HIV testing and treatment services for all groups of the society. Integration of HIV treatment services into primary health care and availability of free-of-charge ARV treatment services at private clinics is also positive factor towards program sustainability.

Percentage of adults and children receiving ARV out of total number of PLHIV though has been increasing over the last three years did not exceed 33% in 2015. ART coverage remains far below the Fast-Track treatment targets. Linking to treatment and care services, retention and survival rates need to be improved.

PMTCT is integrated with PHC/Maternity care, and services are provided to pregnant women attending antenatal services in both, public and private clinics; though data from private sector is not collected. Coverage of pregnant women with HIV testing and ARV has increased yielding sharp reduction in AIDS paediatric cases and deaths rate, and Jamaica currently moves to elimination of MTCT. Re-introducing PIT among hospital attendees resulted in increasing HIV testing uptake that is critical for HIV case detection. Data on coverage of transgender population, out-of-school youth, and homeless/drug users is not available for recent years.

In general, HIV national program in Jamaica has been successful in various directions (reduction of HIV prevalence among KAPs, reduction of MTCT and AIDS related deaths, etc.), however structural challenges, stigma and discrimination, and weak HIS are limiting country's ability to better track prevention and treatment outcomes. Addressing these challenges will make transition process smoother.

CSO engagement

Jamaica Government has supported engagement of civil society organizations in HIV service provision, including ARV treatment services. There are no laws that would restrict the Government to contract CSOs for health service delivery. However existing legislation may limit Government's legal power to contract civil society

organizations under the public funds for the services targeting MSM and sex workers. Through the consultation with stakeholders it has become obvious that there is a certain level of ambiguity in existing regulations for social contracting, and more in-depth assessment is needed. All CSOs in Jamaica currently are largely dependent on TGF and USAID/PEPFAR funding. It will be crucial to ensure that the GoJ incrementally starts funding CSOs for HIV service delivery as they have substantial capacity to outreach to marginalized communities. Some of the CSOs expressed concerns that accepting funds from the Government in future may potentially cripple their advocacy and watchdog function. During transition period, a national dialogue should be initiated to find out most feasible and suitable ways for sustainability of CSOs engagement in service provision under the public funds.

Organizational Capacity

There is a strong national programme management capacity within the MoH that serves as TGF PR and also manages the national HIV programme. Recent decision of the GoJ to integrate HIV national programme into the National Family Planning Board has emerged a new player into the HIV response management scene. Therefore, significant technical assistance and capacity building interventions will be warranted to expand program management skills to both, existing and newly recruited staff of the NFPB-SHA. CSOs capacity should be strengthened in managing programs under the public funds as well as in fundraising.

The GF procurement and supply chain management is integrated into the national system that is positive factor to make transition smoother. However, Jamaica experiences frequent stock-out of ARV drugs and reasons should be explored and addressed within the transition plan. In 2015, the ARV drugs price skyrocketed that might be due to Jamaica's weak purchasing power with suppliers that can be addressed through using TGF procurement service agent. Another reason might be frequent stock-outs leading to frequent emergency procurements of drugs. The procurement and supply chain management system in Jamaica should be thoroughly assessed to identify system challenges and overhaul the national PSM system.

Transition planning

There are some plans from the GoJ to start absorption of certain elements of HIV/AIDS costs starting from 2016, and they are included in the NISP. However, the NISP has not yet been approved by Government resolution and, thus is not legally empowered.

Jamaica has been privileged to be one of those countries where Transition Preparedness Assessment started well in advance before the transitioning from the Global Fund funding occurs. During the TPA mission, the GoJ demonstrated strong political will to ensure smooth and full transition of HIV national response from external support to country ownership. Country major donors - the Global Fund and USAID are committed to support the country during the transition period. All above mentioned provide solid ground for optimism that Jamaica in collaboration with the GF and other development partners will make concerted efforts to address major challenges identified through the assessment, and will design and implement a well-conceptualized transition plan to ensure HIV program sustainability after the GF funding ends.

5.2 Recommendations

During transition planning stakeholders should focus on straightening a multi-sectoral HIV response and initiate negotiations with high-level officials including representatives of concerned ministries (particularly targeting the Ministry of Corrections, the Ministry of Labour and Social Security, the Ministry of Education, etc), in an effort to manage the mobilization of HIV-dedicated resources within their respective budgets. That may reduce HIV funding burden on the MoH that will be key to sustainability.

The list of recommendations presented below follows the domains of the TPA framework. Based on the sustainability risk and feasibility of proposed activities, the recommendations are presented under different temporal dimensions. The recommendations are not prescriptive and can be adapted to the Jamaican context.

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
EXTERNAL ENVIRONMENT		
POLITICAL ENVIRONMENT		
Recommendation # 1: create conducive legal environment	Immediate step	• Transition preparedness Steering Committee led by the PIOJ and MoH should initiate policy dialogue involving the GoJ and national stakeholders to explore the ways during transition planning how restrictive legislations can be revised to reduce access barriers for MSM and sex workers, prisoners, and mitigate the risk of stigma and discrimination on program success. • Develop SRH & HIV policy to address service barriers for adolescents and women in Jamaica • Intensify HIV awareness and sensitization public campaigns to reduce stigma and discrimination, and generate constructive attitudes among the society
	Medium to long term	• Development and adoption of legislative amendments to restrictive laws
ECONOMIC ENVIRONMENT		
Recommendation #2: Create capacity of the Government to mobilize additional financial resources for health	Immediate step	• Immediate step
INTERNAL ENVIRONMENT		
INPUTS: FINANCIAL RESOURCES		
Recommendation #3: mobilization of adequate financial resources	Immediate step	• Monitor fulfilment of GoJ's pledge about gradually absorbing costs of ARV drugs, laboratory reagents and other commodities in 2016-2018 (per the GF CN & costed NISP) • Prepare HIV national budget forecasts based on existing epidemiological data, and technical & allocative efficiency principles • Ensure that the GoJ is dedicating national budget funds to prevention services specifically targeting KAPs, including MSM, sex workers, homeless, OSY, & prisoners
	Medium to long term	• Ensure that adequate funding from public sources is available for HIS strengthening, M&E and HIV research activities, including Bio-BSS and population size estimation studies.

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
Recommendation #2: Create capacity of the Government to mobilize additional financial resources for health	Immediate step	• Conduct fiscal space analysis. This becomes even more important given that health-financing reform currently is in progress in Jamaica.
INTERNAL ENVIRONMENT		
INPUTS: FINANCIAL RESOURCES		
Recommendation #3: mobilization of adequate financial resources	Immediate step	• Monitor fulfilment of GoJ's pledge about gradually absorbing costs of ARV drugs, laboratory reagents and other commodities in 2016-2018 (per the GF CN & costed NISP) • Prepare HIV national budget forecasts based on existing epidemiological data, and technical & allocative efficiency principles • Ensure that the GoJ is dedicating national budget funds to prevention services specifically targeting KAPs, including MSM, sex workers, homeless, OSY, & prisoners
	Medium to long term	• Ensure that adequate funding from public sources is available for HIS strengthening, M&E and HIV research activities, including Bio-BSS and population size estimation studies.
INPUTS: HUMAN RESOURCES		
Recommendation #4: strengthen HR in HIV field and institutionalize HIV related training modules into formal education system	Immediate step	• Transition planning Steering Committee should initiate dialogue with the Ministry of Education to institutionalize HIV related training modules that have been created and successfully implemented through the GF and other donor-funded programs into the formal education curricula at undergraduate and postgraduate levels. • Consult with the MoE and professional associations to institutionalize lifelong learning (continuous education) courses through accreditation of training programmes for in-service professionals
	Medium to long term	• Explore feasibility of institutionalization of accredited practical training (internship) programs for students from relevant faculties (medical, social workers, statistician, psychologists, juridical, etc.) in HIV service organizations. Students, in exchange for academic credits can be deployed in service areas where staff shortage is most severe.
	Long term	• Challenges in terms of HRH is a larger problem of the national health care system, and even though the HR shortage will certainly affect HIV program sustainability, this problem may not be resolved during the transition period. However, Jamaica within the GF CN for the next round under the HSS component may request assistance for development of a comprehensive policy for production/training of HR in health
INPUTS: INFORMATION SYSTEMS		
RECOMMENDATION # 5: Enhance surveillance systems and build research capacity at national and local levels	Immediate step	• Strengthen HIV surveillance system through improved prevention and treatment databases that ensure linkages within all treatment sites (including private clinics and paediatric clinics), and with all prevention service provider sites, and allow data disaggregation and minimize double-counting of clients. • Collate data and produce surveillance reports that allow disaggregation by age, gender, social groups, geographic regions and other key characteristics of beneficiary groups, including transgender population, at-risk youth, out-of-school youth, homeless drug users.

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
		• To properly understand injecting drug use problem in Jamaica, conduct rapid assessment study to assess the prevalence of drug abuse and characteristics of drug user populations. Ensure appropriate representation of under 18s, out-of-school youth, and those who are street involved in the rapid assessment/survey. Collect and analyse data from drug courts. Based on the findings, estimate service needs and conduct budgetary analysis as appropriate. • Ensure that Bio-BSSs using more rigorous methodologies are conducted among general population and KAPs: MSM, sex workers, prisoners, OSY, drug users, and youth regularly, at least once in every 2-3 years. • Conduct Population Size Estimation (PSE) for key priority groups
	Medium to long term	• Negotiate with donors and development partners to provide capacity building of local staff on surveillance studies/PSE studies to build in-country institutional and human capacity for conducting surveys without external support after the donor funding ends.
GOVERNANCE		
GOVERNANCE		
Recommendation #6 Enhance Governance of National Programs	Immediate step	• National Integrated Strategic Plan for 2014-2019 with its budget and M&E Plan should be formally approved by the Cabinet/or other government resolutions to ensure it becomes legally binding document.
	Medium to long term	• Transition preparedness Steering Committee should initiate dialogue among national stakeholders including civil society to define most appropriate model for HIV coordinating structure (CCM vs. NFPB) which will continue coordination function after transitioning from the GF funding. Ensure that the coordination body is placed adequately within the Government hierarchy to coordinate multi-sectoral response. Ensure that civil society organizations, including HIV constituencies have legally determined seats on the coordination body.
ACCOUNTABILITY		
Recommendation #7: Increase transparency and accessibility of HIV program data	Immediate	• Ensure production and availability of descriptive and analytical reports describing results of the national response, implementation of transition elements and declared commitments from the Government, disease program specific epidemiological and financial expenditure data, program performance results, program outcomes and challenges. • Improve the quality and timeliness of National AIDS Spending Assessment reports.
PROGRAMME		
SERVICE DELIVERY		
Recommendation #9: enhance HIV service delivery	Immediate	• Conduct HIV program technical efficiency study (perhaps from WHO/UNAIDS) that may help identify program operational bottlenecks that will be critical for program (and expenditure) optimization. • Conduct study to identify reasons for unfavorable treatment cascade, poor treatment retention and low viral suppression rates. • Assess accuracy of vital registry in Jamaica, and subsequently, the AIDS-related deaths data • Scale up the coverage of KAPs with comprehensive prevention packages that are defined and formally approved by the MoH.

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
Recommendation #10: create enabling environment for CSO contracting to ensure that CSOs are engaged in HIV prevention services through government funding	Immediate	• While the overall legal environment is conducive to NGO/CSO contracting under the public funds, thorough assessment of CSO contracting mechanisms in Jamaica is warranted to identify potential barriers the Government may face to fund the services targeting populations with criminalized behaviors. The social contracting assessment exercise should examine not only existing legislation, but also the political will of the Government, established practices of the MoH in contracting non-governmental organizations for health-related service delivery under the public funds. Potential challenges in terms of exchanging patients data between the government and CSO that was named as problematic by the PIOJ/MOH staff should be further explored.
	Medium to long term	• An open, results-oriented and constructive policy dialogue between the government and civil society should be initiated to explore potential solutions to CSO contracting, and agree on the mechanism that is well-balanced and acceptable for both, the GoJ and CSOs (e.g. disbursing grants through establishing a trust fund).
ORGANIZATIONAL CAPACITY		
Recommendation #11: Strengthen organizational capacity of all involved stakeholders including government institutions and CSOs for better sustainability	Immediate	• The function, management and governance structure, and operations of the NFPB-SHA should be clearly defined and strengthened. The NFPB-SHA should strive to establish partnership-based linkages with civil society organizations that seemed somewhat sceptical about the NFPB plans to sustain well-established coordination among government, civil society, donor communities and private sector. • NFPB capacity should be strengthened through establishment of effective management team with strong background in both, HIV and family planning. The team should serve as 'bridge builders' across stakeholders from the two, previously independent programs – HIV & Family planning. • CSOs capacity should be strengthened to be able to deliver a wider spectrum of services to various groups. Training of CSOs on program management, M&E, financial management, organizational strengthening, proposal writing (topics can be prioritized based on the training needs assessment) will increase their capability and competitive power for fundraising in a resource-constrained environment.
PROCUREMENT AND SUPPLY MANAGEMENT		
Recommendation #12: Enhance procurement and supply management system in Jamaica to ensure uninterrupted access to ARV drugs and other program commodities.	Immediate	• Conduct thorough analysis of Jamaica current procurement and supply chain system (in coordination with the USAID/PEPFAR study initiated in August 2016) to identify the reasons for frequent stock-outs of ARV drugs and other HIV program commodities. • Strengthen LMIS and linkages between the NHF central warehouse and all pharmacies dispersing ARV drugs to make sure that the system is capable of generating reports on stock balances and ARV consumption in real time to avoid stock-outs and emergency procurement. • Explore reasons for high prices of ARV drugs; plan strategies how Jamaica can strengthen its purchasing power with suppliers. • Consider using TGF procurement service agent if that potentially leads to cost-savings.

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
TRANSITION PLANNING		
Recommendation #13: Develop, implement and monitor transition plan for Jamaica	Immediate	• Develop a multi-year (3 to 5 years) Transition Plan which clearly identifies time-bound activities, outlines roles and responsibilities of a transition process management; incorporates M&E plan and budget for implementation of the transition plan. • Ensure greater engagement of HIV program partners such as CSOs, development partners, other ministries, etc. in the transition plan development, implementation and monitoring process. • The Transition Plan should become an integral part of the NISP, which is approved by Government resolution. • Consider commissioning external team – Peer Review Mechanism (outside from the MOH/PIOJ) for supervision, monitoring and evaluation of the transition plan implementation process.[96]

Annex 1: Transition Preparedness Assessment Table

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
EXTERNAL ENVIRONMENT					
	PG1	Existence of political will to prioritize health investments	Share of government spending on health out of General Government Expenditure in 2014 was 8.1%. Over the last 5 years this indicator has varied from its lowest in 2011 (6.5%) to the highest in 2013 (9.7%), that is below the mean for UMIC (12% in 2013). Total Health Expenditure has been fluctuating over the last 5 years reaching its peak in 2013 (57.9%). In 2014, the share of government spending out of THE was 52.38% which has been the lowest since 2011. There are no regulations/ laws that would prevent the Government from CSO contracting. According to the stakeholders, the ministry of Education, Ministry of Social Security, as well as Ministry of Health have practiced CSO contracting under the public funds.	High Risk	High Risk
	PH2; PH3	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases & Rule of Law		High Risk	
	PG4; PG5	Government ability to contract with CSOs; CSO contracting practices		Low Risk	
	EG1	Favourable economic indicators	GDP has been increasing over the last four years, however the growth averaged less than 1 percent a year. The country still faces substantial debt-burden and according to the World Bank, Jamaica's debt to GDP ratio is one of the highest in the developing world reaching almost 150% of GDP in 2014. The share of General Government Revenues as % of GDP has been stably high over the last 5 years ranging from 30.4% in 2011 to 32.4% in 2013. This indicator is above the mean for the same income group countries - 28.9% in 2012.	Low Risk	Low Risk

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
INTERNAL ENVIRONMENT					
INPUTS					
Financial Resources	FH1	Budgetary commitment to disease	HIV budget lines are included in the Jamaica multi-year national budget. The latest NASA report provides AIDS spending data by various program areas, however cross-tabulation of spending by prevention priorities, by beneficiary groups and by financial sources is not available. Goals Model impact assessment study, & Modes of Transmission study were conducted in Jamaica. HIV program financial sustainability study was also completed. Unit costs of comprehensive package of HIV prevention targeting KAPs has been conducted for the USAID/PEPFAR project; established unit costs can be applied for planning and projection purposes. Budget allocations have been informed by these studies. HIV screening tests, ARV drugs are partially funded from public sources. The Government's share in financing treatment adherence costs is minimal. The exact share of public funding in financing these services is not known. The assumption is based on the stakeholders' opinion.	High Risk	High risk
	FH2	Prevention priority		High Risk	
	FH3	Allocative efficiency		Low Risk	
	FH4	Treatment / input financing from public sources		Moderate Risk	
	FH5	Prevention financing from public sources		High Risk	
Human Resources	HRH1	Sufficient human resources for disease (quantities, geographic distribution and aging)	The full time equivalent of currently deployed health care workers (HCWs) in HIV response is 62% of the optimal level required with the largest gap in non-medical, support staff. The number HCWs providing HIV treatment services has not kept the pace with the increased number of patients. Substantial portion of staff training remains heavily relied on donor-supported grants. Only some training, mostly training about HIV/AIDS clinical management have been institutionalized into formal curricula of medical schools. Majority training for non-medical staff has not been institutionalized into formal education system. A policy for production of CSO personnel/non-medical, social and support services does not exist. Stakeholders confirm that donor-funded HR salaries in most cases are aligned with national pay-scale. However, substantial portion of HR costs still is covered by external support.	High Risk	High Risk
	HRH2; HRH3; HRH4	Institutionalization of donor supported programs; Existence of policy for production/training of CSO personnel (non medical, social service); Donor funded HR salaries aligned with national pay-scale		High Risk	
Information Systems	HISH1	Routine statistical reporting - Integration in the national system	HIV Program data is integrated into the national system; however, the quality of reporting is suboptimal. ARV and PMTCT data from private providers is not integrated; pediatric treatment data is not completely integrated. AIDS treatment database is operational	High Risk	High Risk
	HISH2	Routine statistical reporting - Level of advancement		High Risk	

