

**Review of Differentiated
Service Delivery and
Other Service Delivery
Approaches
for HIV Testing and Treatment
in the Philippines**



Differentiated Service Delivery
- Strategic Initiative

SEPTEMBER 2022

Review of Differentiated Service Delivery and Other Service Delivery Approaches for HIV Testing and Treatment in the Philippines

Report developed by FHI 360

This report is financed by Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) as part of the Differentiated Service Delivery Strategic Initiative (DSD-SI), which aims to address gaps in testing and treatment for key populations, men, adolescents, and children. Analyses and recommendations in this report will support the Government of Philippines (GoP)'s goal of scaling differentiated service delivery (DSD) models to meet clients' preferences and facilitate a resilient health system.

1 Background

Differentiated service delivery (DSD) is a people-centered approach that tailors service delivery to the needs of different client groups in order to improve service quality and increase access to healthcare while reducing the unnecessary burden to the healthcare system. Several DSD approaches are already being implemented in the Philippines as part of national policy, such as community-based testing, or as pilot implementations, such as HIV self-testing. Earlier this year, the Department of Health (DOH) released updated national guidelines on HIV testing¹ and treatment² that emphasized differentiated service delivery approaches, establishing DSD as a fundamental national strategy in HIV service delivery.

An important aspect of the context in which DSD is being further implemented and developed is the ongoing reforms under the country's Universal Health Care Act. Under the UHC Act, people-centered primary care is to be strengthened as the foundation and central element of the health care system. In line with this, the DOH has recently released the Omnibus Health Guidelines (OHG) to serve as the overarching policy issuance that defines the services and other elements of health care across all health programs that are appropriate for each life stage under primary care. The OHG groups health interventions into the following: 1) self and household care, 2) screening of asymptomatic individuals, 3) diagnosis of symptomatic individuals, and 4) management.

DSD shares the core tenet of person-centeredness with the UHC Act and strengthens the responsiveness of health services to the needs of client groups. The HIV continuum of care, across

¹ Department of Health. Administrative Order No. 2022-0035: Guidelines in the Implementation of Differentiated HIV Testing Services. 2022 Aug 22.

² Department of Health. Administrative Order No. 2022-0024: Guidelines on Differentiated Treatment for People Living with Human Immunodeficiency Virus (PLHIV) and Prophylaxis for HIV-Exposed Infants. 2022 Jun 30.

which DSD is applied, is also aligned with the Omnibus Health Guidelines (Figure 1), with self and household care encompassing the continuum, screening and diagnosis, and management of disease corresponding to antiretroviral therapy initiation, retention, and viral load suppression.

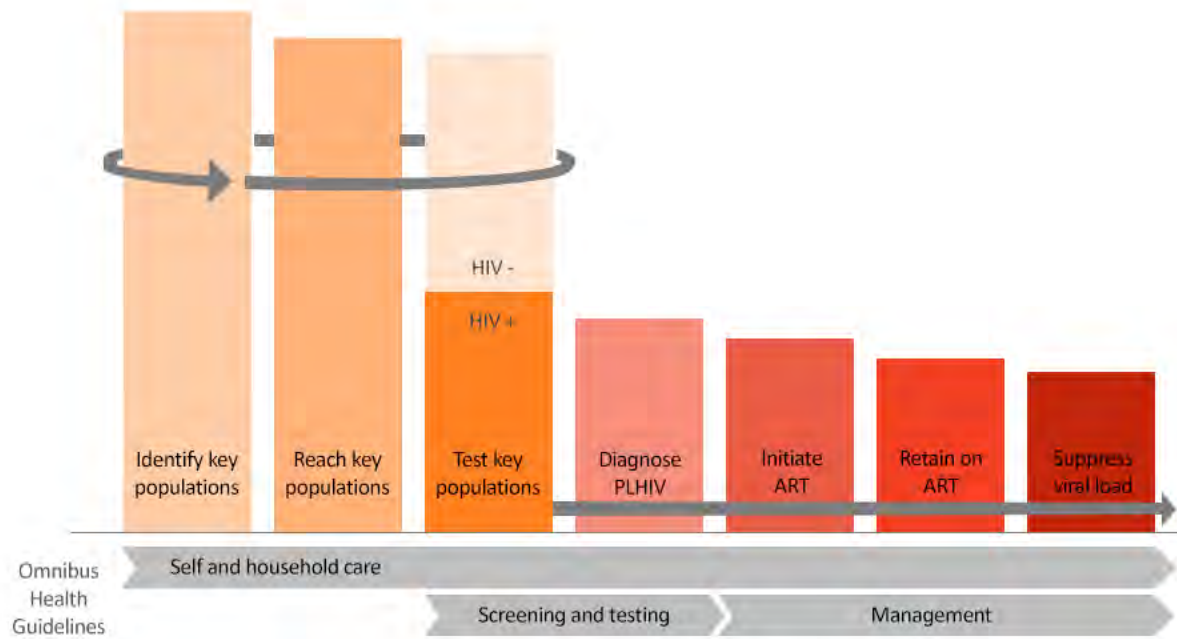


Figure 1: HIV continuum of care aligned with OHG structure

A review of the current state of DSD implementation, including good practices, lessons learned, and existing points of primary care integration, can be useful for national and local stakeholders in applying or scaling up DSD approaches and integrating these with primary care. While DSD can apply to the whole spectrum of HIV care, this report focuses on DSD in testing and treatment, which is the scope of the Differentiated Service Delivery Strategic Initiative under which this review was undertaken.