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
	HISH3	HIV Second generation surveillance - Methodologies, Timeliness	with limited capacity for data disaggregation by KAPs, age, gender, regions, etc. Prevention database does not exclude double-counting of beneficiaries; data about transgender, or homeless drug users, out-of-school youth, adolescents at risk of HIV- are either limited or unavailable. Under the PEPFAR funding DHIS is being developed but has not yet been implemented at the national level. KABP among general population is based on solid research methodology. PLACE studies (Bio-BSS) among KAPs used convenience sampling and therefore, study findings lack robustness. In 2016, through USAID support RDS methodology will be introduced for Bio-BSS among MSM. PSE studies have not been conducted. Upcoming BBSS (USAID/PEPFAR) among MSM will be combined with PSE study. Bio-BSS studies have been financed through external funds. Only some research staff salaries are covered by the Government. Population Size Estimation studies have never been conducted and most estimates for KAPs are based on experts' opinion.	High Risk	
	HISH4	HIV Second generation surveillance - Funding from public sources		High Risk	
GOVERNANCE					
Governance	GovH1	Strong political commitment to diseases	The National Integrated Strategic Plan (2014-2019) was developed through participatory process; costing of the NISP was completed in 2016. NISP is not approved by the Cabinet, or by any Government resolution. HIV is identified as a priority in the National Agenda of 2030 Sustainable Development Goals. Stakeholders found it difficult to name legally empowered leading organization, which contributes to effective functioning of HIV response. CSOs named individual champions from civil society organization - Jamaica AIDS Support for Life, who has been most prominent leader in advocating for sustainable funding for HIV response, and protecting vulnerable populations' rights. While, CCM and NFPB-SHA, both are expected to serve as an effective mechanism to strengthen HIV coordination in the country, none of these two structures is placed adequately within the government hierarchy, and is legally empowered to assure strong coordination across the sectors. 40% of seats in the CCM is allocated to civil society. Stakeholders believe that CCM functions effectively.	High Risk	High risk
	GovH2	Strong leadership		Moderate Risk	
	GovG3	Strong coordination mechanisms		Moderate Risk	

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
Accountability	AH1	Programme performance results are available and accessible through public domain	HIV Epidemiological Profile is being prepared by HIV/STI National Programme. Reports are available publicly. Data for some KAPs is not available; data disaggregation and analytical part remain weak. Global AIDS Response Progress (GARP) reports are produced and available on the UNAIDS website. Funding matrix files can be obtained upon request. As of September 2016, last AIDS spending data submitted to UNAIDS was from FY 2012/2013. NASA reports up to FY2012/2013 are available. However, cross-tabulation of spending by beneficiary populations all program areas by financial sources is not available. Program evaluation specific reports are not available. Only GARP report and GF PUDR provides some outcome indicators. Enabling Environment Index for civil society organizations - EEI= 0.55 There are no laws or policies that restrict civil society from playing an oversight role, and civil society is actively engaged in providing oversight.	Low Risk	Low Risk
	AG2	Enabling Environment for Civil Society engagement		Low Risk	
PROGRAMME					
Service Delivery	SH1	Treatment	Percentage of adults and children receiving ARV out of total number of PLHIV though has been increasing over the last three years, did not exceed 33% in 2015. ART coverage remains far below the Fast-Track treatment targets. Treatment cascade is suboptimal. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV is declining over the last three years- from 90% in 2013 to 60% in 2015. PMTCT is integrated with PHC/Maternity care. PMTCT services are available for pregnant women attending antenatal services in both, public and private clinics; though data from private sector is not collected. HIV and TB services are integrated within the PHC system. Family nurse practitioners are legally empowered to manage diseases in primary care facilities inclusive of HIV. The coverage of general population with testing has been on rise since 2004. Data based on rigorous Bio-BSSs regarding the two indicators - coverage of MSM and sex workers with prevention services is missing; therefore the indicators were qualified as "worsening" the coverage. The MoH has practiced social contracting mechanism in health sector.	High Risk	Moderate Risk
	SH2	Integrated services		Low Risk	
	SH3	Key populations reach with preventive services		High Risk	
	SG4	CSOs contracting in health		Low Risk	
Organizational Capacity	OH1	Strong management of the National Disease Programme Management Entity	There is strong national programme management capacity within the MoH that serves as TGF PR and also manages the national HIV programme. TGF funded	Low Risk	Moderate Risk

COMPONENT	INDICATOR ID	INDICATOR	DESCRIPTION	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
	OH2	Procurement & Supply Management	procurement is conducted using national system in compliance with state procurement regulations. Supply chain management is integrated into the national system. Stock outs for ARV drugs, including for 1st line ARV drugs, happens few times a year. Emergency procurements of drugs become necessary due to frequent stock outs. ARV drugs price from 2011 through 2014 followed similar trend of that for UMICs. However, in 2015, the price in Jamaica skyrocketed. Analytical capacity at MoH is adequate to produce reports, such as GARP, NASA. However, the quality of the reports is not optimal. Reports are more descriptive and analytical part is weak. TGF Concept Notes and National strategic Plans are based on the evidences generated from program data or researches.	Moderate Risk	
	OH3	Monitoring & Evaluation		Moderate Risk	
Transition Planning	TH1	Legally binding and actionable Transition plan / Transition elements	Jamaica initiated working on its transition process in 2016. There are some plans from the GoJ to start absorption of certain portion of HIV/AIDS costs starting from 2016, and they are included in the NISP. However, the NISP has not yet approved by Government resolutions and, thus has limited legal power. Transition plan in Jamaica has not yet been developed. Once the plan is developed and approved, the data in the TPA tool can be updated and the risk will be recalculated.	High Risk	High Risk
	TH2	Transition plan / Transition elements characteristics		High Risk	
TRANSITION RISK SCORE FOR HIV/AIDS				**26.92%**	High to moderate risk

Annex 2: Table of Key Indicators

T.11 DEMOGRAPHIC AND SOCIAL INDICATORS

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Population, total (thousands)	2,643.6	2,653	2,662.5	2,671.9	2,681.4	2,690.8	2,699.8	2,707.8	2,714.7	2,721.3	2,725.9
Population growth (annual %)	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.2	0.2

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Population ages 0-14 (% of total)	30.4	29.8	29.2	28.6	27.9	27.1	26.5	25.7	24.9	24.2	23.6
Life expectancy at birth, total (years)	73.4	73.7	74.0	74.3	74.6	74.8	75.1	75.3	75.5	75.7	
Inflation, consumer prices (annual %)	15.3	8.6	9.3	22.0	9.6	12.6	7.5	6.9	9.3	8.3	3.7
Poverty headcount ratio at national poverty lines (% of population)	14.8	14.3	9.9	12.3	16.5	17.6		19.9			
Unemployment, total (% of total labor force) (modeled ILO estimate)	10.9	9.6	9.4	10.6	11.4	12.4	12.7	13.7	15.0	13.2	

Source: The World Bank Data Base

T.12 MACROECONOMIC AND HEALTH FINANCING INDICATORS

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
GDP per capita (current US$)	4238	4487	4817	5119	4489	4902	5332	5446	5254	5119	5138
GDP per capita growth (annual %)	0.5	2.5	1.1	-1.1	-4.8	-1.8	1.4	-0.9	0.3	0.5	0.7
GINI index (World Bank estimate)											
Revenue, excluding grants (% of GDP)	30.7	31.6	32.3	31.7	32.5	31.3	30.4	31.4	32.4	31.1	
GNI per capita growth (annual %)				0.2	-6.1	0.0	2.0	1.4	-0.7	0.2	
GNI per capita, Atlas method (current US$)	3920	4230	4480	4750	4500	4570	4810	5240	5300	5200	5010
Health expenditure, total (% of GDP)	4.1	4.2	4.9	5.4	5.2	5.3	5.2	5.7	5.9	5.4	
Health expenditure per capita (current US$)	170.7	187.1	230.5	272.6	229.1	255.7	273.3	302.9	305.9	266.2	
Health expenditure, public (% of government expenditure)	3.5	4.5	5.5	6.4	5.5	8.5	6.5	7.1	9.7	8.1	

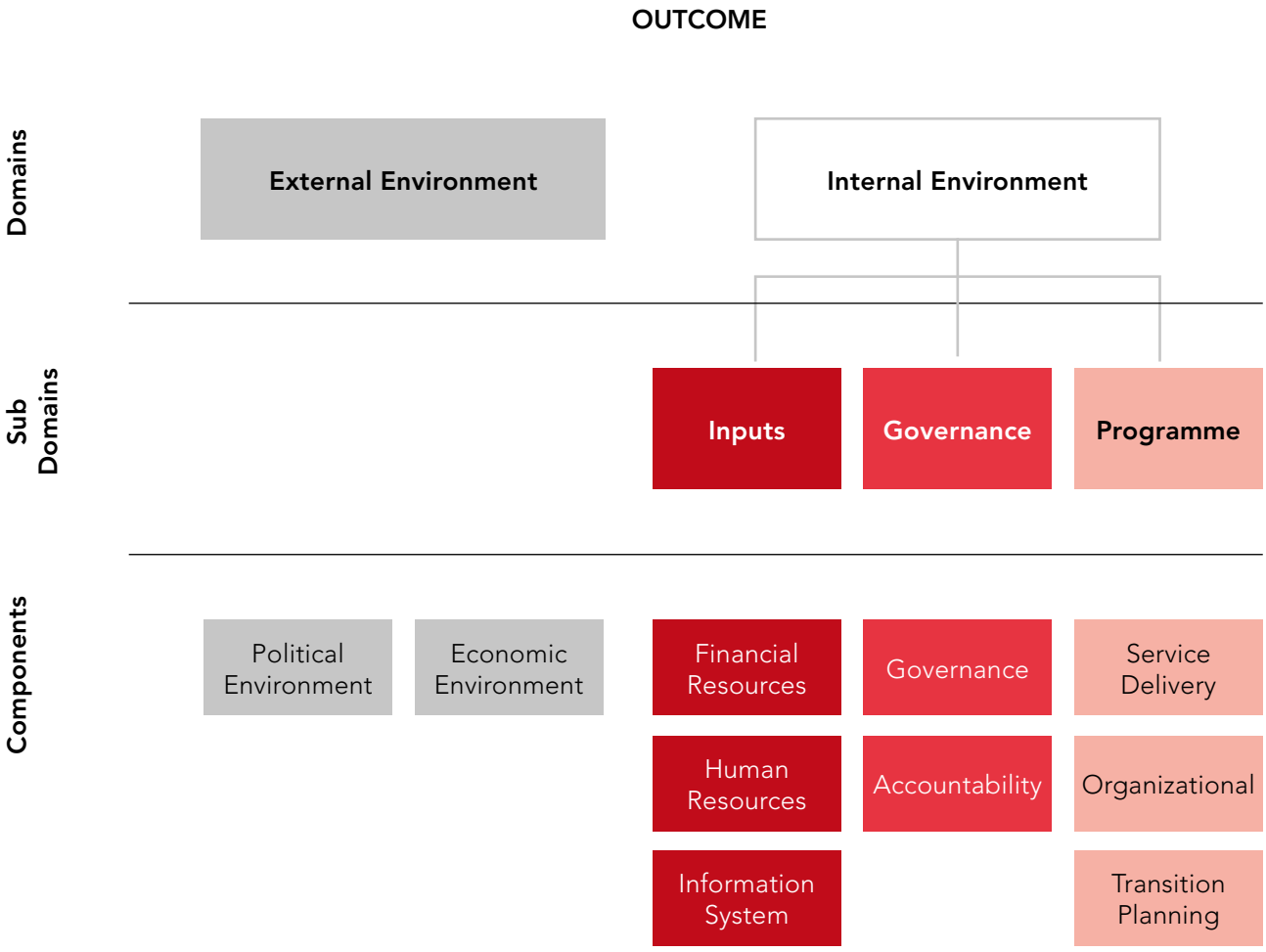
Source: The World Bank Data Base

Annex 3: Methodology

TPA Framework is divided into two domains: the external environment and the internal environment.

The external environment encompasses the elements outside of the health sector and covers political and economic environment and the internal environment of the program, further sub-divided into three sub-domains of inputs, governance and program represent the factors within the health sector. Sub-domains are further divided into components affecting transition as well as the sustainability of the public health programs, after graduating from donor support. The final expected outcome of this process is the successful transition when programme outcomes are either retained and or enhanced.

F.10 **TPA FRAMEWORK**



Source: Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. (2016). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation.

The **Inputs** entail the resources currently available for the disease-specific programme. The resources are subdivided into **financial resources, human resources and health information systems.** Financial resources are assessed by examining the budgetary commitment and financial dependence on donor/external funding for both diseases, and by looking at the prioritization of investments for preventive and treatment interventions, especially for epidemiologically important population groups. Human resource component is measured by assessing the availability of sufficient human resources, the institutionalization of donor-supported trainings; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale. Health Information Systems is assessed by evaluating the integration of comprehensive routine statistical reporting in the national health information system(s) for both diseases, as well as by evaluating HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, funding sources and integration of the data in the national reporting.

Governance sub-domain includes the actors/ institutions involved at an organisational level, how they make decisions, their roles and motivations towards the adequate transition of disease programmes and their relationship with other actors. Identified enabling factors related to governance are sub-divided into **governance**-specific factors and **accountability**. Governance-specific factors include a strong political commitment to the disease treatment and fostering political support for the programme; effective leadership/ management ensured through a legally empowered organization and the existence of champions/ individuals that advocate for and/or manage the disease-specific programmes; and appropriately coordinating all parties involved in the programme through a dedicated, legally empowered and well-functioning coordinating body.

Programme sub-domain encompasses the activities included within the health programme and the operational capacity to implement these activities. It is composed by **service delivery, organizational capacity** and **transition planning** components. Within service delivery we look at integration for certain services, service coverage and treatment outcomes. Concerning the organizational capacity to provide services, management of the national disease programmes; procurement mechanisms; and the existence of appropriate monitoring and evaluation mechanisms, including adequate analytical capacity, is crucial for the effective transition of these disease programmes. A direct measure of forward thinking disease programs currently receiving external funding is the ability to plan the take-over of responsibilities both at the programmatic level and in terms of funding. The appropriate tracking of the transition process requires transition planning through strategies that align the programme with national policies that are informed by international guidance and/or evidence; programme management arrangements to assure appropriate transfer of responsibilities; and an effective monitoring and evaluation of the transition.

Quantitative and/or qualitative indicators are used for each component measurement. These indicators assess possible risk for transition using a scoring system 2=low or no risk, 1=medium/ moderate risk and 0= high risk. The indicators are converted into numerical values, and risk category is assigned to each component according to the overall scores. To define a country's overall risk, scores for each category are summarized and aggregated, based on the percentage of scores accumulated for all domains/sub-domains/categories. Weighting was not applied during the scoring approach. A summary score for a disease identifies the overall risk for the program transition and the components scores identify areas that pose the highest risk and should be addressed during the transition process.

Annex 4: List of Reviewed documents

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9. GARP Funding Matrix. Jamaica. 2016

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31. National AIDS Spending Assessment (NASA) report. Jamaica 2014

32. National AIDS Spending Assessment (NASA) report. Jamaica 2014

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35. National Integrated Strategic Plan for HIV 2014-2019

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37. National Survey on Homophobia, Jamaica. 2012

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39. NCPI Report. Jamaica. Ministry of Health. 2013

40. PAHO/WHO Health in the Americas 2012

41. PEPFAR/JAMAICA Country Work Plan; October 2015 - September 2016

42. PLACE Worker and Patron Survey. Jamaica 2014

43. Recommendations for efficient resource allocation and prevention strategies, 2012 UNAIDS

44. Strengthening Adolescent Component of National HIV Programmes through Country Assessments in Jamaica. Preliminary Report of Rapid Assessment. May 1, 2015

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Health Sector to Improve Effectiveness, Efficiency and Quality of Care in Jamaica. Report Phase I. Government of Jamaica

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57. UNICEF, Synthesis Report of the Rapid Assessment of Adolescent and HIV Programme Context in Five Countries: Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe.

Annex 5: List of Interviewed People

NAME	ORGANISATION /Position
CIVIL SOCIETY ORGANIZATIONS (CSOs)	
Ricky Pascoe	President, Jamaica Network of Sero-positives (JNPLUS)
Neish McLean	J-FLAG
Conroy B. Wilson	Executive Director, The Ashe Company
Kandasi Levermore	Executive Director, Jamaica AIDS Support for Life
Claudette Richardson-Pious	Executive Director, Children's First
Mickel Jackson	Project Manager, Jamaica AIDS Support for Life
Karen Dayce	HOPE Worldwide Jamaica
Kendra Frith	Colour Pink Foundation
Monica Brown	Project Coordinator, Caribbean Vulnerable Communities Coalition
Olive Edwards	ICW Regional Coordinator, Jamaica Community of Positive Women (JCW+)

NAME	ORGANISATION /Position
Tanique Robinson	RISE Life Management Limited
Ainsley Reid	National Family Planning Board (NFPB/ GIPA)
Nacia Davis	Jamaica Community of Positive Women (JCW+)
Loreine Graham	JNPLUS
A'Keiha McLean	JNPLUS/ CCM
Althea Cohen	Project Assistant, Jamaica Community of Positive Women (JCW+)
Marlon Taylor	Executive Director, Sex Workers Association of Jamaica (SWAJ)
Sue Anne Wallace-Brown	JNPLUS
Delores Davis-Powell	Jamaica Community of Positive Women (JCW+)
Ms. St. Rachel Ustanny	FAMPLAN; Chief Executive Officer
USAID	
Deborah Kaliel	USAID/ PEPFAR
Anthony Hron	Senior HIV Technical Advisor
Sandra McLeish	"Country Programme Manager, Health Policy Plus/ Palladium Group"
UNAIDS	
Dr. Nkhensani Mabathathe	Acting Country Director; UNAIDS Jamaica
Erva-Jean Stevens	Strategic Information Advisor
Melissa Sobers	Regional Investment and Efficiency Advisor, UNAIDS Jamaica
GOVERNMENT OF JAMAICA	
Coleen White	Chief Policy Analyst, Cabinet Office, Office of the Prime Minister
Nicholette Williams	Director , Intl.Org. Dept., Ministry of Foreign Affairs and Foreign Trade
MINISTRY OF EDUCATION, YOUTH AND INFORMATION	
Phillipa Livingston	Statistician, Policy and Planning Unit
Mrs. Anna Kay Magnus Watson	Director, HIV Health Education, Health and Family Life Education (HFLE)
Mrs. Takesha Shay Barnes	Director of Programme Implementation, Adolescent HIV Programme
Mrs. Michelle Small Bartley	Senior Director, Youth Director
Mrs. Fern McFarlane	Guidance and Counselling Unit
MINISTRY OF LABOUR AND SOCIAL SECURITY	
Mr. Damion Cox	"Chief Technical Director, Labour Division"

NAME	ORGANISATION /Position
Mr. Marlon Mahon	Occupational Health Manager
Ms. Khadera Folkes	Senior Legal Officer
Mr. Conrad Saunders	Project Officer, HIV Unit
MINISTRY OF HEALTH	
Sannia Sutherland	"Director, Technical Coordination and Programme Management"
Dr. J. Brown- Tomlinson	Director, TCS, HST
Dr. Simone Spence	Director, Family Health
Dr. Tanya Green Douglas	Medical Officer, Ministry of Health
Joi Chambers	"Programme Officer, Adolescent Health"
Howard Lynch	Director, Policy and Planning
Jasper Barnett	Director Acting, HSIB
Karlene Temple-Anderson	Grants Manager
Sasha Martin	M & E Officer
Zahra Miller	Director, M&E
Janice Walters	Director, Finance and Administration
Dr. Nicola Skyers	Senior Medical Officer
Paula Prince	Programme Officer
PLANNING INSTITUTE OF JAMAICA	
Barbara Scott	Senior Director, External Cooperation Management
Delores Wade	Senior Economist, ECM
Denise McFarlane	Health Specialist
Stacy-Ann Robinson	Demographer
Mr. Easton Williams	Director, SPRRD
Mrs. Toni-Shae Freckleton	Manager, Policy and Health Unit
Mrs. Saskia Frater Smith	Programme Officer, ECM
MINISTRY OF FINANCE	
Ms. Darlene Morrison	Deputy Financial Secretary
Ms. Alicia Forrester	Programme Officer, International Financing

NAME	ORGANISATION /Position
MINISTRY OF LOCAL GOVERNMENT AND COMMUNITY DEVELOPMENT	
Mrs. Marsha Henry Martin	Director, Urban Planning
Mr. Clive Edwards	Consultant
NATIONAL FAMILY PLANNING BOARD	
Mrs. Dana Morris Dixon	Chairman of the Board
Denise Chevannes	Executive Director
Ms. Andrea Campbell	Director of Health Promotion and Prevention
Mr. Joseph Reynolds	Director, Finance and Accounting
Mrs. Jennifer Williams	Director, H and R
Mr. Devon Gabourel	Director, Sustainability and Environment
Ms. Tazh Moye Crawford	Director, Monitoring and Evaluation
PRIVATE TREATER'S GROUP/ MEDICAL DOCTORS TREATING PLHIV at private clinics	
Dr. Tanya Green Douglas	Medical Officer, Ministry of Health
Dr. Donna Royes Powe	Medical Officer, Correctional Services
Professor Brendan Bain	Honorary Consultant Physician
SOUTHEAST REGIONAL HEALTH AUTHORITY	
Dr. Dutris Bourne	Regional Technical Director
Staff member	HIV/ STI Coordinator
Staff member	Finance Officer
Staff member	Project Administrator
Staff member	Treatment, Support and Care Officer
SOUTHERN REGIONAL HEALTH AUTHORITY	
Dr. Tyrone Roberts	Regional HIV/ STI/ TB Coordinator
Dr. Vitillius Holder	Regional Epidemiologist
Mr. Michael Bent	Regional Director
Miss Jennilyn O'Connor	Regional Pharmacist
Mr. Donovan Leon	Medical Technologist

THE PHILIPPINES HIV/AIDS PROGRAM TRANSITION FROM DONOR SUPPORT TRANSITION PREPAREDNESS ASSESSMENT

Produced by: Curatio International Foundation - APW with UNAIDS 2016/628448

Country report

Author: Tamar Gotsadze, MD., PhD

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Disclaimer

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International consultant: Tamar Gotsadze, MD PhD

Local consultant: Dr. Marilyn Noval-Gorra, MPH, Doctor of Public Administration

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
CCM	Country Coordination Mechanism
CSO	Civil Society Organizations
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GDP	Gross Domestic Product
GNI	Gross National Income
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
KAP	Key Affected Populations
LGBT	Lesbian, Gay, Bisexual and Transgender
MOH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NGO	Non Governmental Organization
NSEP	Needle and Syringe Exchange Programs
OST	Opioid Substitution Therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infections
SW	Sex Worker
TG	Transgender People
TGF	The Global Fund
TPA	Transition Preparedness Assessment
UMIC	Upper-Middle Income Country
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Executive summary

The Philippines country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program, which examines the country's disease program readiness for transition from external support. The research intends to understand the factors affecting HIV/AIDS program sustainability and aims to inform an adequate transition planning process from Global Fund support in Philippines. The assessment has utilized mixed methods entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees included government officials, donor representatives, staff from international organizations and civil society members, among others.

The transition preparedness assessment singles out system-wide and programme level bottlenecks that may impede the sustainability of the national HIV response in the Philippines. A summary score of transition risk (36.7%) indicates that the country is exposed to moderate to high risk. A carefully designed transition plan is needed to ensure that the public health gains achieved through the concerted efforts from the Government of Philippines and donor funded programs are sustained after Global Fund support ends. The findings presented in the report follow the TPA framework and are organized around two overarching domains: the external environment and the internal environment, and various sub-components under each major domain.

External environment

Economic development. The Government of the Philippines fails to ensure continued and sustainable economic growth. The fluctuation in Gross Domestic Product (GDP), couple with a fall in the share of government revenues as percentage of GDP, poses a high risk to the transition and sustainability of Global Fund supported programs.

Political commitment. The political will of the government, as expressed in investment in health, is not adequate. Although out of total government expenditure the Philippines spends a substantial share of the public budget on health and maintains a steady growth in health expenditures, the observed levels of budgetary spending on health still remain below of the Low Middle Income Country (LMIC) average. Furthermore, there is a lack of regulations and/or adequate enforcement of laws protecting Key Affected Populations (KAP), which increases the overall risk arising from political environment. The Civil Society Organization (CSO) contracting for service provision has been put into practice in the past; however, complicated contracting requirements to access public funding have been introduced recently that demotivate the CSO sector to tap public funding. This, in turn, may cause the discontinuation of CSO provided prevention and outreach services when external funding ends and puts the country at a high risk.

Internal environment

Financing: The Philippines has prioritized HIV treatment interventions for public investment and has taken decisive steps to eliminate treatment dependence on external funding. However, while replacing donor funds for treatment with national resources is visible, a more aggressive pace might be warranted for transitioning funding of preventive services for KAPs, who are mostly donor dependent and face numerous barriers.

Human Resources: After transition from TGF support, challenges are also expected to emerge in the retention of already practicing professionals, as well as in the production/ reproduction of adequately trained health and CSO cadre. Most likely, sustaining the current training efforts will not be possible due to the lack of institutionalization of TGF supported trainings and knowledge dissemination. The availability of well-trained and appropriately distributed human resources is crucial for the program's success. This is even more critical in a transition scenario due to the importance of continuing care for patients with HIV[1]. Such challenges in donor-funded trainings are not only relevant to the Philippines and/or to TGF; they also have greater implications for other countries and donors alike[2]. Moreover, tackling these problems during the transition period may not be feasible due to numerous structural barriers observed: i.e. the lack of an adequate cadre of trainers in established training institutions, the lack of state support/ funding for such training, etc. To achieve sustainability, it seems essential to address these challenges with the help of well thought through mechanisms that enhance human resource production for health. Whatever mechanisms will be developed for these purposes, it is critical to ensure that they are self-sustainable and scalable to deliver long-term sustainability.

Information Systems: The Philippines has an advanced health information system and routinely collects the necessary information that can be used in program evaluation and/ or intervention planning at the national level. Progress has also been attained in the institutionalization of a robust secondary surveillance system in the country, which has been fully funded from the public purse. Nevertheless these achievements were not without limitations. The unified surveillance system combining prevention, treatment and adherence information is functional at the national level but is still mostly paper-based. At local levels the system remains fragmented; the information system does not incorporate HIV incidence; data on treatment, retention and TB-HIV co-infection is also limited; and the system uses a mixture of electronic and paper based data collection methods. Nevertheless, it seems possible for the remaining challenges to be addressed during a well planned transition, with the exception of analytical capacity limitations that could remain for a while due to structural limitations in the education sector and public sector employment.

Developing and enforcing accountability mechanisms to ensure commitments remain key drivers for sustainability. This requires communicating performance results through the public domain, including reporting expenditure data and targeted activities for KAPs. Moreover, since most efforts to hold actors accountable are conducted by civil society organizations, it is therefore crucial to enhance the enabling environment in which civil society organizations operate[3].

Governance: The Government remains committed to continuing the HIV national program. A new national program (AMTP 6) has been developed and awaits governmental approval. However, the lack of independence and resource base (budget) that limits the effective operation of the National AIDS Council (PNAC) poses risks to the transition and sustainability of the national AIDS response. While the Department of Health (DOH)

[1] Building Resilient and Sustainable Systems for Health: the Role of the Global Fund, The Global Fund, 2015.
[2] Vujicic M., Weber S.E., Nikolic I.A., Atun R., Kumar R. 2012. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. Health Policy Plan. (2012 27 (8 : 649-657. doi: 10.1093/heapol/czs012.
[3] T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio International Foundation, 2015

remains as the chair of the plenary, the PNAC resource base must not remain dependent on DOH only. The PNAC must urgently find a way of mobilizing resources within the Philippine bureaucracy through member agency budgets and from development partners, so that it maintains its autonomy. Planned and ongoing reforms may mitigate these risks if implemented appropriately and may lead to a smoother transition from TGF funding. The Philippines has a good enabling environment for civil society engagement, maintaining rich performance data and offering stakeholders easy access to the required information. Streamlining the national program coordination function and ensuring easy access to program performance information[4] are expected to minimize challenges during transition.

Program. The government's willingness to sustain an effective national response towards the HIV epidemic is encouraging. However, in order to achieve a positive public health impact with possible financial limitations, the country has to ensure an effective coverage of KPs by improving the allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed by reinforcing prevention activities; building linkages between the health sector and non-governmental and social service providers; streamlining patient pathways among TB and HIV service providers; and enhancing follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges the Philippines will face after transition from TGF support.

Organizational Capacity. There are several prerequisites for a smooth transition and attaining the desired public health gains. They are: strengthening the organizational capacity of national program implementers and service providers, including CSOs[5]; streamlining procurement functions to allow the procurement of HIV commodities at a lower price by deploying procurement practices from international platforms as in case of drugs; and enhancing M&E and evidence based program planning and implementation.

Overall transition readiness. The assessment of the transition readiness of HIV/AIDS programs revealed that the Philippines faces a moderate to high risk after TGF support ends. Early transition planning that addresses the riskiest areas of the program and systems as well as effective implementation will allow the country to experience a painless transition and ensure the sustainability of national programs.

Recommendations

Recommendation #1: Create an enabling legal environment - Enhance anti-discrimination protection through legislative changes to promote the human rights of KAPs, people living with HIV (PLHIV), vulnerable communities and providers of HIV services through: i) Adoption of revised HIV/AIDS legislation that protects KAPs and allows access to needed services, including legislation supporting harm reduction; ii) Revision of regulations hampering KAP access to HIV/AIDS preventive, treatment, care and support services; iii) Promotion and approval of a range of measures and interventions aimed to prevent stigma and discrimination among the general population.

Recommendation #2: Create government capacity to mobilize additional financial

[4] Transparency and streamlined accountability: what watchdogs, grant implementers and OIG want, Aidspan, 2015 http://www.aidspan.org/node/3354.
[5] T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio Internataional Foundation, 2015

resources for health through: i) Mobilization of domestic funding in support of national HIV/AIDS programme from other sectoral ministries, Local Government Units (LGU) and the private sector; iii) Introduction of separate budget line for the HIV/AIDS program in the budgets of all involved line ministries, including DOH and LGUs; iv) Use available resources efficiently and effectively. Investments should be strategic and geared towards prevention interventions targeting KAPs and in areas where most infections come from; v) Increasing the share of public funding for preventive services; vi) Introduction of a dedicated budget line for outsourcing outreach and case management services to CSOs under the HIV Program; vii) Institutionalization of a functioning monitoring mechanism that generates and collects financial information at the local level in order to provide a more accurate picture of spending levels in the country.

Recommendation #4: Ensure an adequate and continuous supply of qualified human resources. Human resources (HR) pose a larger problem to the national health care system, and even though the HR shortage will certainly affect the sustainability of the HIV program, this problem may not be resolved during the transition period and only for HIV/AIDS program. However, within the new Global Fund allocation for the years 2017-2020 the Philippines may request assistance for the development of a comprehensive policy for the production/training of HR in health under the HSS component of the grant. There is a need to: i) Revisit staffing plans for effective service provision; ii) Explore the feasibility of institutionalizing accredited practical training and internship programs for students from relevant faculties (medical, social workers, statistician, psychologists, juridical, etc.) in HIV service organizations. Students, in exchange for academic credits can be deployed in service areas where staff shortage is most severe; iii) Ensure the integration of HIV training modules into the continuous education systems with the potential of further integration of the HIV training modules into the undergraduate education systems in a long-term perspective; iv) Elaborate a training and capacity building strategy for NGOs/CSOs.

Recommendation #5: Improve the effectiveness of the coordination function at national and local levels for better programmatic planning, budgeting, implementation and M&E. In order to enhance the coordination function, there is an urgent need to: i) Reform the Philippines National AIDS Council (PNAC) as the main governance platform to guarantee efficiency and effectiveness of its operation in addressing the HIV epidemic and ensure its autonomy by changing its place in the government hierarchy; ii) Enhance coordination at local levels by revisiting the role of the Local Authority Councils (LAC) in the overall national response; iii) Supporting local responses from the national level on how to access funds and plan programs; and iv) Allow PNAC to regularly monitor implementation of local responses and provide support and advise on corrective measures when needed.

Recommendation #6: Streamline service delivery. Removing barriers to HIV testing and treatment through strengthening cooperation between the governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services is of high importance. This can be achieved by improving timely and complete diagnosis, the prompt prescription of correct treatment and good adherence to ART. Priority should be given to ensure the full integration of PMTCT services into primary and perinatal care and the expansion of HIV outpatient treatment insurance package by adding case detection/diagnosis and treatment adherence support, which will allow the minimization of lost follow-up cases.

Recommendation #7: Create an enabling environment for CSO contracting to ensure that CSOs are engaged in HIV prevention services through government funding. To ensure continuation of preventive services when external funding ends, the government is advised to: i) Develop/revise the detailed SCO contracting rules/procedures to ensure delivery of preventive services; ii) Initiate an open, results oriented and constructive policy dialogue between the government and civil society to explore potential solutions to liberalize SCO accreditation process; and iii) Consider establishing umbrella CSO Organizations or networks to allow the continued engagement of CSOs in the provision of preventive services to KAPs.

Recommendation #8: Strengthen the organizational capacity of all involved stakeholders including government institutions and CSOs to ensure greater sustainability. The capacity of the national program management structure at DOH should be strengthened through the establishment of an effective management team with adequate staffing positions. To increase the sustainability of local NGOs, there is a need to enhance their advocacy efforts, promote the sustainable development of professional and local communities, and improve the quality of services delivered by NGOs to the communities. Activities include organizational capacity development, specialized training for NGO management, M&E, financial management, organizational strengthening and proposal writing. Topics can be prioritized based on a training needs assessment to increase their capability and competitive power for fundraising in a resource constrained environment.

Recommendation #9: Develop a transition plan, integrate it into the new AMTP annual operational plan and closely monitor its implementation. To safeguard a smooth transition from external funding, the Government should: i) Develop a time-bound and actionable transition plan with adequate indicators to monitor implementation, and ensure the incorporation of this plan into the AMTP6 and Annual Operation plans; ii) Ensure sufficient resources are available for transition by preparing a budget for AMTP 6 which includes transition plan elements; and iii) Ensure that the PNAC is charged with the mandate, equipped with the competence and legal power and assumes the responsibility for coordination, planning, implementation and monitoring of the transition process.

T.1 TRANSITION PREPAREDNESS ASSESSMENT FOR HIV/AIDS - SUMMARY TABLE

COMPONENT	INDICATOR	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
EXTERNAL ENVIRONMENT			
Political Environment	Existence of political will to prioritize health investments	High risk	High risk
	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases & Rule of Law	High risk	

COMPONENT	INDICATOR	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
	Government ability to contract with CSOs; CSO contracting practices	Low risk	
Economic Environment	"Favorable economic indicators	High risk	High risk
INTERNAL ENVIRONMENT			
Inputs			
Financial resources	Budgetary commitment to disease	High risk	High risk
	Prevention priority	High risk	
	Allocative efficiency	Low risk	
	Treatment / input financing from public sources	Moderate risk	
	Prevention financing from public sources	High risk	
Human Resources	Sufficient human resources for disease (quantities, geographic distribution and aging)	Moderate risk	High risk
	Institutionalization of donor supported programs; Existence of policy for production/ training of CSO personnel (non-medical, social service; Donor funded HR salaries aligned with national pay scale	High risk	
Information Systems	Routine statistical reporting R Integration in the national system	Moderate risk	Low risk
	Routine statistical reporting R Level of advancement	Moderate risk	
	HIV Second generation surveillance Methodologies, Timeliness	Low risk	
	HIV Second generation surveillance Funding from public sources	Low risk	
Governance			
Governance	Strong political commitment to diseases	Low risk	Moderate risk
	Strong leadership	Low risk	
	Strong coordination mechanisms	High risk	
Accountability	Program performance results are available and accessible through public domain	Low risk	Low risk
	Enabling environment for Civil Society engagement	Low risk	
PROGRAM			
Service Delivery	Treatment	Moderate risk	High risk
	Integrated services	High risk	
	Key populations reach with preventive services	High risk	
	CSO contracting in health	Moderate risk	

COMPONENT	INDICATOR	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
Organizational Capacity	Strong management of the National Disease Program Management Entity	Low risk	Moderate risk
	Procurement & Supply Management	Moderate risk	
	Monitoring & Evaluation	Moderate risk	
Transition Planning	Legally binding and actionable Transition plan / Transition elements	High risk	High risk
	Transition plan / Transition elements characteristics	Moderate risk	
	Transition M&E	High risk	
Transition risk score for HIV/AIDS-36.7%			Moderate risk to high risk

1. Introduction

Purpose of the assessment: As the Philippines moves towards middle income country status and donor support for AIDS begins to wind down, the need for a rapid and sustainable increase in domestic investment is becoming more urgent. Equally importantly, the country needs to ensure that the available limited public resources are spent where they will have the most impact. The country report draws on the findings of the Transition Preparedness Assessment (TPA) of the HIV/AIDS program. The assessment examines the country's disease program readiness for transition from external support. The TPA identifies areas of high, moderate or low risk for successful transition and outlines the necessary steps towards programming for sustainable transition. The assessment follows the TPA Framework for data collection, analysis and transition risk assignment. The TPA Framework was developed by Curatio International Foundation with Global Fund financial support. Details of the TPA Framework are provided in Annex 2.