This review has the following objectives

- Describe current DSD models for testing and treatment in the Philippines and their coverage
- Determine current general primary care screening and management services at HIV care facilities
- Identify good practices and gaps in DSD implementation
- Provide recommendations on improving implementation, scaling up of DSD models, and integrating with primary care

2 Methods

The following methods were used for this review:

Online guided facility survey: Facility-level information on DSD approaches and primary care services currently being implemented were obtained through an online survey for HIV treatment facilities. Facility managers/coordinators were invited to a virtual meeting and were given an orientation on DSD before answering the online survey during the meeting. This approach was decided upon after consultation with selected stakeholders who suggested that respondents may need a prior orientation before answering the questionnaire as not all respondents may be familiar with the DSD terminology and concept.

All 179 current treatment facilities were targeted for the survey and 62 facilities participated. Table 1 summarizes the characteristics of the surveyed facilities.

Most of the facility respondents (81%) had not heard of the term DSD. Among the 19% who did, their sources of information were scientific conferences including IAS, regional program managers and other work colleagues, and discussions with partners particularly from PSFI and WHO.

Interviews with facility providers and PLHIV support group members: Interviews were conducted to obtain more context on the DSD approaches being used in the country. Thirty-two representatives from different PLHIV support groups were virtually interviewed in five groups: women, youth, and representatives from Luzon and the National Capital Region, Visayas, and Mindanao. Many of the representatives were engaged in HIV service provision, particularly in information dissemination, community-based screening, and case management. Service providers from 12 facilities and sites were also interviewed virtually on their experiences with implementing DSD approaches to identify good practices, lessons learned, and challenges.

Desk review: Existing and upcoming policies supporting DSD, and available DSD coverage data from surveillance were reviewed.

Table 1: Characteristics of surveyed facilities

Facility type	
Treatment hub (hospital)	45 (73%)
Primary care clinic	17 (7%)
Ownership type	
Government	51 (82%)
Private*	11 (18%)
Region	
III - Central Luzon	13 (21%)
NCR - National Capital Region	12 (19%)
IV - CALABARZON	9 (15%)
VI - Western Visayas	5 (8%)
VII - Central Visayas	5 (8%)
I - Ilocos Region	4 (6%)
MIMAROPA	4 (6%)
XI - Davao Region	3 (5%)
V - Bicol Region	2 (3%)
X - Northern Mindanao	2 (3%)
CAR - Cordillera Administrative Region	1 (2%)
IX - Zamboanga Peninsula	1 (2%)
XIII - CARAGA	1 (2%)

*Includes facilities run by community-based organizations

Consultation meetings with key national and sub-national stakeholders: Consultation meetings were done prior to the conduct of the facility survey to gather feedback for improvement of the questionnaire.

While virtual interventions are mentioned briefly in this report, an analysis focused on current virtual HIV interventions in the Philippines is available as a separate report ([link](#)).

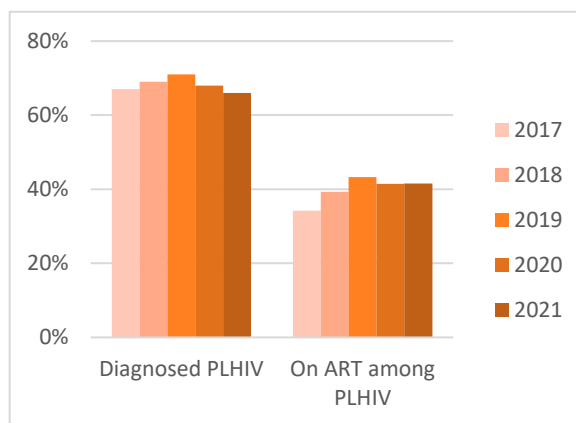
3 Context of the HIV epidemic in the Philippines

HIV prevalence in the Philippines has remained less than 1% among a population of about 110 million, but new infections continue to increase annually. Key populations are most affected, predominantly men who have sex with men, with an estimated prevalence of 5%³, as well as transgender women and persons who inject drugs.

With regards to the 95-95-95 targets, the Philippines still has to bridge considerable gaps. Among estimated PLHIV in 2021, diagnosis coverage was 66% and treatment coverage was 63% among those diagnosed (41% of total estimated PLHIV). Viral load testing coverage remains low although increasing at 32%; among those tested for VL, 96% show viral suppression.

The trend in diagnosis coverage among PLHIV in the past five years (Figure 2) shows a persistent gap in the proportion of PLHIV not being diagnosed. The incremental growth in ART coverage also suggests that strategies in linkage to treatment need to be improved to bridge the gap between testing and treatment.

Figure 2: Diagnosis and treatment coverage among PLHIV in the Philippines, 2017-2021⁴



3 UNAIDS (2021). Data Book

4 Department of Health – Epidemiology Bureau (2021 Dec). HIV Care Cascade Report.

4 Self and household care

4.1 Promotion of healthy lifestyle practices

Online sources of information on sexual health and HIV are important, as the Philippines has very high internet and social media use. Cognizant of this, service providers now widely use virtual mechanisms to provide information on sexual health and HIV as part of demand generation for testing and other services. All surveyed primary HIV care clinics and 89% of treatment hubs used at least one virtual method to support their outreach efforts. Having an official social media page is the most common method used, by 84% of surveyed facilities overall.

Virtual approaches are also used to support provision of commodities for STI and HIV prevention, particularly condoms and lubricant. An example of this is Safe Spaces, a condom and lubricant distribution network managed by LoveYourself, a community-based organization in Metro Manila. The network is composed of different types of non-medical facilities in the community, such as wellness facilities, restaurants and bars, cafes, and schools, that serve as access points for free condoms and lubricants. The Safe Spaces app shows users the nearest access points, and official Safe Spaces social media accounts also assist people online in finding access points and individuals who can directly give the commodities to the users.

More information on the use of virtual HIV interventions can be found in the report *Situational Analysis of Virtual HIV Interventions in the Philippines* ([link](#)).

4.2 Self-testing

HIV self-testing has been implemented in the country since early 2020 in the context of a demonstration study and pilot implementation in Global Fund project sites led by LoveYourself in partnership with WHO and University of the Philippines Manila. The inclusion of HIV self-testing in the Omnibus Health Guidelines and the DOH Administrative Order 2022-0035 (Guidelines in the Implementation of Differentiated HIV Testing Services), both recently released in 2022, will enable its uptake by more service providers throughout the country.

Access to the LoveYourself-led self-testing program is currently through a dedicated Facebook page. Virtual assistants, in the form of pre-recorded instructions and messages by celebrity ambassadors, guide the clients on how to access, use and report the results from the test kits, which are then delivered to the clients with an offline and online kit guide. Once a client reports their result, volunteers take over from the automated virtual assistants to assist linkage to confirmatory testing.

This service delivery design was constructed in the context of pandemic-related mobility restrictions during the initial implementation, although the online modality was also favored by most respondents in the feasibility and acceptability study conducted prior. During the time of strict mobility restrictions, LoveYourself also established transportation services to pick up the client from their home, ferry them to the facility for same-day confirmatory testing and ART initiation, and take them back home. In the

first month of pilot implementation in Metro Manila, about 1,800 kits were distributed, with a reactivity rate of about 7% and linkage rate of about 80% among reactive clients, based on LoveYourself's data.

The initial rollout was to additional clients in Metro Manila and nearby provinces, then later through GF PROTECTS sites throughout the country that had experience with WHO's previous self-testing studies. Several of these sites are able to fulfill orders from on-site stocks, but for the rest, orders are fulfilled from LoveYourself's base in Metro Manila. Orientation and consultation with other regions, training on the use of the virtual platform, including data privacy measures and data privacy agreements, and rolling out to other community-based organizations throughout the country are being undertaken to further expand the self-testing service in GF sites. Future developments planned for self-testing include offline access, since not all potential clients may have smartphones or adequate connectivity.

A main challenge in self-testing is the rate of results reported by clients, which is the trigger for linkage to confirmatory testing and treatment. To address this, LoveYourself modified its messaging strategy to motivate clients to report their test result. They also established a system of following up clients who do not report back within a period of time in order to conduct life-coaching approaches to identify and respond to reasons for not reporting back. Some interviewees whose facilities and organizations did not offer self-testing also expressed reservations about the appropriateness of self-testing in some contexts, particularly in places far from municipal or city centers where access to the nearest treatment facility is difficult and means of communication with a health service provider to support them is limited.

4.3 Community activities

Community-based organizations (CBOs) are key stakeholders in leading and organizing advocacy and information dissemination activities in communities, which are often linked to other prevention as well as testing services. These activities are coordinated with local government officials, health facilities, and other institutions, and may be linked to existing community events such as sports events and pageants, or be a featured event on its own.

PLHIV support groups help empower their members through psychosocial support, guidance in accessing and adhering to care, and other forms of assistance. Some support groups conduct learning group sessions with their members on topics related to HIV and to other health conditions as well. For example, a support group for women conducted learning group sessions on HPV and cervical cancer accompanied by free cervical cancer screening services in partnership with health care providers. The learning group sessions are usually conducted face to face, although virtual sessions were also used during pandemic restrictions. Virtual group chats on messaging apps are also a key method for PLHIV support groups to communicate and check in with each other, as well as coordinate activities and assistance.

5 Screening and diagnosis

5.1 Differentiated HIV testing

Several differentiated testing approaches are currently used in the Philippines. Community-based screening (CBS) is supported by national interim guidelines, while self-testing and social and sexual network testing are currently in pilot implementation and has been included in the recently released update of national testing guidelines, along with index testing.

Table 2: Examples of strategies for differentiated testing

Reach/Mobilization	Testing	Linkage to Care
Mass/group <ul style="list-style-type: none"> • Traditional media • Social media • Community gatherings 	Health facility	Referral Accompanying Compensation Same-day ART initiation Friendly services Tracing
Network-based <ul style="list-style-type: none"> • Social and sexual network testing 	Non-health facility <ul style="list-style-type: none"> • Workplaces • Schools • Prisons and other closed settings 	
Partner notification and index testing <ul style="list-style-type: none"> • passive notification (patient directly mobilizes their partner) • voluntary assisted partner notification (health provider contacts partner to offer HTS) 	Community <ul style="list-style-type: none"> • Client's home • Bars • Parks • Other venues 	
	Self-testing/self-testing	

Adapted from: International AIDS Society, 2018. *Differentiated Service Delivery for HIV: A Decision Framework for HIV Testing Services*

5.1.1 Testing in non-health facilities

The majority (74%) of surveyed health facilities conduct testing in non-health facilities, including workplaces, prisons and other closed settings, schools, community, and clients' homes (Figure 3). Most interviewed facilities said the frequency of these activities depend on the invitations they receive, although a few have formal agreements such as with schools or workplaces for a set frequency of testing. Testing in prisons and other closed settings are done in closer coordination with the management and health team within the prison or facility.