Main definitions: The Global Fund's definitions of transition and sustainability used in the report are:[6]

- Transition is *"the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate".*

- Sustainability - *"the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after the removal of external funding by the Global Fund and other major external donors".*

Beneficiaries of the assessment: The TPA findings provide valuable information

[6] The Global Fund Sustainability, Transition and Co-financing Policy. Board Decision. GF/B35/04 – Revision 1. 35th Board Meeting. 26-27 April, 2016

primarily to national stakeholders for the transition plan development or incorporation in the National Disease Strategy. In addition, the assessment findings will be useful for the donors, particularly the Global Fund, to guide the country through the transition process.

Structure of the report: The report is divided into five main sections, starting with an introduction to the report, a brief explanation of the methodology used, followed by a chapter that sets the stage by explaining the main HIV epidemiological trends and the grants that the country received from TGF. Chapter 4 presents the main findings by assessing the enabling, external and internal environments for transition. Chapter 5 provides a discussion of the main opportunities and challenges in the Philippines and provides general conclusions and recommendations for the transition to programmatic sustainability.

2. Methodology

The assessment utilized mixed methods entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders: government officials, donor representatives, staff from international organizations, civil society members, and those directly working with donor supported programs. They were identified based on their relationship with these grants as well as through the snowball technique. The quantitative and qualitative data were triangulated in line with the TPA framework domains, sub-domains and components.

During the country mission, CIF consultants met and interviewed more than 40 individuals including representatives of the Senate, the Philippines AIDS Council, the Department of Health, the National Economic Development Agency, the Department of Education, the Department of Budget Management, the Health Insurance Agency, and other government agencies; the UNAIDS local team, representatives of local civil society organizations targeting PLHIV, MSM, sex workers and other vulnerable populations, and other development partners (Annex 4). No site visits were conducted; instead, skype conference calls were organized with Regional Health Authorities.

More than 50 documents and online sources were reviewed, including national level documents about national budgets, health sector development, HIV/STI strategic plans, Global Fund concept notes and progress reports, National AIDS Spending Assessment reports, Global AIDS Response Progress (GARP reports), HIV related surveys, the Aids Medium Term Plan evaluation report, biological behavioral surveillance surveys, and other operational research and publications.

3. Setting the stage

This background and its relationship to the transition will be addressed further when the report discusses the external and internal environment in more detail. However, as a necessary first step, in this section we describe the context in which the Global Fund began to provide funding for HIV/AIDS in the Philippines and how the epidemiological trend has evolved since.

3.1 The context

Demographics: The Philippines has an estimated population of 100.7 million[7] with an annual growth rate of about two percent. Rapid population growth puts stress on the country's economic resources and negatively affects the delivery of social and health services. Rapid population growth has contributed to widespread unemployment in the Philippines. A shortage of available jobs in the country has pushed an estimated seven million Filipinos to work overseas. Although life expectancy at birth increased from 66 years in 2000 to 68 years in 2014, high rates of adult morbidity and mortality, especially among the working age population, coupled with the changing age and gender structure of the population have significant challenging economic and social consequences.

Brief description of health system: 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 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. Overall, assuring access to health services remains the fundamental objective for the government. However, problems persist with the quality and effectiveness of these services. Attempts to improve health outcomes through various reforms in the public health care system are continuously being pursued.

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

[7] World Bank database, www.worldbank.org accessed on December 2, 2016

DOH budget. A comparison of the allotments and actual spending of the "obligated funds", however, points to underutilized 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[8].

While the DOH 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.

As a third-party payer, PhilHealth, the Philippine Health Insurance Corporation, regulates the accreditation of health providers that are in compliance with its quality guidelines, standards and procedures and procures services for the insured population. Under the National Health Insurance Program (NHIP) of PhilHealth, PLHIVs are eligible for outpatient benefits. The Outpatient HIV/AIDS treatment (OHAT) package was introduced in 2010[9]. This benefit aims to increase the proportion of the population with access to an effective AIDS treatment package in PhilHealth, which is a critical step in guaranteeing the sustainability of access to Antiretroviral treatment (ART) packages. The benefits cover outpatient routine ART monitoring e.g. laboratory tests, CD4 count, and to some degree, even the cost of in-patient treatment for opportunistic infections[10].

The Food and Drug Administration (FDA) regulates pharmaceuticals along with food, vaccines, cosmetics and health devices and equipment. The DOH ensures centralized procurement of medicines for PLHIV and distributes these to the local areas, whilst LGUs procure all other commodities through their own LGU bids and awards committees. DOH is attempting to restore some of the purchasing power lost during devolution through the establishment of pooled procurement mechanisms[11].

3.2 HIV/AIDS epidemiology overview

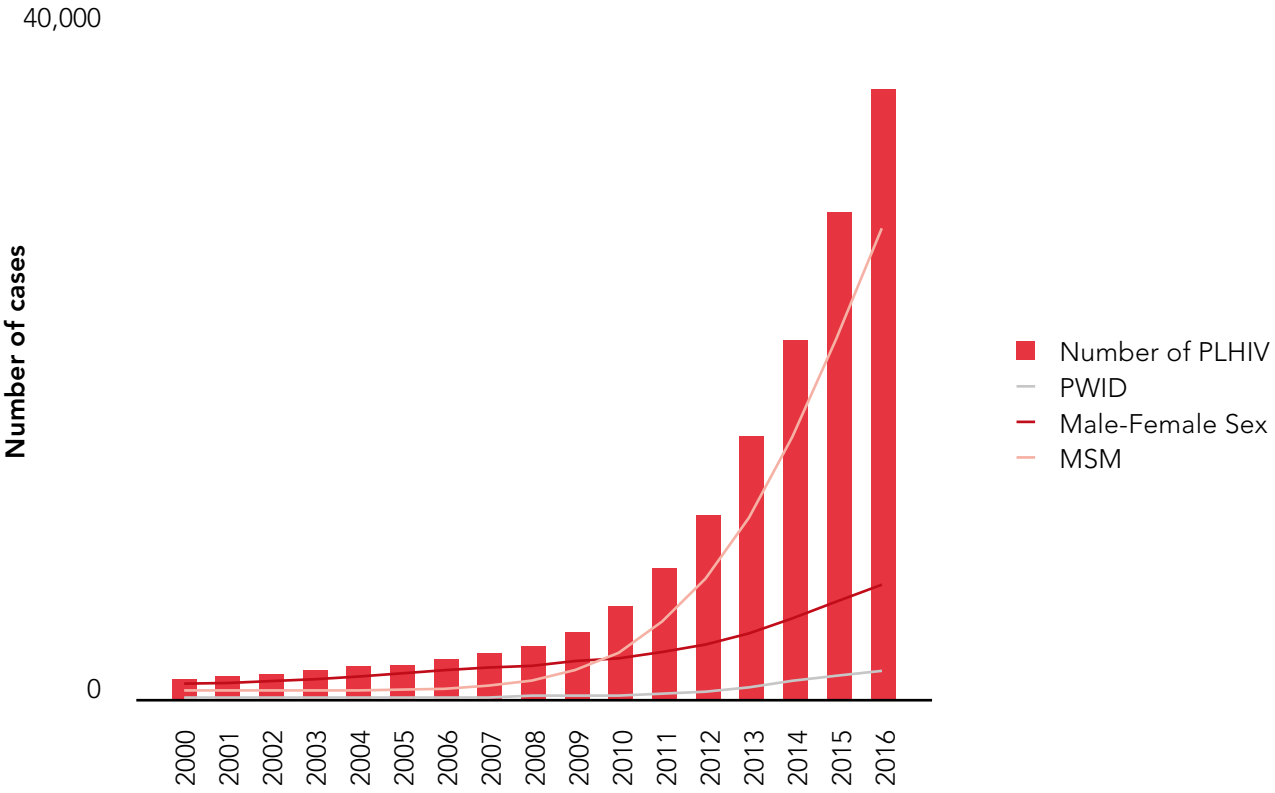
The Philippines is at a critical juncture in its response to HIV and AIDS. After more than two decades of low HIV prevalence and slow expansion, the country is now on the verge of an explosive epidemic[12] (Figure 1). In total, by October 2016, 38,114 HIV sero-positive cases were reported, out of which 20% were registered only in the period January to October 2016 and 84% of all diagnosed cases in the Philippines were reported from January 2011 to October 2016. While one new

[8] The Philippines Health System Review, WHO, 2011
[9] Standard Concept Note, The Global Fund, 2014
[10] Global AIDS Response Progress Report, Philippines, PNAC 2014
[11] The Philippines Health System Review, WHO, 2011
[12] Global AIDS Report, UNAIDS, 2012

HIV case was diagnosed per day in 2008, as of October 2016, 26 new cases are recorded each day. Apart from a growing epidemic, this sudden growth of new cases starting from 2008 could partially be attributed to increased donor support, which has created greater diagnostic and outreach capacities and funds CSOs to reach MSM.

F.1

CUMULATIVE NUMBER OF HIV TRANSMISSION BY YEAR, JANUARY 1984-OCTOBER 2016[13]



HIV infection predominantly affects the male population (93% of all cases), but the absolute number of cases among females is on the rise. The age group with the biggest proportion of registered cases has become younger since 2001. From 2011 to 2016 (October), newly diagnosed HIV cases among young key affected populations (YKAP) increased by 230%, out of which male to male sex and males who have sex with both males and females were the two predominant sources of infection transmission (58% and 26%, respectively)[14]. There were also 9% who were infected from sex between males and females.

[13] HIV/AIDS and ART registry of Philippines, DOH, Epidemiology Bureau, October, 2016
[14] HIV and ART Registry of the Philippines (HARP . Department of Health – Epidemiology Bureau, Manila, Philippines. December 2015.

T.2 REPORTED MODES OF HIV TRANSMISSION[15]

	JAN 2011- OCT 2016N=32,099		CUMULATIVE JAN1984—OCT 2016 N=38,114	
	M	F	M	F
Sexual Contact	29,165	1,338	33,408	2,511
Male-Female Sex	3,146	1,338	4,461	2,511
Male-Male Sex	15,798	0	17,65	0
Sex with Males & Females	10,221	0	11,297	0
Blood/Blood Products	0	1	5	15
Sharing of Infected Needles	1,456	80	1,593	98
Needle Prick Injury	0	0	2	1
Mother to Child	30	24	58	48
No data available	5	0	287	77

Notably, 7% (85) of all new infections among adolescents were transmitted through sharing of infected needles. This alarming increase in new HIV cases is consistent with the doubling of HIV prevalence particularly among adolescent males/transgender and men who have sex with men (MSM) in the past five years[16]. Evidence from both the HIV/AIDS & ART Registry of the Philippines (HARP) and the 2015 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) indicate an escalating HIV problem among Filipino adolescents.

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. Among females, male-female sex was the most common mode of transmission (1,338 or 48%) followed by sharing of infected needles (80 or 6%)[17]. IBSS also showed that HIV prevalence (see Table 3) increased among MSM and Female Sex Workers (FSW), particularly among freelance sex workers.

[15] HIV/AIDS and ART registry of Philippines, DOH, Epidemiology Bureau, October, 2016
[16] The Growing HIV epidemic among adolescents in the Philippines, National HIV/AIDS & STI Surveillance and Strategic Information Unit Epidemiology Bureau, Department of Health, 2015
[17] HIV/AIDS and ART registry of the Philippines, DOH, Epidemiology Bureau, October, 2016

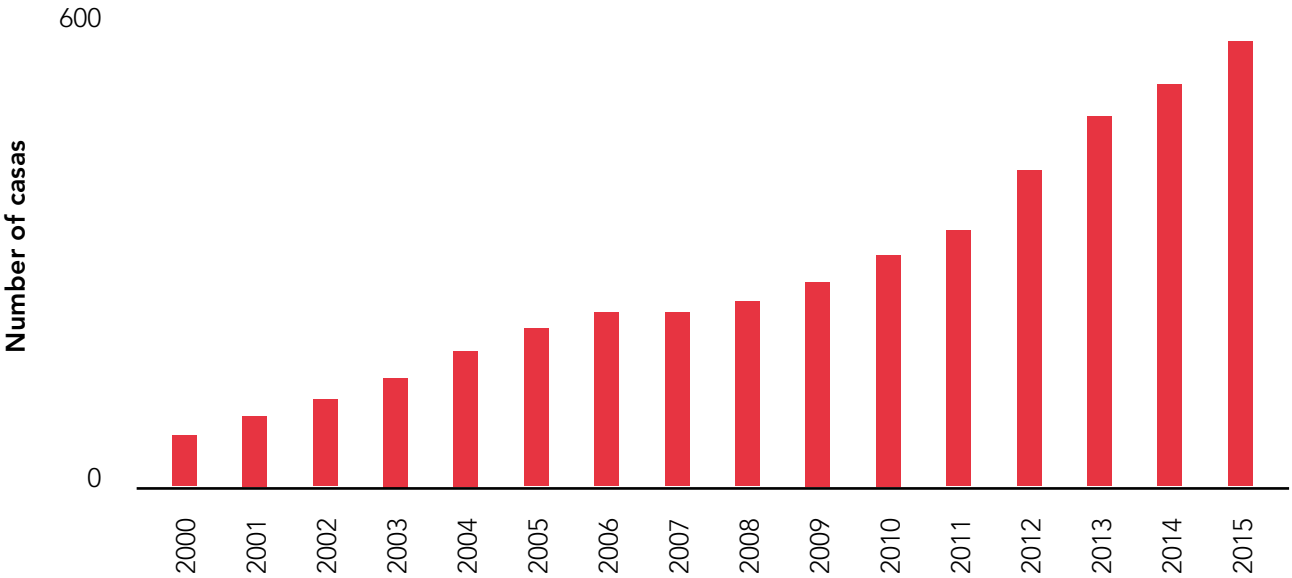
T.3 HIV PREVALENCE AMONG MSM, PWIDS AND SW IN SENTINEL SITES 2007-2015[18]

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

Geographically, reported cases are concentrated in three highly urbanized areas: Greater Metro Manila Area (which includes the provinces adjacent to Metro Manila like 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.

F.2 TREND IN AIDS DEATH CASES 2000-2016[19]



[18] IHBSS studies, DOH, Epidemiology Bureau
[19] Aids Info, UNAIDS Spectrum Analysis, http://www.aidsinfoonline.org/devinfo/libraries/aspx/dataview.aspx, accessed on 5.12.2016

According to UNAIDS spectrum analysis, the cumulative number of AIDS death is estimated to be about 4,500 cases, 50% of which took place between 2011 - 2015 (Figure 2). However, according to the Philippines HIV/AIDS and ART register, a total of 1,912 deaths were registered since the first case of infection in 1984 up until October 2016, 88% of which were male. Of the reported deaths, almost half (47%) belonged to 25-34-year age group, 29% were in the 35-49-year age group, while 14% were youth aged 15-24 years old. 16% were reported deaths among those who were infected through mother-to-child transmission (MTCT). The epidemiological, biological and behavioral data clearly indicate that the country is facing a fast growing HIV/AIDS epidemic which has not yet been brought under control. If the Philippines does not act now, the epidemic could spiral out of control.

3.3 Funding overview

In the Philippines, HIV/AIDS spending from international sources has been steadily decreasing since 2013. In 2015 spending from external sources represented only 35% of total HIV/AIDS spending, with the Global Fund being the biggest contributor. Other international sources include various UN agencies and USAID[20]. Since 2004, the Global Fund has allocated more than US$ 44 million to support the response to HIV in the Philippines. This consisted of the five grants described in Table 4 below.

T.4 **HIV/AIDS GRANTS**

TYPE OF FUNDING	GRANT TITLE	DURATION	PR	AMOUNT	RATING
PHL-304-G03-H	Accelerating STI and HIV prevention and care through intensified delivery of services to vulnerable groups and people living with HIV in strategic areas in the Philippines	2004-2010	Tropical Disease Foundation Inc.	US$ 5,262,179	A1 = closed
PHL-506-G04-H	Upscaling the national response to HIV/AIDS through the delivery of services and information to populations at risk and people living with HIV/AIDS	2006-2010	Tropical Disease Foundation Inc.	US$ 4,279,597	A1=closed
PHL-607-G08-H	Scaling Up HIV Prevention, Treatment, Care and Support Through Enhanced Voluntary Counseling and Testing and Improved Blood Safety Strategies	2007-2015	Department of Health	US$ 19,706,935	B1=financial closure
PHL-509-G10-H	Upscaling the national response to HIV/AIDS through the delivery of services and information to populations at risk and people living with HIV/AIDS	2010-2012	Department of Health	US$ 1,086,949	A2=closed
PHL-HIV-NFM	Philippines HIV NFM Grant	2015-2017	Save the Children Federation, Inc.	US$ 14,047,183	B2= active
TOTAL SIGNED				**44,382,843**	
TOTAL COMMITTED				**36,729,270**	
TOTAL DISBURSED (as of December 5, 2016)				**34,102,777**	

[20] Global AIDS Response Progress Report, the Philippines PNAC 2014

In the early years of TGF support, the Tropical Disease Foundation, a private, non-profit organization that seeks to control and prevent the spread of infectious diseases with public significance, was selected as the PR of the Global Fund grant. From 2007 till 2016, the PR function was transferred to the Department of Health (DOH), although during the application for funds through the New Funding Modality the Country Coordination Mechanism (CCM) took the decision to hand over the PR function to Save the Children, a non-governmental organization. Transfer of PR function from DOH to Save the Children was based on a number of justifications including efficiencies in fast tracking financial transactions, as DOH perceived its current policies limiting fast implementation of essential prevention services.

4. Assessment findings

4.1 external environment

Based on the TPA framework, the external environment is subdivided into the economic and political environments, both of which are essential components for a successful transition from external support.

4.1.1 economic environment

An enabling economic environment is crucial for sustained and/or increased and predictable domestic investments in health and specifically to allow for a successful transition of the HIV program. This component was assessed by analyzing the annual Gross Domestic Product (GDP) growth trend, as well as the share of general government revenue as a percentage of GDP.

The Philippines is considered an upper low middle-income country, with a per capita income of about US$ 2,899 in 2015 according to the World Bank[21]. About 55.15% of its GDP comes from service industries, while industry and agriculture contribute 29.93% and 14.92% to GDP, respectively. Manufacturing, previously a major economic activity, has been on the decline over the last two decades. Services and remittances from overseas Filipino workers (OFW) are a major source of national income, comprising 10% of the country's GDP[22].

The Philippine economy grew at its fastest pace with GDP growth exceeding 5%, but growth slowed in 2008 as a result of the global financial crisis[23] and started to slowly recover afterwards. GDP growth has fluctuated over the last five years, amounting to 4.2% in 2015. The share of government spending as a percentage of GDP slightly increased in the period 2006 – 2013 followed by a decline, reaching 10.4% in 2014, which is significantly below the average for Low Middle Income Countries (LMIC) (11%).