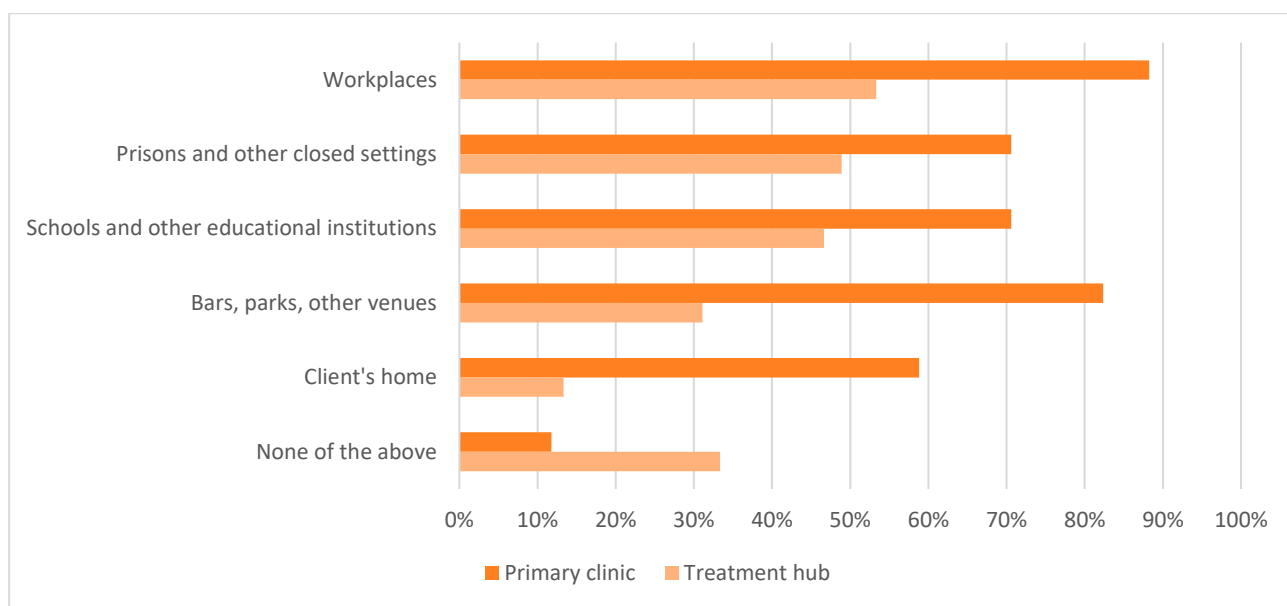


Figure 3: Proportion of facilities conducting testing in locations outside of the facility, by type of facility (n = 62)

5.1.2 Community-based screening (CBS)

Community-based screening is a "non-laboratory rapid HIV screening procedure performed by a trained member of a community-based organization." It was developed as a strategy to be able to screen members of key populations who are harder to reach through conventional facility-based testing or outreach events. (1) The term "screening" emphasizes that subsequent confirmatory testing is needed to establish HIV diagnosis, and that CBS is meant to complement existing testing modalities. CBS contributes to expanding testing reach, since previously only medical technologists who completed HIV proficiency training could carry out any component of HIV testing. Through CBS, trained non-medical persons known as CBS motivators, who may be members of community-based organizations or KP members hired by local government units and other organizations, then carry out motivational dialogue, HIV screening, and linkage to treatment or prevention services. Since the initial training and roll-out to Global Fund-supported sites in 2016-2017, CBS has become a widely used strategy. Among the surveyed facilities, 65% conduct community-based screening and 98% receive referrals from partners and other organizations performing CBS.

Table 3: General DSD building blocks of community-based screening

	Mobilizing	Testing	Linking
WHEN	Targeted time to reach key population	At agreed upon time with client; repeat every 6 months for those at higher risk	As soon as possible after reactive result; active follow-up for 3 months
WHERE	Online and community outreach	Community	To client's selected treatment facility
WHO	CBS motivators (trained peer workers)	CBS motivators	CBS motivators

WHAT	Outreach	Screening with rapid test kit	Accompanying to facility; support for baseline labs and related expenses
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CBS motivators mobilize potential clients through several means. One is through social networking and dating apps where they give information about their offered screening services and other HIV-related topics, and connect with individuals to carry out CBS, which is then done with the client at an agreed upon place and time. Another means is through community gatherings and other events, such as local beauty pageants, by coordinating with partners such as LGBTQ+ groups and individuals, barangay (village) officials, and other key persons who can organize and/or extend invitations to these events. Another way is through coordinating with non-health facilities, such as workplaces, schools, prisons and other closed settings, and conducting the screening or testing there. Some HIV care facilities who have their own or partner CBS motivators decide to deploy either medical technologists or CBS motivators or both to different events and non-health facilities, depending on what they think will work best for the situation.

When a screening result is reactive, a CBS motivator offers options on HIV treatment facilities where confirmatory testing can be done and treatment initiated, and often physically accompanies the client to their chosen facility. Depending on available support such as Global Fund’s (GF) enabler’s funds, the CBS motivator may be able to cover transportation and food costs or use personal funds if the client cannot afford linkage-related costs.

Reaching the harder-to-reach with CBS: The experience of community-based organization HIV and AIDS Safe House, Inc. (HASH)

HASH has been closely involved since the beginning of CBS through the development of training manuals, conduct of training, and pilot implementation. Presently, they continue to train staff and volunteers of local governments and development partners, as well as develop their own network of CBS motivators and volunteers. HASH’s internal strategy focuses on their CBS motivators tapping into their social and sexual networks and continuing to train more volunteers in order to reach more networks and individuals at higher risk of HIV, and this has yielded higher reactivity rates.