[21] www.worldbank.org
[22] An HIV epidemic is ready to emerge in the PhilippinesFarr and Wilson Journal of the International AIDS Society 2010
[23] Budgeting in the Philippines Blöndal J.R., OECD 2010

T.5 GDP PER CAPITA AND GOVERNMENT SPENDING, 2005-2015[24]

TYPE OF FUNDING	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
GDP per capita growth (annual %)	2.9	3.5	5.0	2.6	-0.3	6.0	2.1	5.0	5.3	4.5	4.2
Government spending, percent of GDP	9.0	9.2	9.3	8.8	9.9	9.7	9.7	10.8	10.8	10.4	
LMIC: Government spending, percent of GDP	10.7	10.6	10.7	10.8	11.8	11.1	10.9	10.9	10.7	11.0	

4.1.2 political environment

The transition and ultimate sustainability of the HIV program require adequate political support to ensure that health investments are prioritized and sustained by the Government. The political environment as an enabling factor for an adequate transition of the HIV program was assessed by analyzing the existence of political will to prioritize health investments within the government's budget; the existence of laws, regulations and policies that make possible prevention, treatment and care service delivery for KAP and people living with the diseases and the ability of the government to enforce these laws; as well as the existence of mechanisms within the government to enable CSO/NGO contracting for the delivery of various services funded out of state or local budgets.

Prioritization of health investments: The political will to ensure that health investments are prioritized was assessed using two indicators: a) the share of government spending on health out of the General Government Expenditure; and b) the share of public spending out of Total Health Expenditure (THE).

T.6 TREND OF GOVERNMENT EXPENDITURE ON HEALTH[25]

TYPE OF FUNDING	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Health expenditure, public (% of general government expenditure)	8.9	8.7	8.2	8.1	8.7	9.3	8.1	8.0	8.5	10.0
Health expenditure, public (% of total health expenditure)	38.4	36.7	34.7	32.9	35.1	36.0	30.5	31.1	31.8	34.3

[24] www.worldbank.org, accessed on August 4,2016
[25] World Bank database, www.worldbank.org accessed on December 5, 2016

As shown on Table 6, the Philippines has spent a comparable share of the public budget on health over past decade out of total government expenditure and maintained a steady growth of health expenditures as percentage of government expenditure since 2005, but the observed levels of budgetary spending on health are slightly below the average for LMIC (11%). The share of public financing for health out of THE fluctuated between 30%-38% in the past decade. Maintaining on average 34% public financing for health out of THE places a high burden on the population, households and the non-state sector.

Civil society landscape & contracting: The following area of assessment for the political environment is the ability of the government to contract civil society organizations for all sectors[26] using existing laws, rules and procedures or by demonstrating that they currently do this effectively.

CSOs in the Philippines include a very diverse set of organizations such as socio-civic organizations, religious groups, professional associations (lawyers' and dentists' associations for example), non-profit schools and hospitals, people's organizations (associations of farmers, fishers, drivers, neighborhood associations, etc.), development NGOs and many others. An important sub-set of the broad CSO or NGO sector would be what in the Philippines is called development NGOs. Development NGOs would include nonprofit organizations committed to and working for economic, political and socio-cultural development that base their work on a clear belief in the need for systemic and structural change in society, even though their particular organization may be focused on one or a few aspects of that change. In other words, development NGOs are not content only with dole-outs or occasional activities to help the poor such as intermittent medical clinics or livelihood seminars. Development NGOs are often more institutionalized and often (but not always) have a few full-time staff. The term "development NGOs" is also used in the Philippines to refer to "people's organizations" and cooperatives with the characteristics described above.

Many laws recognize and promote CSOs and their role in the development of the country. Among the most important is the Local Government Code (LGC) of 1991. The LGC devolves the authority, assets, and personnel of various national government agencies to LGUs to provide primary responsibility for basic services and facilities. It further provides for the participation of CSOs in local government planning and policy making and in the delivery of social services. The code mandates the formation of local development councils, which play a role in local planning, and also provides for the formation of other local special bodies, including the local health and school boards, all of which must also have CSO members. In addition, several administrative orders of the central government that implement the constitutional provisions and the LGC regarding public participation, require that all local councils at all levels should be represented by various NGOs and people's organizations.

Under the General Appropriations Act (GAA), certain programs and projects are allowed to be implemented by LGUs in partnership with CSOs. To facilitate implementation, the Department of Social Welfare and Development (DSWD), the Commission on Audit (COA) and the Department of Budget Management (DBM) were mandated to issue guidelines for accreditation of CSOs as eligible implementing entity of government programs and projects. On December 29, 2014, the DSWD, COA and DBM issued Joint Resolution No. 2014-001 providing the guidelines for accreditation of CSOs. Only CSOs accredited by DSWD are allowed to participate in bids

[26] For the political commitment the framework looked at general laws, not health sector specific. The latter ones are more thoroughly evaluated under the program domain of the framework.

conducted by the Government Agencies for the implementation of programs and projects. The selection of participating CSOs is governed by the Implementing Rules and Regulations of Republic Act No. 9184 and the guidelines issued by the Government Procurement Policy Board under its Resolution No. 12-2007.

CSOs in the Philippines engage in a broad range of activities, the most common being: i) education, training, and human resource development; ii) community development; iii) enterprise development and employment generation; iv) health and nutrition; v) law, advocacy, and politics; and vi) sustainable development.[27]

The legal and social context: A well elaborated legal framework that is adequate to protect the rights of KAP and to deliver preventive, curative and care services, including those delivered by CSOs, is also an important factor for transition, especially for HIV services. However, the existence of such a legal framework will not be sufficient, unless mechanisms are in place to upheld/enforce these laws.

Laws, regulations or policies that hinder effective prevention, treatment, care and support for KAP and PLHIV: The Philippines has signed and ratified core human rights instruments, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on the Rights of People with Disabilities, the Convention on the Elimination of all Forms of Racial Discrimination and other human rights treaties[28]. The Philippines also has a general (not specific to HIV-related discrimination) anti-discrimination law, which protects discrimination against the population in the Philippines[29]. The Constitution states that the State guarantees full respect for human rights and every person has the right to equal protection of the laws, although sexual orientation and gender identity are not explicitly mentioned. The Revised Penal Code of the Philippines, as well as other criminal laws, do not have provisions punishing hate crimes. Overall, the general legislative environment for protecting human rights is conducive but the country lacks specificity in its legislation/ regulations that protects MSM, PWID and the transgender population (Table 7).

T.6 NON-DISCRIMINATION LAWS/REGULATIONS WHICH SPECIFY PROTECTIONS FOR SPECIFIC KAP AND OTHER VULNERABLE GROUPS[30]

KAP/VULNERABLE GROUPS	LEGISLATION PROTECTING KPS	LEGISLATION / REGULATIONS PRESENTING OBSTACLES
People living with HIV	Yes	No
Men who have sex with men	No	No

[27] Civil Society Briefs Philippines, Asian Development Bank, https://www.adb.org/sites/default/files/publication/30174/csb-phi.pdf
[28] Standard Concept NoteTGF 2014
[29] The Philippines Report NCPI, PNAC 2014
[30] The Philippines Report NCPI, PNAC 2014

KAP/VULNERABLE GROUPS	LEGISLATION PROTECTING KPS	LEGISLATION / REGULATIONS PRESENTING OBSTACLES
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	Yes
People with disabilities	Yes	Yes
PWIDs	No	Yes
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	No	Yes
Women and girls	Yes	Yes
Young women/young men	Yes	Yes

Much improvement is also expected from the Revised Philippine HIV and AIDS Policy and Program Act of 2012, which amends the AIDS Law RA 8504, which is still under preparation. All together, these policy frameworks potentially provide a powerful enabling environment for the response, if implementation is effective and closely monitored. Indeed, the "Philippine AIDS Prevention and Control Act" of 1998 has served as the legal framework of the national AIDS response in the country. Although this AIDS law was supportive of general measures to fight against stigma and discrimination, and provide access to services and commodities needed for HIV prevention and treatment, care and support, there was a growing need to adapt this legal framework 15 years later in lights of the changes in the HIV epidemic[31].

There are also legal, regulatory and policy barriers to access by KAP to HIV prevention services. These include the lack of a regulatory framework that allows the operation of needle/syringes programs, mistreatment by police of KAP, the lack of mandated representation by KAP in local government structures and poor understanding of KAP and HIV in local government units and law enforcement agencies[32].

In the Philippines, there is pervasive misconception about stigmatized, infected individuals who are easily discriminated against. 6 out of 10 lose their jobs; 1 out of 10 is denied job promotion; and 1 out of 10 is forced to leave their residence or denied of a place to stay.

[31] External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
[32] Standard Concept Note, The Global Fund, 2014

Prejudice towards lesbians, gay, bi-sexual and transgender (LGBT) people continues to exist in Philippine society and culture[33]. Discrimination, harassment and intolerance of homosexuality, particularly male homosexuality, have resulted in MSM becoming a "hidden" population group, even though a high share of reported HIV cases involve male-to-male transmission. With high intolerance, it is difficult to provide MSM with HIV/AIDS information, education and treatment[34]. Stigma and discrimination among MSM continue to be a major obstacle to improving public health interventions among MSM and increasing service coverage. The external review of AIDS Medium Term Plan 5 (AMTP5) noted that the weak uptake of HIV testing and counseling is the most obvious result of the fear of LGBT populations to face the results of HIV testing[35].

Failure to measure, monitor and control HIV stigma and discrimination in the country, coupled with the presence of a high level of behavioral risk, may therefore provide an ideal environment for future increases in the rates of HIV infections. But despite these policies, very little has been done on a large scale to address the stigma and discrimination experienced by PLHIV. There is a great need to ensure that the above-mentioned state laws and policies are enforced. The end goal of these policies is to change attitudes towards infected people and their families. More supportive attitudes should translate into more supportive behavior, transforming a hostile world into one that is compassionate and constructive. These policies seek to break the silence surrounding the disease, partly by involving people living with HIV and their communities in an active response. It is hoped that more open discussion will help to reduce the fears and misconceptions that reinforce high-risk behavior.

The climate of religious conservatism, which prohibits condom use and the open education on issues such as sexual orientation and sexual reproductive health and rights, also hinders MSM and TGs, particularly the young sub-populations, from accessing information and services from SHCs and health facilities[36]. Gender bias against TGs is perceived as existing in health care settings and viewed as one of the reasons for the absence of TG specific services. Gender disaggregation of services for MSM, PWID and their female partners, including the integration of reproductive health, has not yet been sufficiently addressed. This includes the lack of orientation of women to reproductive choices; safe pregnancy; abortion and post-abortion care; and reproductive tract cancer screening. Counseling on hormone use and referral to other gender enhancement practices for TGs is still lacking in the current continuum of HIV prevention, care and treatment services.

Rule of Law: Apart from unfavorable socio-legal environment hindering access to services by key population and widespread stigma and discrimination, the country exhibits weak rule of law as demonstrated by the low Governance Indicators. According to the Worldwide Governance database, the rule of Law Index is -0.33[37], which indicates weak rule of law in the country.

[33] Cited from "The Status of LGBT Rights in the Philippines Submission to the Human Rights Council for Universal Periodic Review, 13th Session", Rainbow Rights Project (R-Rights and Philippine LGBT Hate Crime Watch, pp.1-2. Annex 11.
[34] An HIV epidemic is ready to emerge in the Philippines, Farr and Wilson Journal of the International AIDS Society 2010
[35] Standard Concept Note, The Global Fund, 2014
[36] Standard Concept NoteTGF 2014
[37] http://info.worldbank.org/governance/wgi/index.aspx#countryReports , accessed on August 4, 2016

4.2 Internal environment

4.2.1 Inputs

The inputs are the resources that are available for the HIV program. These are subdivided into components that include: i) financial resources, ii) human resources and iii) health information systems.

4.2.1.1 Financial resources

Without dedicated financial resources, it would be difficult for any programme to survive. Resources should be predictable and proportionate to the disease burden in the country. However, the available resources are strongly related to the weak economic environment and the lack of adequate political will (as described in previous section). These financial resources were assessed by examining the budgetary commitment and financial dependence on donor/external funding and by looking at the prioritization of investments between preventive and curative interventions, especially for epidemiologically important population groups.

Budgetary commitment to the HIV program: Total expenditure on AIDS, including private sources demonstrates an increasing trend since 2011 (Table 8). The total expenditure growth continued until 2014 and slightly declined in 2015; however, the budget appropriation for the HIV program started to increase again in 2016 (US$ 13 mln) and 2017 (US$ 20 mln). The total budget increased from 8 to 17 million US$ in the period of 2011-2015.

T.8 **SOURCES OF HIV/AIDS PROGRAM FINANCING, 2011-2015 (IN THOUSAND USD)**

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%

The increase in total spending on HIV during 2011-2015 was mainly caused by the increase in domestic spending by the central government, local governments and the private sector. Nevertheless, a decline of funding from private sources is observed since 2011, which can possibly be explained by: i) the absence of accurate information on private spending; and ii) the introduction of the Outpatient AIDS treatment insurance program. Among external sources, the biggest contribution is from the Global Fund. Other external contributors include UN agencies including WHO and United States Agency for International Development (USAID). The global reduction in donor contributions to HIV

and AIDS may cause risks to the sustainability of the HIV programme if not adequately replaced by domestic resources.

The public budget for HIV accounted for 73% of total resources in 2015. Although domestic funding is increasing, the growth is not fast enough to meet the needs, which are growing faster still. As a result, the national HIV program still remains underfinanced.

The annual national health budget is part of the "Social Services Expenditure Program" of the government's general appropriations. A sub-category of the health budget is the "Other Infectious Diseases and Emerging and Re-Emerging Diseases", which includes HIV and AIDS together with dengue, food and water-borne diseases. Nevertheless, although there is no separate budget line for the national HIV programme, appropriations are factored in three year national budgets based on the costed national HIV program. The latter is largely informed by the investment case recommendations developed with the support of UNAIDS in 2014.

Prevention financing from public sources: HIV/AIDS spending on prevention remains a low priority. Since 2009, the overall allocations to HIV prevention have gradually decreased from 63% (2007-2009) to 32% during 2011-2015[38]. Likewise, the trend of prevention in overall funding from the public purse decreased from 60% to 27% between 2011-2015[39]. Based on DOH data, only 10% of the DOH budget is allocated for prevention. Prevention programs in the country include: communication for behavior change, condom social marketing, counseling and testing, improving management of Sexually Transmitted Infections (STI), interventions for vulnerable population, programs for KAPs. In the period of 2009-2013, public funding for prevention activities targeted at sex workers and their partners declined, but budget increase is observed for intervention targeted at MSM and PWIDs[40]. Unfortunately, no data is available on the funding allocation by KAP groups since 2013 allowing analysis of most recent public spending per KAPs.

Treatment financing from public sources: Adequate financing of treatment and care services is an important component of a healthy HIV program that can sustain public health gains in the long-term. Therefore, the dependence of these services on external support was examined closely to evaluate transition preparedness.

T.9 PHILLHEALTH SPENDING ON PLHIV OUTPATIENT BENEFITS, 2010 -2015

YEAR	AMOUNT PAID FOR OHAT CLAIMS (PHP)	YEAR	AMOUNT PAID FOR OHAT CLAIMS (PHP)
2010	238,975	2013	43,582,500
2011	8,027,545	2014	69,225,000
2012	17,002,500	2015	91,987,500

[38] GARP 2014 - 2015 and National AIDS Spending Assessment (NASA), 2011-2014
[39] GARP 2014 - 2015 and National AIDS Spending Assessment (NASA), 2011-2014
[40] GARP reports 2009-2013

Case detection and diagnosis is partially funded by the public budget. In the absence of detailed funding data for the recent years[41], around 30%-40% is covered from domestic resources, according to key informants. A significant increase in spending can be observed in care and treatment given the increasing number of PLHIV who are now enrolled in anti-retroviral therapy (ART). First and second line ARVs are centrally procured by the Department of Health and have been fully funded from the public budget since 2015[42]. Access to outpatient treatment for PLHIV is also improving, as shown by the significant increase in claims paid by PhilHealth on OHAT since its introduction (2010) (see Table 9). According to the majority of respondents interviewed, adherence support to treatment, such as transportation costs for example, is not fully funded by external sources.

4.2.1.2 Human resources

The human resources include the service providers who provide prevention, treatment and care/support services to HIV affected-communities and individuals. The availability of adequately trained and distributed human resources is important for any program success and long-term sustainability. This component was measured by assessing the availability of sufficient human resources. This was also assessed by measuring the institutionalization of donor-supported trainings (i.e. continuous professional development) in the national education systems; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale.

HR sufficiency/availability: At present, there is no actual count of active health workers deployed in HIV/AIDS sector, and such data are not regularly collected[43]. The high turnover, migration and maldistribution of health human resources are common in the Philippines. Staff turnover at the treatment hubs with ARV programs was described by local management and staff as a major concern. Apparently, after staff were trained on HIV treatment, they move on to better paying jobs[44]. The turn-over of medical technologists providing HIV testing (not all health centers have medical technologists)[45] also poses a challenge to the timely diagnosis and initiation of ART. Overall, limitations in the health workforce availability and adequacy were noted by respondents. To manage the migration flows of health professionals and as part of the HRH master plan[46], more comprehensive labor agreements are currently being pursued by the Philippine Overseas Employment Administration, the Department of Foreign Affairs, the Department of Labor and Employment and the Department of Health with destination countries. However, so far no evident positive dynamics have been observed in the field of HIV/AIDS as a result of the HRH master plan. Respondents were largely ignorant of how the HRH plan addresses health workforce challenges in the field of HIV/AIDS. Therefore, it should be acknowledged that the challenges in terms of HRH are a structural challenge of

[41] NASA and GARP reports does not provide detailed breakdown of the expenditure data by TPA categories
[42] GARP 2014 - 2015 and National AIDS Spending Assessment (NASA), 2011-2014
[43] The Philippines Health System Review Health Systems in Transition 2011
[44] Global Fund Round 6 HIV Grant Philippines 2007-2012, Carael M., Manaloto C.R., Singh U. 2013
[45] Standard Concept Note, The Global Fund, 2014
[46] In 2005, the DOH, in collaboration with WHO-WPRO, prepared a long-term strategic plan for HRH development. The 25-year human resource master plan from 2005 to 2030 was to guide the production, deployment and development of HRH systems in all health facilities in the Philippines. The plan includes a short-term plan (2005- 2010) that focuses on the redistribution of health workers as well as the management of HRH local deployment and international migration. A medium-term plan (2011-2020) provides for an increase in investments for health. A long-term plan (2021-2030) aims to put management systems in place to ensure a productive and satisfied workforce. The DOH also created an HRH network composed of different government agencies with HRH functions to support implementation of the master plan.

the health sector that goes far beyond the HIV program, and is doubtful that it will be adequately addressed within the limits of HIV programming.

HR development & trainings: Even if broader HRH issues will be adequately addressed by the Government, donor supported training programs are not fully integrated into the national undergraduate, postgraduate and continuous education systems, which poses a risk to sustainability that is specific to the HIV/AIDS program and will be considered under the transition planning process. The timely integration of donor funded trainings could help the production and deployment of the qualified staff at HIV/AIDS service provision sites.

Existence of policy for CSO training/ development: The country lacks a well formulated policy for CSO training and development in general, and in the field of HIV/AIDS in particular[47].

Alignment of salaries: Donor funded human resource salaries vary by type of employment, position and function. For consultants with term contracts in the public facilities, donor funded salaries are two times higher than those of civil servants with a permanent employment status. For the civil servants at DOH, according to legislation, donors are allowed to pay a top-up of 20% only to cover insurance and benefits, whereas for example for peer educators deployed under the donor financed projects, payments are below the national pay scale. Moving forward would require better alignment of donor paid salaries with those in the local economy and public sector.

4.2.1.3 Health information system

One important step for an adequate response to the HIV epidemic is to "know your epidemic". The country health information systems collect and disseminate the data to support program and resource planning and contribute to evaluating program outcomes and impacts. Quality, timely, adequate and reliable data are an essential part of sustaining any public health program, including HIV. This component was assessed by evaluating the degree of integration of the comprehensive and routine statistical reporting in the national health information systems as well as evaluating the HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, the funding sources and the integration of the data in the national reporting.

Routine Surveillance system: The unified surveillance system combining prevention, treatment and adherence information is functional at the national level whilst at local levels the system remains fragmented. Locally, the information system does not incorporate HIV incidence, treatment and retention data[48]. Data about TB-HIV co-infection are also limited. The external Mid-Term Review of AMTP5 identified important gaps in the type of data produced by surveillance in the Philippines and recommended changes to increase the robustness of this information[49]. Thus, routine statistical reporting is partially advanced. At the national level, sufficient disaggregation of data has been ensured since the last assessment, but is still mostly paper based. At local levels, the system lacks sufficient disaggregation and uses a mixed electronic and paper based data collection and analysis system.

[47] Validated with DOH and Philippine National AIDS Council (PNAC)
[48] External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
[49] Ibid

Second generation surveillance: Second generation surveillance is conducted every two years through the Integrated HIV Behavioral and Serologic Surveillance (IHBSS). In 2015, the sixth round of IHBSS was conducted. The IHBSS uses a robust methodology that includes time location sampling among MSM and Registered Female Sex Workers, Probability-Proportionate to Size Sampling for Freelance Female Sex Workers, and Respondent-Driven Sampling fro PWIDs[50]. Nevertheless, the following weaknesses were observed: IHBSS data analysis, dissemination and utilization were limited up until recently; monitoring the behaviour of the most-at-risk groups e.g. condom use, number of partners, needle/syringe sharing, to guide local prevention is limited; HIV testing and counselling data of pregnant women from antenatal care services to detect trends in HIV prevalence are weak; and there is no systematic screening or surveillance of behaviors in prisons. Commendably, IHBSS and Population Size Estimates (PSE) are fully funded by the DOH, thus assuring promising prospects for sustainability.

4.2.2 Governance

The governance sub-domain is sub-divided into a governance-specific components that includes all of the actors and institutions involved at the organizational level and steering the HIV program and the factors fostering accountability, which is an important to ensure that organizations are fulfilling their roles and commitments.

4.2.2.1 Governance

Appropriate governance is the cornerstone of any program. This area was assessed by looking at three indicators: a) strong political commitment (non-financial), as revealed by a well elaborated disease-specific National Plan with sufficient legal power to drive national budgetary allocations and disease programs that are given adequate priority in the national health sector strategy; b) strong institutional and individual leadership of the disease program (not Principal Recipient); and c) an appropriately placed and well-functioning coordination mechanism within the governance structure of the country.

Coordination mechanism: The national response is coordinated through the Philippine National AIDS Council (PNAC), which acts as the highest advisory, planning and policy-making body on AIDS and is composed of government agencies, CSOs, professional organizations and representatives of PLHIV. The PNAC is in charge of planning, coordinating and monitoring the country's national response to HIV and AIDS as well as ensuring that all HIV and AIDS projects and initiatives in the country respond to or are harmonized with the AMTP. The PNAC is supported by a Secretariat, whose function is to support the PNAC plenary in its policy-decision making, ensure the availability and utilization of strategic information for program planning, coordination and monitor implementation of sector-specific responses and provision of administrative support to PNAC. Until recently, the PNAC was part of the DOH structure and lacked a legal basis and separate/independent budget, which had a negative effect on its operations. In order to further improve the effective operation of the PNAC, the decision has been made to reform it into a separate legal entity subordinated to the DOH. At the time of the assessment, the PNAC reform was in progress.

[50] Global AIDS Response Progress Report, The Philippines, PNAC 2014

At the local level, the Provincial Health Office leads the planning and the overall coordination and implementation of the HIV and AIDS Program within the jurisdiction of the City/Provincial Government. The office coordinates closely with the City Health Office (CHO), Rural Health Units, and DOH regional and central offices. The CHO manages service delivery, health promotion, community and social mobilization and logistics management at the grassroots level. The CHO works with the multispectral Local Authority Council, which apart from other sectorial representation also involves CSOs.

Apart from the PNAC, the Philippines has established a Country Coordination Mechanism (CCM) within the DOH, which has oversight functions for the effective implementation of Global Fund grants and supervises the PR's performance and capacity for resource management in support of effective and efficient achievement of program objectives. In carrying out this role, the CCM ensures that Global Fund's principles of partnership, community engagement, inclusiveness, transparency and accountability are adhered to. The CCM secretariat is fully funded by the Global Fund grant.

Effectiveness of coordination: Findings from the field show a general perception of weakness on the part of the PNAC. Outcomes from the aforementioned reform initiative have yet to be realised and bear fruit. It is important at this point is that the PNAC should exercise stronger leadership and tighter controls over its membership. Critical to these is addressing the challenging issue of the PNAC not having a clear resource base to play a stronger role as the only national coordination body leading the national response to HIV/AIDS prevention and control in the country. In the absence of a clear and sustained resource base and autonomy, the Council remains limited in overseeing an integrated and comprehensive approach to HIV prevention and control. Furthermore, the Secretariat is severely limited in its efforts to coordinate the formulation, monitoring and evaluation of plans, programs, policies and strategies to ensure effective and efficient implementation of the national response. Over the years, the Council has been plagued with the problem of inconsistent representation and uneven participation. Membership of the Council remains unnecessarily large and with mandate that lack clarity[51].

Political commitment: At present the national response to HIV/AIDS is guided by the legally approved 5th AIDS Medium Term Program, the Philippines Strategic Plan on HIV/AIDS 2011-2016. The 6th AMTP for the next 5-year period is under preparation and is planned to be approved by end of December 2016. HIV/AIDS is a priority in the National Health Sector Strategic Plan 2020 (HSSP). The HSSP identifies four strategies and objectives to guide the country response to the HIV epidemic: i) Continuum of HIV and STI prevention, diagnosis, treatment and care services to KAP; ii) Health promotion and communication on HIV and STI prevention and care services; iii) Enhanced strategic information systems; and iv) Strengthened health system platform for broader health outcomes.

Leadership: The DOH in general and the HIV/AIDS and STI Unit at the DOH in particular is a legally empowered organization leading the management of

[51] External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014

effective AMTP implementation. Apart from this unit, according to key informants there are couple of individual leaders who lobby and promote resolutions of HIV/AIDS related issues in the Senate and among City Mayors.

In conclusion, the findings of the Governance sub-component reveal relatively strong political commitment on the part of the government to deal with the epidemic, which is enhanced with the strong leadership capacity of individuals as well as involved institutions. However, weaknesses in the existing national coordination mechanism will pose a risk to the transition, unless they are addressed in a timely manner.

4.2.2.2 Accountability

Transparency promotes accountability by communicating program performance results, allowing interested stakeholders to engage in program monitoring/ oversight and ensuring that government commitments are upheld. All of this could contribute to a successful transition and could lead to sustainability. Civil society actors usually place demands for accountability on program results, which is why they need an enabling environment to operate and keep program managers and governments accountable to the society/ community. Accountability has been measured by Enabling Environment for Civil Society engagement in the country and by examining availability and accessibility of program performance results freely available and accessible in a public domain.

Enabling environment for CSO engagement: According to data from www.civicus.org, the environment for the Philippines is rated as enabling for the citizens, who are individually or collectively able to participate and engage in civil society (IEE - 0.53)[52]. The important role of civil society in the national response to HIV/ AIDS has been recognized in the Philippines. CSOs assist national agencies and Local Government Units to implement sector-specific responses in various locations. CSOs have been rated highly for their involvement in planning and budgeting for the AMTP. Currently CSOs represent six sectors (PWID, MSM, sex workers, OFW, Labor and PLHIV) participate in governance and are represented in the PNAC. PLHIV is also a member of the CCM of the GFATM and are usually members of the LACs.

Access to program performance results: A significant number of important studies have been undertaken over last 10 years. Efforts are in place to widely disseminate study results to a range of stakeholders. Access to surveillance data, IHBSS, programmatic performance evaluation reports, technical reports and findings are now easily accessible to the public[53] The only challenge remains with expenditure data, as the responsibility for carrying out a fully fledged National Aids Spending Assessment was handed over to the PNAC from the National Economic Development Agency (NEDA) in 2015. These reports become only available to public after the publishing the bi-annual Global AIDS Response Progress GARP report.

All of this suggests that the country environment and exiting mechanisms are adequate to facilitate accountability and that this component therefore presents a low risk for transition.

[52] www.civicus.org , Accessed on September 17th, 2016
[53] According to the findings of External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014, IHBSS studies were only disseminated using Facts Sheets, while full reports were not accessible.

4.2.3 Program

4.2.3.1 Service delivery

This sub-component seeks to understand how the program is currently functioning and its impact on transition. As such, service delivery is measured by: i) Treatment coverage and outcomes; ii) The integration of existing disease-specific services into general services; iii) the coverage of KAP with preventative services; and iv) CSO contracting for the delivery of health services.

Coverage of KAP with preventive services: The coverage of key affected populations with testing on HIV has improved over the time, but still remains low (Table 10). According to IHBSS studies, only 20-30% of the KAP in the Global Fund supported sites received an HIV test and knew the results. There are two major bottlenecks identified in HIV testing service provision that impede higher coverage: i) access to free and confidential HIV testing; ii) rapid HIV testing with same-day results. Currently, the government is providing free HIV testing through government-run Social Hygiene Clinics (SHC) mandated to provide STI and HIV services to female sex workers. SHCs are not present in all cities and in most instances, other key populations (e.g. MSM) are hesitant to access the services being offered by SHCs. Hence, there is a need to expand free and confidential HIV testing services beyond the realm of SHCs. Furthermore, the current HIV testing protocol requires a confirmatory test that takes around 4 weeks before the results are released. This leads to significant losses to follow-up, missing an opportunity to access life-saving treatment and prevention of onward transmission of HIV infection[54].

T.10 TESTING RATES AND PREVALENCE OF SAVE BEHAVIORS AMONG KEY POPULATION

YEAR	KAP	2011	2012	2013	2014	2015
Testing	PWID*	4.8	4.8	6.3	6.7	23.8
	SW**	16.5	16.5	12.6	22	24.6
	MSM**	5.2	5.2	9.3	9.3	16.1
PWID: Safe injecting practices		24.7	24.7	30.7	33	63.6
SW: Condom use		64.9	64.9	47.4	69.6	70.6
MSM: Condom use		36.3	36.3	40.7	40.7	49.8

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

[54] WB Aid Memoire, 2015

The percentage of MSM exposed to testing interventions has slightly increased over the years, reaching its highest level in 2015 (16.1%), although it is still too low to deliver significant public health gains. Prevention activities among MSM have been largely dependent on standalone information and communication and/or behavioral change communication efforts. There are weak linkages between peer outreach and HIV testing, STI and other services. Current reach for peer education and outreach services for behavior change among MSM is weak and in some instances not fully adequate. Only around 50% of MSM report using condoms during their last sexual intercourse (Table 10). This may be attributed to the low quality of peer education, an inappropriate choice of peer educators expected to engage with middle income MSMs, single Peer Educator encounters instead of repeated encounters, and low follow up rates. Peer educators are not adequately supported with the appropriate tools, which negatively affects the quality of provided services.

Stigma and discrimination keep the MSM population away from health services, which makes them difficult to reach. Both the actual and perceived levels of stigma in health care settings are high. Addressing stigma and discrimination, enhancing the appropriate clinical skills, knowledge, and sensitization of health care workers, removing structural barriers to appropriate services delivery, and increasing health seeking behaviors of MSM are also essential to program success.

Prevention work among registered female sex workers revolves predominantly around Social Hygiene Clinics. These sex workers pay for their HIV, syphilis and STI check-ups and for registration. These services represent an important source of revenue for the SHC, although this money is reportedly forwarded to the local government administration. Freelance female sex workers and male sex workers, who are at higher risk of HIV than their registered peers, are inadequately reached by prevention services. Transgender sex workers are generally ignored. Reported condom use among female sex workers over the last three years indicates a slight increase since 2011, but still fluctuates around 70% or less.

Unprotected sex is rampant in all key populations and reported condom use remains low among populations at high risk of HIV and STIs. Condoms are often provided free of charge to key populations in Global Fund supported sites, but lubricants are often not available. The condom social marketing targeting key populations is not actively implemented; condom promotion through the media does not exist; and condom distribution at risky venues is not allowed, due to the barriers imposed by local ordinances. Although supplied by the Department of Health to Social Hygiene Clinics, condoms are not always available or promoted in these facilities. Peers, volunteers and outreach workers do not always carry condoms or promote their correct and consistent use[55].

Like MSM, the current HIV prevention program among PWIDs is minimal and coverage is low, although improvements were noted in 2015 with testing rates reaching 23%. However, achieved levels of testing remain inadequate. In the 2015 report, only 64% of PWIDs reported using sterile injecting equipment the last time they injected. PWID sites are few considering that needle/syringe sharing is an important driver of the epidemic[56]. Overall, harm reduction interventions, particularly needle and syringe programs, do not exist on an adequate scale. Although in 2014 a resolution from the Dangerous Drug Board paved the way for the implementation of needle/syringe exchange programs as

[55] External Mid-Term Review of the 5th AIDS Medium Term Plan, PNAC 2014
[56] Standard Concept Note, The Global Fund, 2014

part of the National HIV program, they only existed as an operational research project in Cebu city, which was discontinued recently. This situation requires creating an enabling environment that promotes health-seeking behaviors, is supported by national laws or local ordinances and allows the implementation of harm reduction programs.

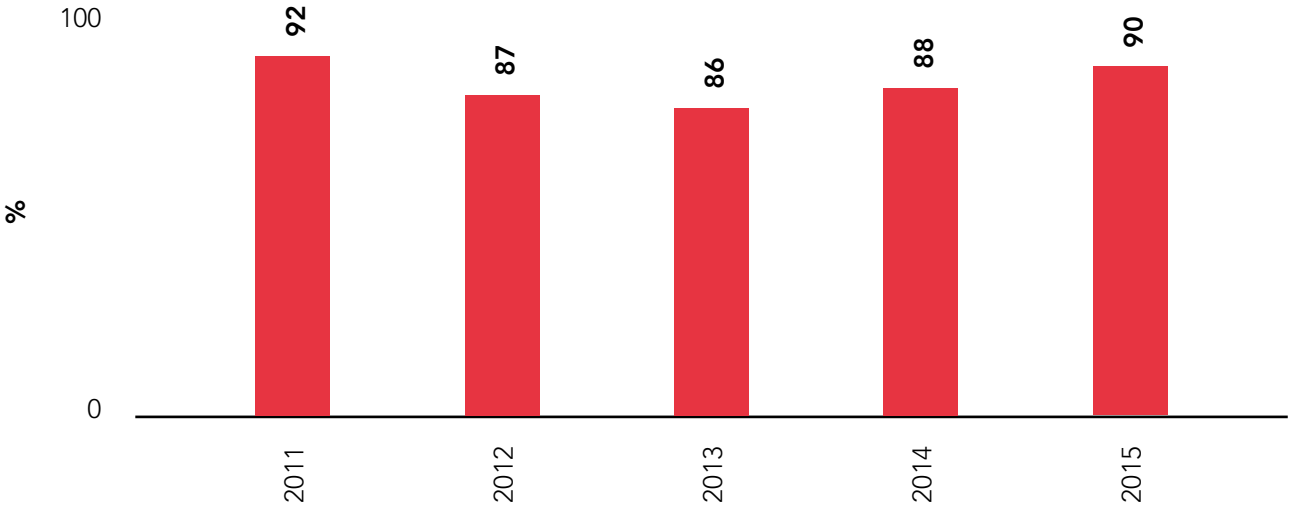
Treatment coverage and outcomes: A total of 16,637[57] PLHIV were on ART as of September 2016. Most (97%) were males. The median age of patients enrolled in treatment was 31, out of an age range from 1 to 78. 95% of PLHIV receive first line regimen, while the remainder receive the second line regimen. The enrolment of PLHIV in ART treatment has improved since 2010. According to key informants from the DOH, almost 88% of eligible PLHIV are currently benefitting from ART.

The National ART registry shows that the average CD4 count at treatment initiation is 156 cell/mm, whilst new national ART guidelines since early 2015 recommend shifting treatment eligibility from a CD4 count of 350 or less to a CD4 count of 500. Nevertheless, it is apparent that most PLHIV are late initiators of treatment due to loss to follow-up after initial testing, since they are unaware of their CD4 count early in the disease or they are altogether unaware of their status until they are at a more advanced disease stage.

There are number of reasons for low ART coverage. According to national regulations, PLHIVs can receive ART free of charge once enrolled with the PhilHealth for Outpatient HIV/AIDS treatment package (OHAT). PLHIVs become eligible for OHAT coverage only after their HIV status is confirmed. Provided that the waiting time for confirmatory test results is almost 4 weeks, it is probable that a large number of PLHIV are lost between testing and treatment enrolment. Furthermore, very few PWIDs who are eligible for ART are actually enrolled in treatment. Limited access to their CD4 count and the possible interaction of injected drugs with ARVs create obstacles to enrolment in and adherence to ART by this population.

F.3

TREATMENT ADHERENCE - TWELVE-MONTH RETENTION ON ANTIRETROVIRAL THERAPY, 2010-2015



[57] This is the total number of adult and pediatric patients currently enrolled and accessing antiretroviral drugs (ARV) in the 40 treatment hubs and satellites. It does not include patients who were previously taking ARV but have already died, have left the country, have been lost to follow up, or opted not to take ARV anymore.