In several years of training and implementation, HASH has recognized some important factors for CBS. Constantly engaging local governments and organizations is crucial for the continuity of the CBS programs, and HASH has point persons regularly visiting them to maintain and develop these relationships. The sustainability of providing test kits and materials and supporting the conduct of testing and linkage, including transportation costs, is also a critical issue. HASH mobilizes and transfers available resources in its network to sites where they are needed, and projects such as EpiC are currently able to support some of these. However, HASH is also looking into how local governments can support CBS more fully in the future, with the expected additional financing flowing into local governments with further devolution of health care services and responsibilities under Universal Health Care.

Linkage to treatment and care was perceived by many of the facility and PLHIV interviewees to be more challenging among clients screened outside of a health facility and had a reactive result than those who visited a facility for voluntary counseling and testing. Some of the reasons given were the costs involved in traveling to a treatment facility for baseline laboratory tests and ART initiation, especially in regions with fewer facilities; conflicting schedules between the client's work or school hours and the facility's service hours; and the clients' fear of the repercussions linked to a positive result, including stigma and discrimination. The cited measures taken to address these include physically accompanying a client to the treatment facility; tapping financial assistance mechanisms to cover travel, food, lodging, and some laboratory costs, although these may not be available for all cases; and giving time and emphasis to pre- and post-test counseling. Some also felt that the number of CBS motivators in their area was inadequate and suggested training CBS motivators at the *barangay* (village) level, instead of only at the municipal or city level.

5.1.3 Index testing (IT) and social and sexual network testing (SSNT)

Seventy six percent of surveyed facilities indicated that they offer index testing, which involves offering testing to sexual partners, injecting partners, and biological children and parents of diagnosed PLHIV. Most interviewed facilities clarified that they encouraged clients who tested positive to encourage their partners as well to avail of testing, but this was not systematically followed up, recorded or reported, as there were no national guidelines yet. Some also raised the need for a referral and support network for cases of gender-based or intimate partner violence that may be revealed in the course of offering index testing.

Over half (55%) of surveyed facilities also indicated that they engage in social and sexual network testing. But as with index testing, some interviewed sites also said this is not done or reported systematically given the lack of national guidelines. Pilot implementation in selected GF and EpiC sites, with some started last year and others this year, includes incentivized approaches for MSM, TGW, and PWID populations.

5.2 Screening for other health conditions

All surveyed primary HIV care clinics offered screening for other STIs, and most offered screening for hepatitis B or C (94%) and TB (88%). About half (53%) screened for diabetes mellitus, and around a third screened for cardiovascular diseases (29%), depression (35%), and anxiety (29%). Only one respondent among the primary HIV care facilities surveyed screened for cervical cancer (6%), and none screened for colon cancer (Figure 4: Coverage of screening for selected health conditions by type of surveyed facility).

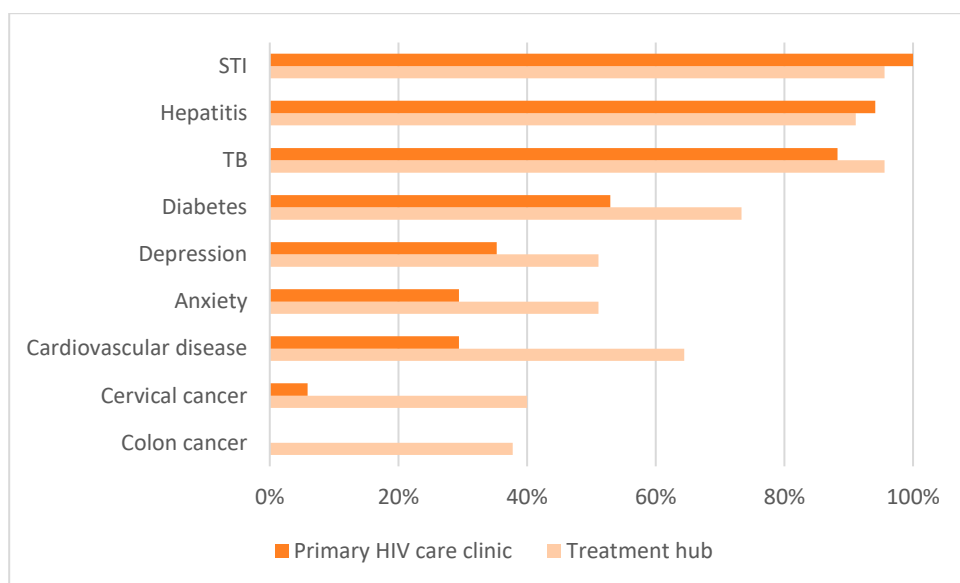


Figure 4: Coverage of screening for selected health conditions by type of surveyed facility

Screening rates for surveyed treatment hubs are generally higher than in primary HIV care clinics, which may be explained by the greater availability and accessibility of trained personnel and screening equipment in hospitals. The majority of surveyed treatment hubs screened for other STI (96%), TB (96%), and hepatitis B or C (91%). Most also screened for diabetes mellitus (73%) and cardiovascular diseases (64%). Only about half screened for anxiety (51%) and depression (51%), and less than half screened for cervical cancer (40%) and colon cancer (38%).

6 Management

6.1 HIV treatment and care

6.1.1 Same-day and rapid ART initiation

The Rapid HIV Diagnostic Algorithm (rHIVda) for confirmatory testing, which began implementation in 2019, can produce confirmatory results within the day of testing and enables faster linkage to treatment. In 2021, there were 29 rHIVda sites throughout the country, which are HIV treatment facilities as well. Other facilities near a rHIVda site may send testing samples for confirmation there instead of to the National Reference Laboratory for a faster turnaround time.