Retention on treatment after 12 months of ART initiation shows promising results. Retention rates are reported to be high, reaching over 85% since the introduction of the OHAT in 2010, which fully covers treatment costs. Overall retention rates over the last five years have remained largely stable. In 2015 90% of PLHIV remained on ART (Figure 3).

4.2.3.2 Integration of services

PMTCT integration into maternal care and PHC: According to the 2014 Global AIDS response progress report, PMTCT is only integrated into a few facilities that provide antenatal care/maternal and child health care[58]. This finding has been supported by respondents interviewed, who noted no further progress in the integration of PMTCT services.

HIV-TB Integration: As a response to the TB-HIV epidemiology, an Administrative Order (AO 2008-0022) otherwise known as the "Policies and Guidelines in the Collaborative Approach of TB and HIV Prevention and Control" was signed and disseminated in 2008. The AO was further revised later in 2014[59]. To date, Provider Initiated Counseling and Testing is conducted in almost all TB and HIV facilities. The treatment hubs administer treatment for TB co-infection as well refer TB co-infection to their nearest TB DOTS center for co- management and to obtain TB drugs for free. The results of the high level of integration of HIV/TB services are measured by number of indicators presented in Table 11 below.

T.11

HIV/TB INTEGRATION INDICATORS[60]

INDICATOR	RESULT
% of TB patients who had an HIV test result recorded in the TB register	80% of Registered TB and MDR TB cases
% of HIV-positive registered TB patients given an anti-retroviral therapy during TB treatment	100% of HIV and TB cases
% of HIV-positive patients who were screened for TB in HIV care or treatment settings	90% of PLHIV accessing HIV hubs care
% of new HIV-positive patients started Isoniazid Prevention Therapy during the reporting period	50% of new PLHIV with inactive TB

4.2.3.3 Cso contracting in the health sector

In the 1970's and 1980's, the CSOs in the Philippines were used as alternative channels for the delivery of primary care or community based health programs due to the limited capacity of the government to provide these services in rural or hard-to-reach areas. They have proven that they were effective

[58] Global AIDS response progress report: Country Progress Report, Philippines, 2014
[59] Standard Concept Note, The Global Fund, 2014
[60] Source: Standard Concept Note, The Global Fund, 2014

in delivering primary care services to poor communities. However, this approach was not sustained due to the CSOs' limitations in capacity, resources and referral networks. Besides, parallel structures further reinforced the fragmentation and nonintegrated delivery of health care services. Although contracting of CSOs in others sectors of the economy continued, it has been practiced on a limited scale in the health sector in more recent years.

In response to recent cases of corruption observed in CSO contracting, the contracting requirements have been tightened to require CSO accreditation in order to access public funding. Newly introduced stringent accreditation requirements create administrative barriers for CSOs to access public funding, as the majority of CSOs are not registered legal entities and/or lack the capacity to meet the accreditation requirements. Only a few, big CSOs have managed to obtain accreditation and access public funding. Furthermore, although contracting rules and procedures are in place and well defined, there is limited knowledge whether these rules are appropriate for the procurement of preventive services currently provided by CSOs in the field of HIV/AIDS with Global Fund support.

CSOs play a significant role in the national response to HIV and AIDS, including: prevention, care and support as well as provision of legal services to KAPs; assisting national agencies and LGUs in the implementation of sector-specific responses in focus geographical sites; contributing to the behavior change needed for HIV prevention; PLHIV participation in the treatment model to implement ART with hospital-based treatment facilities; facilitating a strong referral network between treatment hubs and the PLHIV/ MSM support groups, resulting in increased ART enrollment and retention; psychosocial support to PLHIV; and participation in the governance of HIV/AIDS.

T.12 PERCENTAGE OF SERVICES PROVIDED BY CSOS[61]

TYPE OF SERVICES	PERCENTAGE OF SERVICES PROVIDED BY CSOS
Prevention: PLHIV	51–75%
Prevention: MSM	51–75%
Prevention: SW	25-50%
Prevention: Transgender	51–75%
Palliative care	51–75%
Testing and Counselling	51–75%
Know your Rights/ Legal services	51–75%

[61] The Philippines Report NCPI, PNAC 2014

TYPE OF SERVICES	PERCENTAGE OF SERVICES PROVIDED BY CSOS
Reduction of Stigma and Discrimination	51–75%
Clinical services (ART/OI)	<25%
Home-based care	51–75%
OVC support	<25%

Thus far, however, they are fully financed from external resources, mainly the Global Fund grant The role of CSOs and the importance of continuation of preventive services after the end of external funding should not be underestimated. As shown in the Table 12, HIV prevention services among KAPs are predominantly provided by CSOs. If the government of the Philippines does not address CSO contracting issue today, there is a risk that the preventive services currently provided by CSO sector will be discontinued.

To conclude, the component of service delivery entails risk when trasitioning from the Global Fund support. Preventive services among KAPs are expected to be negatively affected because current preventive interventions, which are already at a low level, are mainly funded by TGF and delivered by CSOs paid out of the Global Fund grant. Recently introduced accreditation requirements for CSO pose a risk as they may increase barriers for future CSO contracting by the government. Finally, the weak integration of some preventive (PMTCT) and treatment services (e.g. adherence support, harm reduction and ART for PWID) may further challenge the service delivery component.

4.2.7 Organizational capacity

Program Management Capacity: The Office of Technical Services and Disease Prevention and its Technical Bureau sub division supervises the implementation of the HIV/AIDS program in the country. The department provides technical oversight of the program in both government and externally funded programs. Presently the group that is tasked with the management of the national program at the DOH is represented by two full time public employees and eight consultants contracted under the Global Fund grant. While human capacity is adequate and annual performance assessment of staff at central and sub-national levels is a well-established practice, there are concerns about the continued effectiveness of the national program management after the end of external support, due to the limited staffing of the respective unit under the national budget. The same problem is detected at the epidemiology Bureau, which is responsible for routine and second generation surveillance and is currently supported by consultants contracted through the Global Fund grant.

As stated previously, the PR function was handed over from the DOH to Save the Children in 2015. Nevertheless, according to key informants from the DOH and the national AIDS program management unit, there is close cooperation with the new PR.

Procurement and Supply: The centralized procurement of ARVs from international platforms has been fully organized and funded by the DOH since 2015. According to key informants, this practice will continue after the end of external support allowed by the enabling legal environment. Using an international procurement platform allows the country to efficiently use scarce public resources and avoid the higher costs of ARVs experienced in the past, when the drugs were procured locally.

Consumables and other required commodities are predominantly procured by the PR using international procurement procedures and are not integrated into the public procurement system. Rare stock outs of rapid tests were reported by key informants in the past, which was mostly explained by poor forecasting and delayed purchases. Recent efforts to train respective staff in forecasting methods already show positive results.

Monitoring and Evaluation Capacity: Key informants anonymously agreed that the country produces sufficient evidence on a regular basis to inform planning and funding, but sufficient analytical capacity is lacking at central and local levels, and so requires of regular external support.

Based on this evidence, it seems that the country has sufficient organizational capacity as well as well a functioning Procurement and Supply Management (PSM) system, with minor limitations, and an effective M&E system all managed, funded and implemented by the Government (except for the part currently handled by the PR). This certainly creates a conducive environment for the transition. However, it would be important to address issues related to the staffing, especially consultants contracted under the Global Fund grant, during transition to lower the risk.

4.2.8 Transition planning

A direct measure of forward thinking for an HIV program currently receiving external funding in any country is the ability to plan for the take-over of responsibilities particularly at the programmatic level, for which funding issues are important. In this area, elements such as the existence of a legally binding plan with clear time-bound activities and a dedicated budget for transition were assessed.

The Philippines has not yet developed a legally binding transition plan as a stand-alone document, or as a part of the *National Strategic Plan*. Nevertheless, some aggressive steps were undertaken to ensure the gradual transition of programmatic elements from external to domestic support. To name a few:

The HSSP on HIV and STI 2015-2020 sets the national direction for the HIV response. It includes the Operational Plan 2015-2017 which contains the cost estimates for the initial 3-year implementation. There are four major strategies, each one of which has specific activities with a corresponding budget for each year, including the funding sources.

The new AMTP 6, which is currently under preparation, aims to gradually move towards a fast track initiative and increase the budget for the disease as well as the share of domestic funding.

Since 2010, the PNAC has worked towards the institutionalization of HIV and AIDS response at the national and local levels. As of 2014, considerable progress has been achieved in the policy environment that has a direct bearing on treatment, care and support. For instance, the implementation of an OHAT package since 2010 with rapidly increasing funding aims to raise the proportion of the population with access to effective AIDS treatment and full funding of ARVs by the DOH. This is a critical step in guaranteeing the sustainability of access to ART treatment.

Lobbying for proposed amendments in the Philippines HIV/AIDS Policy and Program Act of 2012, which amends the Republic Act (RA 8504 or the Philippine AIDS Prevention and Control Act of 1998) is another positive development in ensuring elimination/minimization of legal barriers to KAP accessing services. The new law will restructure the legal framework on HIV/AIDS by harmonizing it with evidence-based strategies and approaches. The revisions to the National AIDS Law, if passed, will remove many non-supportive HIV policies that are

barriers to current efforts in HIV prevention such as the Comprehensive Dangerous Drugs Act (Republic Act or RA 9165, which prohibits the distribution of clean needles and injecting equipment). The senate is initiating the development of a separate Act promoting harm reduction programs in the country.

Other important national policies and laws adopted in the country are: a) the HIV in the workplace policy of the Civil Service Commission; b) a Memorandum of the Department of Interior and Local Government on "Strengthening Local Responses Towards More Effective and Sustained Responses to HIV and AIDS", which enjoins all cities and provinces to create the LACs; c) a Referral System for the Care and Support Services for PLHIV, a tool which was developed by the Department of Social Welfare and Development to facilitate the collaboration of service providers and LGUs in providing care and support for PLHIV; and d) The Responsible Parenthood and Reproductive Health Act, which facilitates education on sexuality, reproductive and sexual health, including HIV, for young people.

At the LGU level, the Quezon City Government has passed the first anti-discrimination ordinance that specifically tackles the issues confronting the LGBT community.

5. Conclusions and recommendations

This section of the report summarizes the findings arising from this country case study and, separately, some general findings that resonate and align with the results of other studies[62] and lead to more general conclusions from those that are purely country specific.

5.1 THE MAIN RISKS OF TRANSITION AND SUSTAINABILITY

Table 13 below presents the list of indicators that were used to assess possible risk to transition from TGF support. Each indicator has been assessed according to the criteria and has been assigned a score for low risk, moderate or high risk. The component scores are summed up to form a final score of transition risk in the country.

T.13 HIV/AIDS TRANSITION PREPAREDNESS ASSESSMENT – SUMMARY TABLE

COMPONENT	INDICATOR	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
EXTERNAL ENVIRONMENT			
Political Environment	Existence of political will to prioritize health investments	High risk	High risk

[62] Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of Global Fund supported programs. Curatio International Foundation, 2015

COMPONENT	INDICATOR	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with diseases & Rule of Law	High risk	
	Government ability to contract with CSOs; CSO contracting practices	Low risk	
Economic Environment	"Favorable economic indicators	High risk	High risk
INTERNAL ENVIRONMENT			
Inputs			
Financial resources	Budgetary commitment to disease	High risk	High risk
	Prevention priority	High risk	
	Allocative efficiency	Low risk	
	Treatment / input financing from public sources	Moderate risk	
	Prevention financing from public sources	High risk	
Human Resources	Sufficient human resources for disease (quantities, geographic distribution and aging)	Moderate risk	High risk
	Institutionalization of donor supported programs; Existence of policy for production/ training of CSO personnel (non-medical, social service; Donor funded HR salaries aligned with national pay scale	High risk	
Information Systems	Routine statistical reporting R Integration in the national system	Moderate risk	Low risk
	Routine statistical reporting R Level of advancement	Moderate risk	
	HIV Second generation surveillance Methodologies, Timeliness	Low risk	
	HIV Second generation surveillance Funding from public sources	Low risk	
Governance			
Governance	Strong political commitment to diseases	Low risk	Moderate risk
	Strong leadership	Low risk	
	Strong coordination mechanisms	High risk	
Accountability	Program performance results are available and accessible through public domain	Low risk	Low risk
	Enabling environment for Civil Society engagement	Low risk	

COMPONENT	INDICATOR	INDICATOR RISK CATEGORY	TRANSITION RISK SCORE
PROGRAM			
Service Delivery	Treatment	Moderate risk	High risk
	Integrated services	High risk	
	Key populations reach with preventive services	High risk	
	CSO contracting in health	Moderate risk	
Organizational Capacity	Strong management of the National Disease Program Management Entity	Low risk	Moderate risk
	Procurement & Supply Management	Moderate risk	
	Monitoring & Evaluation	Moderate risk	
Transition Planning	Legally binding and actionable Transition plan / Transition elements	High risk	High risk
	Transition plan / Transition elements characteristics	Moderate risk	
	Transition M&E	High risk	
Transition risk score for HIV/AIDS-36.7%			Moderate risk to high risk

External environment

Economic development. The Government of the Philippines fails to ensure continued and sustainable economic growth. Fluctuations in Gross Domestic Product (GDP) along with the decline in the share of government revenues as a percentage of GDP pose a high risk to the transition and sustainability of Global Fund supported programs.

Political commitment. The political will of the government, as expressed in investment in health, is not adequate. Although the Philippines spends a comparable share of the public budget on health out of total government expenditure, and maintains a steady growth in health expenditure, the observed levels of budgetary spending on health still remain below the average for Low Middle Income Countries (LMIC). Furthermore, there is a lack of regulations and/or adequate enforcement of laws protecting Key Affected Population (KAP), which increases the overall risk arising from the political environment. The Civil Society Organization (CSO) contracting for service provision has been a practice in the past; however the recent introduction of complicated contracting requirements to access public funding demotivates the CSO sector from tapping public funding, which in turn may cause the discontinuation of CSO-provided prevention and outreach services when external funding ends, thereby putting the country at high risk.

Internal environment

Financing: The Philippines has prioritized HIV treatment related interventions for public investment and took decisive steps to eliminate treatment dependence on external funding. However, while replacing donor funds for

treatment with national resources is visible, a more aggressive pace might be warranted for transitioning the funding of preventive services for KAPs which are mostly donor dependent and face numerous barriers to being easily transferred onto domestic funding.

Human Resources: After transition from TGF support, challenges are also expected to emerge in the retention of already practicing professionals, as well as in the production/reproduction of adequately trained health and CSO cadre. Most likely, sustaining current training efforts will not be possible due to the lack of institutionalization of TGF supported trainings and knowledge dissemination. The availability of well-trained and appropriately distributed human resources is crucial for the program's success. This is even more critical in a transition scenario due to the importance of continuing care for patients with HIV[63]. These challenges in donor-funded trainings are not only relevant to the Philippines and/or TGF, but also have greater implications for other countries and donors alike[64]. Also, tackling these problems during transition period may not be feasible due to the numerous structural barriers observed: i.e. the lack of an adequate cadre of trainers in established training institutions, the lack of state support/funding for these trainings, etc. To achieve sustainability, it seems essential to remedy this challenge with the help of well thought through mechanisms enhancing human resource production for health. Whatever mechanisms will be developed for these purposes, it is critical to assure that they are self-sustainable and scalable to deliver long-term sustainability.

Information Systems: The Philippines has an advanced health information system and routinely collects the necessary information for use in program evaluation and/or intervention planning at the national level. Progress has also been attained in the institutionalization of a robust secondary surveillance system in the country, which is fully funded from the public purse. However, these achievements were not without limitations. The unified surveillance system combining prevention, treatment and adherence information is functional at the national level but is still mostly paper based. At local levels the system remains fragmented: the information system does not incorporate HIV incidence, treatment and retention data; data about TB-HIV co-infection is limited; and the system uses a mixture of electronic and paper based data collection methods. Nevertheless, it seems possible for the remaining challenges to be addressed during a well planned transition, with the exception of analytical capacity limitations that could remain for a while due to structural limitations in the education sector and public sector employment.

Developing and enforcing accountability mechanisms to ensure commitments remain key drivers for sustainability requires communicating program performance results through the public domain, including reporting expenditure data and targeted activities for KAPs. Moreover, since most efforts to hold actors accountable are conducted by civil society organizations, it is crucial to further enhance and sustain the enabling environment in which civil society organizations operate[65].

[63] Building Resilient and Sustainable Systems for Health: the Role of the Global Fund, The Global Fund, 2015.
[64] Vujicic M., Weber SE., Nikolic IA., Atun R., Kumar R. 2012. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. Health Policy Plan. (2012 27 (8 : 649-657. doi: 10.1093/heapol/czs012.
[65] T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio Internataional Foundation, 2015

Governance: The Government remains committed to continue the national HIV program. The new national program has been developed and currently awaits governmental approval. However, the lack of independence and resource base limits the effective operation of the National AIDS Council (PNAC) and poses risks to the transition and sustainability of the national AIDS response. While the Department of Health (DOH) remains as the chair of the plenary, the PNAC resource base must not remain dependent on it. The PNAC must urgently find a way of mobilizing resources from within the Philippine bureaucracy through member agency budgets and from development partners so that it maintains its autonomy. Planned and ongoing reforms may mitigate these risks if they are implemented appropriately and ensure a smoother transition from TGF funding. The Philippines has a good enabling environment for civil society engagement, maintaining rich performance data at the national level and offering stakeholders easy access to required information. However, access to sub-national data requires improvement. Streamlining the national program coordination function and ensuring easy access to program performance information[66] stall levels are expected to minimize challenges during transition.

Program. The government's willingness to sustain an effective national response towards the HIV epidemic is encouraging. However, in order to achieve a positive public health impact in light of possible financial limitations, the country has to ensure effective coverage of key populations by improving the allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed through the following steps: reinforcing prevention activities; building linkages between the health sector and non-governmental and social service providers; streamlining patient pathways among TB and HIV service providers; and enhancing follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges the Philippines will face after transition from Global Fund support.

Organizational Capacity. There are several prerequisites for a smooth transition and attaining the desired public health gains. They are: strengthening the organizational capacity of national program implementers and service providers, including CSOs[67]; streamlining procurement functions to allow the procurement of HIV commodities at a lower price by deploying procurement practices from international platforms, as in case of drugs; and enhancing M&E and evidence based program planning and implementation.

Overall transition readiness. The assessment of the transition readiness of HIV/AIDS programs revealed that the Philippines faces a moderate to high risk after Global Fund support ends. Early transition planning that addresses the riskiest areas of the program and systems as well as its effective implementation will allow the country to experience a painless transition and ensure the sustainability of national programs.

5.2 Recommendations

The list of recommendations presented below follows the domains of the TPA framework. Based on the sustainability risk and feasibility of proposed activities, the recommendations are presented under different temporal dimensions.