Among surveyed facilities, 47% responded that they offered same-day ART (SDART) initiation and 35% offered rapid ART initiation (within 7 days of testing) but not SDART. Among the 29 facilities that offered SDART, only 8 (28%) are rHIVda sites; among the 22 facilities that offered rapid ART initiation but not SDART, 7 (32%) are rHIVda facilities. Interviewed non-rHIVda facilities who were able to offer SDART said that they did so for clients with a reactive test and advanced HIV disease clinically and/or by CD4 count and no contraindication for starting ART.

A main reason identified by interviewed facilities as to why SDART was not offered was the delay or unavailability of baseline laboratory tests, particularly the GeneXpert test for TB. Some sites estimated

a turnaround time of 3 days for a GeneXpert result, due to the long queue of samples being processed.

6.1.2 ART delivery

Table 4: Summary of current DSD approaches used for ART delivery for clients stable on ART in the Philippines

	ART Refills	Clinical consultations	Psychosocial support
WHEN	Every 3-6 months*	Every 3-6 months	Every 3-6 months or more frequently as needed
WHERE	Health facility (may have fast track lane) Home delivery Other local access points Patient support groups Drop-in centers Pharmacies	Health facility Virtual Drop-in centers/community centers	Health facility Virtual Drop-in centers/ community centers
WHO	Physician/nurse/pharmacist Case manager Support group member	Physician/nurse	Nurse Case manager Patient support groups Social worker Mental health officer
WHAT	ART dispensing	Clinical assessment Laboratory testing for monitoring	Psychosocial support Adherence support

*Updated guidelines released in June 2022 prescribe 6 months duration

Multi-month dispensing (MMD)

Almost all (97%) surveyed facilities said that they dispense multi-month refills (3- or 6-months' supply) to their clients; notably, the survey and interviews were conducted prior to the release of national guidelines stating that MMD was for at least 6 months. Most interviewed facilities preferred to give 3 months' worth of supply, as they wanted to check in with clients in person more frequently than 6 months would allow. A longer duration of supply was given to certain clients in consideration of the distance from their residence to the facility, or if the client was an overseas Filipino worker who would need to spend more than six months away from the country.

The challenges identified by interviewees in relation to multi-month dispensing were delays in the arrival of ARV stocks and short expiration dates of certain ARV stocks when delivered, rendering affected facilities unable to provide a longer supply duration to clients. As a temporary solution, facilities mentioned reaching out to other facilities to inquire and possibly obtain stocks. PLHIV support groups also reached out to their members or groups from other areas to "borrow" and share from their personal supply while the supply issues at the facilities are being resolved.

ART refill access

Among the different approaches to ART refill access, home delivery was the most widely used with 85% of facilities offering this option to clients who are stable on ART (Figure 5). This involves the use of commercial courier services as well as facility staff who deliver the ARV to the clients' homes. Home delivery was deployed widely during the periods of strict mobility restriction during the pandemic. As the restrictions have been relaxed more recently, some facility providers said that more clients now pick up their refill in person and that this service is availed mostly by clients living farther from the facility, where courier expenses are cheaper than personal travel.

Fast-track refill services at facilities are offered by most surveyed facilities as well (74%). About a third used other local access points (31%), which include rural health units/urban health centers and mobile clinics; and/or distribution through patient support groups (27%). Only about a tenth of respondents use external pharmacies (11%) and drop-in centers (10%) for their ART refill services. Other means of ART refill access are through clients' treatment partners or authorized representatives to pick up their ART refill, and meet-ups between clients and clinic staff outside the facility and usually outside of clinic hours.

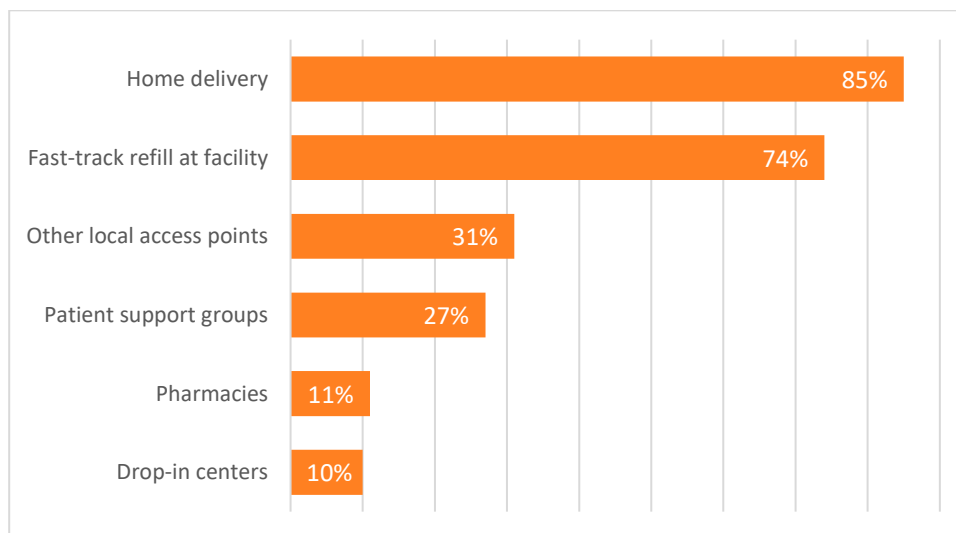


Figure 5: Coverage of ART refill options among surveyed facilities (n = 62)

6.1.3 Extended service hours

About half of facilities (52%) have extended service hours, which include hours outside of the usual office hours as well as operations during weekends. The majority (82%) of primary clinics offer extended hours, while less than half of treatment hubs do (40%). Some support group member interviewees expressed the need for extended working hours particularly in areas with fewer facilities.

6.1.4 Laboratory service access

76% of the respondents offered viral load testing and CD4 count testing at their facilities. Complete blood count (87%) and blood chemistry test (85%) were mostly available at the facilities as well.

If certain baseline laboratories were not available at the facility, more than half of the respondents (55%) collected the client's sample at their facility and sent the sample to a partner laboratory. 29% referred the client to get tested at a partner laboratory in their service delivery network, while 31% had the client go to their laboratory of choice. Two respondents (3%) said that all baseline laboratories were available at their facility.

During strict pandemic lockdowns, some service providers undertook ways to continue access to viral load testing, such as visiting clients at their home or another meeting point to extract blood for viral load testing. However, these ad hoc methods were not continued as part of the regular options for access to viral load testing.

Towards a one-stop shop community center: the experience of Family Planning Organization of the Philippines (FPOP) Iloilo

Originally focused on serving the sexual and reproductive health needs of women and adolescents in underprivileged communities, FPOP Iloilo has expanded their services to cover key populations, primarily MSM, TGW, and young KP, and pioneered approaches by becoming a pilot site or early adapter of different interventions.

One of these is the proxy consent mechanism for children in need of special protection for HIV testing services. This started in 2013 as part of Haiyan disaster response where a number of adolescents in relocation areas needed STI treatment. From 2015 to 2018, FPOP Iloilo were able to test at least 200 adolescents who turned out to have HIV. This contributed to evidence generation for the lowering of HIV testing age without parental consent from 18 years old to 15 years old in the Philippine HIV and AIDS Policy Act of 2018. FPOP Iloilo also stepped up to become a pilot site for community-based screening (CBS) implementation, as they saw this as a way of reaching key population members with increased behavioral risk but were less likely to go to facilities for testing. They eventually became one of the organizations providing CBS training in their region. FPOP Iloilo was also a pilot implementation site for HIV self-testing. Their community center also became an accredited HIV primary care clinic providing treatment services.

They have also invested heavily in training their community center staff for multiple services, including CBS, HIV counselling, proxy consent provision, and family planning so that each staff member can provide services to different types of clients and ensure continuity of care.

Early in 2020, they pre-positioned different access points for the self-test kits, along with preventive commodities, that allowed them to widen their reach in providing these to their clients. When community lockdowns were ordered in response to the COVID-19 pandemic, FPOP continued to bring their services to the key population via rented vans to dispense ARVs and collect blood samples for their regular laboratory analysis. For their clients from areas that are 3-4 hours away

from their clinic, they meet them halfway. A satellite clinic has been planned to be opened as well as a temporary shelter in their main clinic to better serve their patients. FPOP Iloilo plans to further expand their services by becoming a rHIVda site, with the target of being able to offer same-day ART to their clients.

6.2 Management of other health conditions

In general, the proportions of facilities offering treatment for other health conditions were lower than the proportions of those offering screening, for both primary care clinics and treatment hubs (Figure 6). Some of the interviewed primary care clinics referred screened clients for treatment with a specialist, and similarly, some treatment hubs referred clients to the appropriate hospital department for further management of certain non-HIV conditions. Some interviewed treatment hubs and even one primary clinic had rotating internal medicine residents who were able to screen and manage other health conditions, thereby expanding the scope of services they offered.

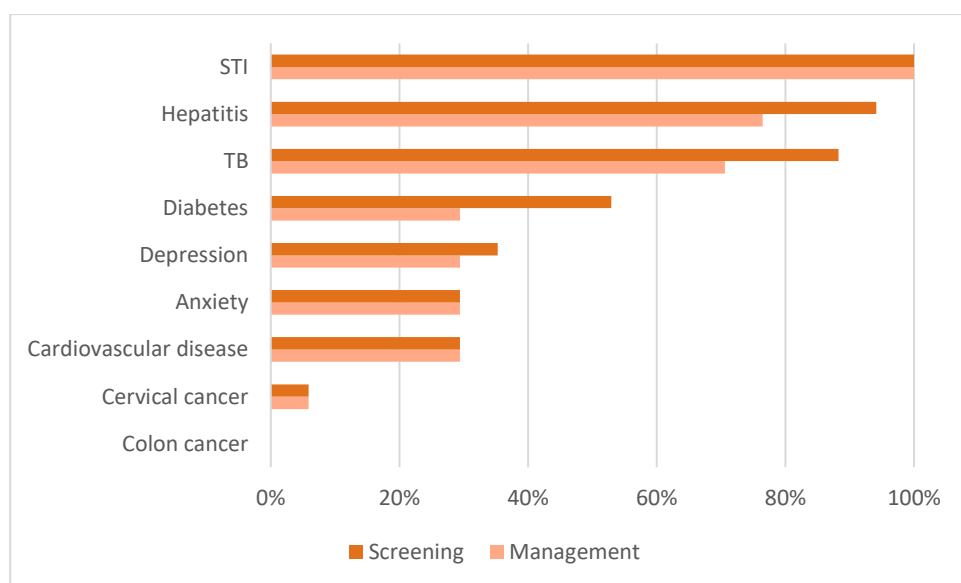


Figure 6: Coverage of screening and management of selected health conditions in surveyed primary HIV care clinics