[66] Transparency and streamlined accountability: what watchdogs, grant implementers and OIG want, Aidspan, 2015 http://www.aidspan.org/node/3354.
[67] T.Gotsadze et al, Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio Internataional Foundation, 2015

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
EXTERNAL ENVIRONMENT		
POLITICAL ENVIRONMENT		
Recommendation # 1: create conducive legal environment	Immediate	Enhance anti-discrimination protection through legislative changes to promote the human rights of KAPs, PLHIV, vulnerable communities and providers of HIV services through: • Adoption of revised HIV/AIDS legislation that protects KAP and allows access to need services; • Revision of other regulations hampering KAP access to HIV/AIDS preventive, treatment, care and support services; • Promotion and approval of a range of measures and interventions aimed to prevent stigma and discrimination among general population; and
	Medium to long term	• Adoption of Harm Reduction legislation.
ECONOMIC ENVIRONMENT		
Recommendation #2: Create government capacity to mobilize additional financial resources for health	Immediate	Conduct fiscal space analysis within the existing macroeconomic context to identify possibilities to grow program financing and cover funding gap necessary for adequate program support.
INTERNAL ENVIRONMENT		
INPUTS: FINANCING		
Recommendation #3: Ensure the adequate funding of national HIV/AIDS programme	Immediate	• Mobilization of domestic funding in support of national HIV/AIDS program from other sectoral ministries, LGUs and the private sector; • Introduction of a separate budget line for the HIV program in the budgets of all involved line ministries, including DOH, and LGUs to drive funding allocations as well as facilitate monitoring of national HIV/AIDS spending;
	Short term	• Move towards fast track targets considered adequate to address this need in the national funding envelope; • Use available resources efficiently and effectively. Investments should be strategic and geared towards prevention interventions targeting KAPs and in areas where most new infection cases emerge;
	Immediate step	• Increase the share of public funding for preventive services; • Introduction of a dedicated budget line for outsourcing outreach and case management services to CSOs under the HIV Program; • Establish a functioning monitoring mechanism that will be able to generate and collect financial information at the local level in order to provide a more accurate picture of the levels of spending of the country.
ECONOMIC ENVIRONMENT		
Recommendation #4: Ensure an adequate and continuous supply of qualified human resources	Long term	• Challenges in terms of HRH are a larger problem in the national health care system; even though the HR shortage will certainly affect the sustainability of the HIV program, it may not be resolved during the transition period. However, within the Global Fund CN for the next round the Philippines may, under the HSS component request assistance for the development of a comprehensive policy for the production/training of HR in health;
	Immediate step	• Revisit staffing plans for effective service provision, particularly considering additional staffing needs required to meet "fast track" initiative targets;

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
		• Explore the feasibility of institutionalizing accredited practical training, such as internship programs for students from relevant faculties (medical, social workers, statistician, psychologists, juridical, etc.) in HIV service organizations. Students, in exchange for academic credits, could be deployed in service areas where staff shortage is most severe;
	Medium to long term	• Ensure integration of the HIV training modules into continuous education systems with the potential of further integrating the HIV training modules into the undergraduate education systems in the long-term;
	Immediate	• Elaborate a strategy to train and build the capacity of NGOs.
GOVERNANCE		
Recommendation #5: Improve the effectiveness of the coordination function at national and local levels for better programmatic planning, budgeting, implementation and M&E	Immediate	• Reform the PNAC as the main governance platform to guarantee the efficiency and effectiveness of its operation in addressing the HIV epidemic by: - Ensuring the autonomy of the PNAC; - Providing that, while DOH remains as the Chair of the Plenary, the PNAC resource base must not remain dependent on it. The Council must urgently find a way of mobilizing resources, from within the Philippine bureaucracy through the member agency budgets and from development partners so that it maintains its autonomy and control in its utilization in accordance to its full mandate as stipulated by law; - Bringing the Secretariat back under the Council; - Making PNAC governance structures and processes optimally functional, as desired and stated in its Manual of Procedures. • Enhance coordination at local levels by: - Revisiting the role of the LACs in the overall national response; - Supporting local responses from the national level on how to access funds and plan programs; - Ensuring PNAC regularly monitors implementation of local responses and provides support and advice on corrective measures when needed.
PROGRAM: SERVICE DELIVERY		
Recommendation #6: Streamline service delivery	Immediate	• Remove barriers to HIV testing, particularly addressing delays in confirmatory test results, and treatment through strengthening of cooperation between the governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services. This can be achieved by improving timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART.

RECOMENDATION	TEMPORAL DIMENSION	PROPOSED ACTIVITIES
	Medium to long term	• Ensure full integration of PMTCT services into primary and perinatal care;
	Medium term	• Consider expanding the HIV Insurance package OHAT by adding case detection/diagnosis and treatment adherence support.
Recommendation #7: Create an enabling environment for CSO contracting to ensure that CSOs are engaged in HIV prevention services through government funding	Immediate	• Develop/revise detailed SCO contracting rules/procedures to ensure continuous and scale-up delivery of preventive services, especially to KAPs;
	Medium term	• Initiate an open, results oriented and constructive policy dialogue between the government and civil society to explore potential solutions to liberalize the SCO accreditation process;
	Medium to long term	• Consider establishing umbrella SCO Organizations/networks to allow continuous engagement of CSOs in the provision of preventive services to KAPs.
PROGRAM: ORGANIZATIONAL CAPACITY		
Recommendation #8: Strengthen the organizational capacity of all involved stakeholders including government institutions and CSOs for better sustainability	Immediate	• Strengthen the capacity of AMTP management structure at DOH through the establishment of an effective management team with adequate staffing positions;
	Medium to long term	• Increase the sustainability of local NGOs, enhance their advocacy efforts, promote the sustainable development of professional and local communities, and improve the quality of services delivered by NGOs to the communities. Activities include organizational capacity development, specialized training for NGO management, M&E, financial management, organizational strengthening, and proposal writing. Topics can be prioritized based on the training needs assessment, and will increase their capability and competitive power for fundraising in a resource constrained environment.
PROGRAM: ORGANIZATIONAL CAPACITY		
Recommendation #9: Develop, implement and monitor the transition plan	Immediate	• Develop a time-bound and actionable transition plan and adequate indicators to monitor plan implementation and ensure incorporation of this plan into the AMTP6 and Annual Operation plans; • Ensure sufficient resources are available for transition by preparing budget for AMTP 6 which includes transition plan elements; • Ensure that the PNAC has the mandate, competence and legal power to assume responsibility for the coordination, planning, implementation and monitoring of the transition process.

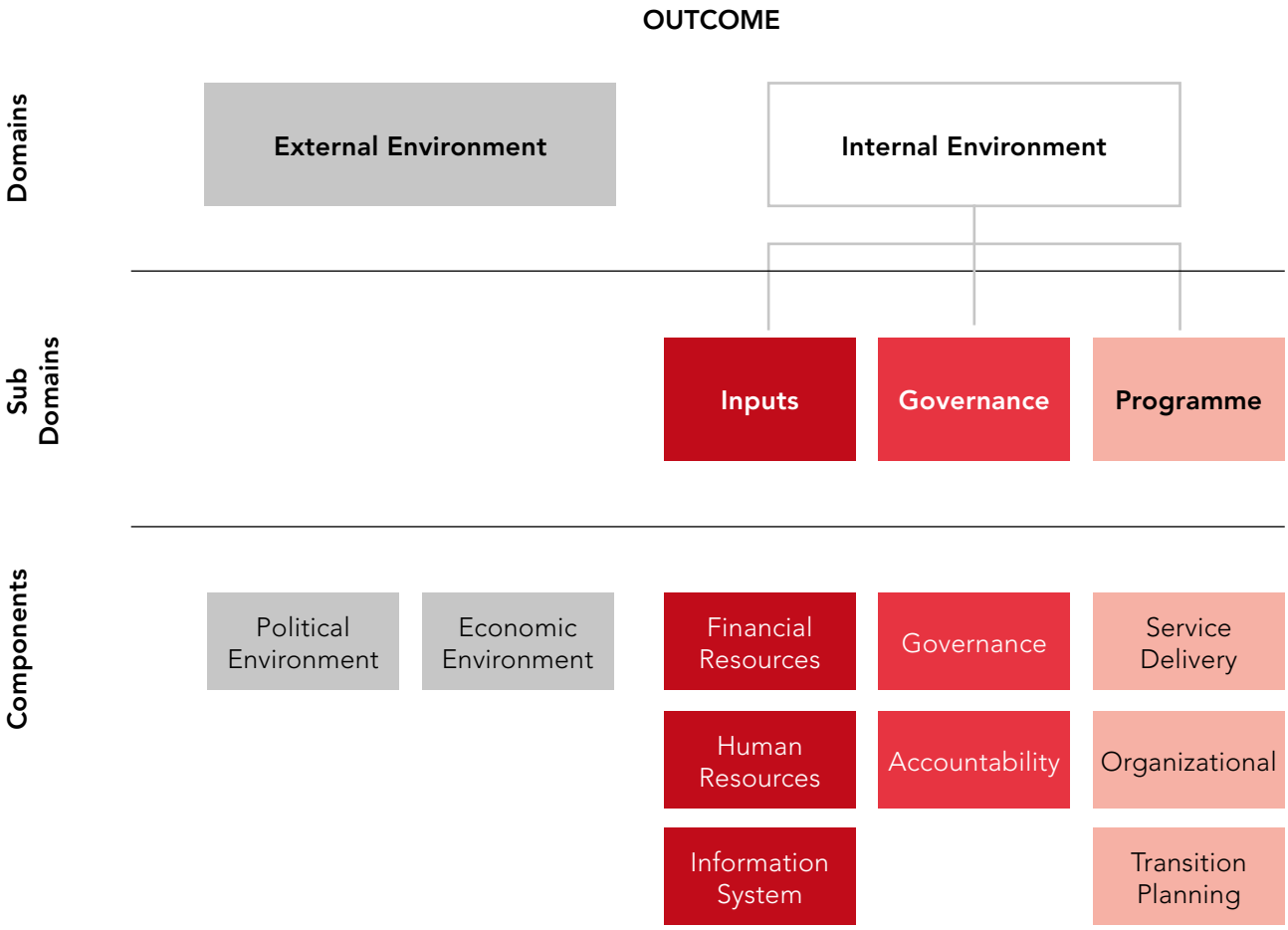
Annex 1: Methodology

The TPA Framework is divided into two domains: the external environment and the internal environment.

The external environment encompasses the elements outside of the health sector and covers political and economic environment. The internal environment of the program, which is further sub-divided into three sub-domains of inputs, governance and program, represents the factors within the health sector. Sub-domains are further divided into components affecting transition as well as the sustainability of the public health programs after graduating from donor support. The final expected outcome of this process is a successful transition when programme outcomes are either retained and or enhanced.

F.4

TPA FRAMEWORK



Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. (2016). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation.

The Inputs entail the resources currently available for the disease-specific program. The resources are subdivided into financial resources, human resources and health information systems. Financial resources are assessed by examining the budgetary commitment and financial dependence on donor/external funding for both diseases, and by looking at the prioritization of investments for preventive and treatment interventions, especially for epidemiologically important population groups. The human resource component is measured by assessing the availability of sufficient human resources; the institutionalization of donor-supported trainings; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale. Health Information Systems are assessed by evaluating the integration of comprehensive routine statistical reporting in national health information systems for the disease, as well as by evaluating HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, funding sources and the integration of the data in national reporting.

The Governance sub-domain includes the actors/institutions involved at an organizational level, how they make decisions, their roles and motivations towards the adequate transition of disease programmes and their relationship with other actors. Identified enabling factors related to governance are sub-divided into governance-specific factors and accountability. Governance-specific factors include a strong political commitment to disease treatment and fostering political support for the programme; effective leadership/management ensured through a legally empowered organization; the existence of champions/ individuals who advocate for and/or manage disease-specific programmes; and appropriate coordination of all parties involved in the programme through a dedicated, legally empowered and well-functioning coordinating body.

The Programme sub-domain encompasses the activities included within the health program and the operational capacity to implement these activities. It is composed of service delivery, organizational capacity and transition planning components. Within service delivery we look at the integration of certain services, service coverage and treatment outcomes. Concerning the organizational capacity to provide services, we examine the management of the national disease programmes; procurement mechanisms; and the existence of appropriate monitoring and evaluation mechanisms, including adequate analytical capacity. All three elements are crucial for the effective transition of disease programs. A direct measure of forward thinking disease programs currently receiving external funding is the ability to plan the take-over of responsibilities both at the programmatic level and in terms of funding. Appropriate tracking of the transition process requires the following: transition planning through strategies that align the program with national policies that are in turn informed by international guidance and/or evidence; programme management arrangements to assure the appropriate transfer of responsibilities; and effective monitoring and evaluation of the transition.

Quantitative and/or qualitative indicators are used to measure each component. These indicators assess the possible risk for transition using a scoring system in which 2=low or no risk, 1=medium/moderate risk and 0=high risk. The indicators are converted into numerical values, and a risk category is assigned to each component according to the overall scores. To define a country's overall risk, scores for each category are summarized and aggregated, based on the percentage

of scores accumulated for all domains/ sub-domains/categories. Weighting was not applied during the scoring. A summary score for a disease identifies the overall risk for program transition, while the component scores identify areas that pose the highest risk and should be addressed during the transition process.

Annex 2: List of Reviewed documents Standard Concept Motet 2014

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8. PHL-506-GO4-H - Upscaling the national response to HIV/AIDS through the delivery of services and information to population at risk and people living with HIV/AIDS, Tropical Disease Foundation Inc. 2006
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13. PHL-607-G08-H - Scaling Up HIV Prevention, Treatment, Care and Support Through Enhanced Voluntary Counseling and Testing and Improved Blood Safety Strategies-1, Department of Health 2007
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27. 4th AIDS Medium Term Plan 2005-2010 Philippines 2005

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38. The Philippines Health System Review Health Systems in Transition 2011

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44. An HIV epidemic is ready to emerge in the Philippines, Farr and Wilson Journal of the International AIDS Society 2010

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49. Sustainable HIV Financing in Transition (SHIFT) Program, AFAO 2016

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Annex 4: List of Interviewed People

#	Name	POSITION	AGENCY/INSTITUTION
1	Risa Hontiveros	Senator	Senate of the Philippines
2	Ramon Navarra	Chief of Staff	Senate of the Philippines
3	Atty Kristine M Mendoza	Staff	Senate of the Philippines
4	Paulyn Russel Ubial	Secretary of Health	Department of Health

#	Name	POSITION	AGENCY/INSTITUTION
5	Rosalind G Vianzon	Medical Officer V, IDPCD	Department of Health
6	Dr Gerardo Bayugp	Undersecretary, Technical Services Office	Department of Health
7	Carolina Taino	Assistant Secretary, Admin, Finance & Procurement Off	Department of Health
8	Larry Cruz	Director IV, Finance Service	Department of Health
9	Noel Palaypayon	Deputy Manager, HIV Surveillance Unit, Epidemiology Bureau	Department of Health
10	Ma. Justina Zapanta	Nurse III, HIV Survieillance Unit, Epidemiology Bureau	Department of Health
11	Krizelle Anne Umali	Surveillance Officer, HIV Survieillance Unit, Epidemiology Bureau	Department of Health
12	Jose Gerard Belimac	Director, National HIV/AIDS & STI Programme	Department of Health
13	Dr Miel Nora	Chief of Party, TGF HIV/AIDS New Funding Model Project	Save the Children, PR
14	Hilario Umali	Logistics Manager, TGF/AIDS New Funding Model Project	Save the Children, PR
15	Rigil Kate Salvado	Monitoring, Evaluation, & Learning Manager	Save the Children, PR
16	Mary Antoniette Remonte	Medical Specialist III, Health Finance Policy Sector	Phil Health
17	Abigail Romero-Estrada	Sr Social Insurance Specialist	Phil Health
18	Arlene S Ruiz	Chief, Econ. Dev. Specialist, Social Development Staff	National Economic & Development Authority
19	Cristina M Clasara	Director, Budget Management Bureau B	Department of Budget & Management
20	Jane V Abella	Assistant Director, Budget Management Bureau B	Department of Budget & Management
21	Nanette R Cabral	Chief Specialist, Budget Management Bureau B	Department of Budget & Management
22	Winona Rose T Caguioa	Sr Specialist, Budget Management Bureau B	Department of Budget & Management
23	Mary Grace G Darunday	Sr Specialist, Budget Management Bureau B	Department of Budget & Management
24	Fides Basas	Specialist, Fiscal Planning & Reform Bureau	Department of Budget & Management
25	Jusrex B Abejero	Analyst, Budget Management Bureau B	Department of Budget & Management
26	Ella Cecilia G Naliponguit	Director, Bureau of Learner Support Services	Department of Education
27	Dr Ma. Corazon Dumlao	Chief, School Health Division	Department of Education
28	Dr. Ann Cuizon	Asst Chief, School Health Division	Department of Education
29	Silvestre Z Barrameda, Jr.	International Partnership Unit	Department of Interior & Local Government
30	Anjela Mae Era	Project Officer, Local Government Adademy	Department of Interior & Local Government
31	Ilya T Abellanosa	Epidemiologist & HIV/AIDS Coordinator,	Cebu City Health Office
32	Teresita Bagasao	Country Director	UNAIDS Country Office

#	Name	POSITION	AGENCY/INSTITUTION
33	Zimmbodilion Mosende	Strategic Information Advisor	UNAIDS Country Office
34	Malou L Quintos	Program Associate	UNAIDS Country Office
35	Mario Balibago	HIV/AIDS Program Officer	UNICEF
36	Gerard Servais	Sr Health Specialist, Southeast Asia Department	Asian Development Bank
37	Roberto Antonio Rosadia	Health Specialist, Health, Nutrition & Population	The World Bank
38	Qi Cui	Portfolio Manager	The Global Fund
39	Leslie A Tolentino	ACHIEVE, Inc	CSO
40	Eden Divingracia	Executive Director	The Philippines NGO council on Population, Health & welfare, Inc (PNGOC)
41	Desi Andrew Ching	Co-founder, REDX & Executive Director, HASH	CSO
42	Jhun Hadjirul	Pinoy Plus	CSO
43	Ruthy C.D. Libatique	Board Member, HIV & AIDS Support House (HASH)	CSO
44	Noemi B. Leis	AMTP6 Consultant & HASH Board Member	CSO
45	Angelo James Esperanzate	The Red Whistle, Board Member	CSO
46	Renier Bona	SHIP Foundation	CSO

HIV ERG

HIV Economics Reference Group

BACKGROUND BRIEF FOR FIRST MEETING

ECONOMICS REFERENCE GROUP

Technical Working Group for Sustainable Financing