Some interviewed facilities expressed the need for guidance in implementing the integration of general primary care with HIV services. In the experiences of other developing countries, the expansion of co-located services in specialized HIV care clinics to include other conditions under general primary care faced issues related to the increased work load and training of additional workforce, availability of drugs, and financing of additional services⁵. Clinical guidelines may need to be tailored to the PLHIV population, in consideration of HIV-related factors such as low CD4 count or

⁵ Njugunaa B, Vorkoperb S, Patel P, et al. Models of integration of HIV and noncommunicable disease care in sub-Saharan Africa: lessons learned and evidence gaps. *AIDS*. 2018; 32 (Suppl 1):S33–S42

drug interactions between ARV and other medication. For example, in some populations, CVD screening tools may underestimate CVD risk among PLHIVs.⁶

7 Recommendations

- Increase awareness among health service providers on DSD models and rationale, including global and regional good practices, and decision frameworks to help them develop and refine their DSD approaches more strategically. These topics can be included in the annual treatment facility conference and can be the focus of specific trainings and webinars.

Differentiated HIV Testing

- Continue to offer and expand use of multiple testing options.
- Improve monitoring of reactivity rates obtained through different DSD approaches for testing, to better assess the efficiency of the approaches in reaching high risk clients. Target differentiated testing approaches accordingly.
- Scale up rHIVda sites in order to ensure all clients receive confirmatory testing in a timely manner and are referred for ART initiation as needed.
- Scale-up index testing and social and sexual network testing
 - Establish guidelines and training for index testing and social and sexual network testing.
 - Consider incorporation of motivational counselling training into index testing training.
 - Develop and strengthen first-line support and referral networks for clients who disclose partner violence.
 - Expand incentivized approaches for social network testing.
- Scale up HIV self-testing:
 - Develop and disseminate self-testing SOPs and training.
 - Continue to scale up online approaches for self-testing
 - Expand options for offline distribution, include distribution of HIVST kits by peer educators, social network distribution, use of pharmacies and convenient pick-up points, distribution at key population drop-in centers and secondary distribution linked to index testing.
 - Expand options for follow-up and reporting, including follow-up by peers, referral and appointment cards, and options for self-report (SMS, toll-free hotlines, online).

⁶ Patel P, Speight C, Maida A, et al. Integrating HIV and hypertension management in low-resource settings: Lessons from Malawi. PLoS Med. 2018 Mar 7. 15(3):e1002523.

Service Delivery and DSD for HIV Treatment

- Strengthen the capacity of HIV treatment providers to implement same-day ART initiation to improve linkage to treatment and care, including the establishment of guidelines for same-day ART and capacity for baseline laboratory testing.
- Explore the option of ART initiation outside the facility as a complement to in-facility ART initiation, including operational considerations, acceptability among clients and providers, and settings for which it can be offered.
- Ensure consistent ART supply chain to ensure consistency in MMD provision.
- Expand decentralized drug distribution (home delivery, pharmacy models, lockers and other convenient pick-up points).
- Expand ART distribution through patient support groups and drop-in centers.

Integration with other health services

- Develop and include operational guidance on expanding primary care services in HIV facilities as part of guidance in strengthening and developing primary care facilities and networks
- Include specific considerations for PLHIV in clinical practice guidelines for other health conditions as applicable
- Support and undertake operational research in incorporating DSD in integrated HIV and general primary care services

Annex

Online Facility Survey Questionnaire

This survey is part of the Differentiated Service Delivery Strategic Initiative supported by The Global Fund and implemented by FHI 360 in the Philippines.

We are trying to determine the current coverage of differentiated service delivery among HIV care facilities/sites in the country. Differentiated Service Delivery (DSD) is an approach that tailors health service delivery for different types of client groups (e.g. key populations, clients who are stable on ART, etc.) by offering various options as to where and how frequently clients can get different services and what type of service providers can give these services to them.

The results of this survey will be used to inform plans to scale up DSD models and to further integrate HIV care and general primary care.

The survey may take up to 10 minutes to complete.

Section 1: Facility information

1. Name of Facility: _____

2.Type of Facility

- Primary HIV Care Clinic (outpatient HIV care)
- Treatment Hub (outpatient and inpatient HIV care)

3.Region (select from drop-down list)

4.Have you heard of DSD prior to this activity?

- Yes
- No

5. If yes, where did you hear it from? _____

Section 2: Screening and Testing

5. Which of the following HIV testing services does your facility offer? Please select all that apply

- Community-based screening
- Receiving referrals for testing from community-based screening partners
- Index testing
- HIV self-testing
- Social and sexual network testing
- Mobile testing
- None of the above

Other (specify) _____

6. Which of the following locations outside of your clinic does your facility also conduct testing or screening at? Please select all that apply

- Workplaces
- Prisons and other closed settings
- Schools and other educational institutions
- Client's home
- Bars, parks, or other venues
- None of the above
- Other (specify) _____

7. Does your facility have alternate or extended hours for HTS services (outside regular office hours, weekends, etc.)?

- Yes
- No

8. Which of the following virtual outreach and marketing approaches does your facility use? Please select all that apply.

- Facility/site listed on Google Maps
- Facility/site has a website
- Facility/site has an official page on social media (like Facebook, Twitter, etc.)
- Facility/site has an online appointment booking platform for clients to use
- Facility/site pays for online or social media ads
- Social media influencers post on social media to promote clinic services
- Community outreach workers reach new audiences online through individual chats (on social media or dating apps)
- None of the above
- Other (specify) _____

9. Which of the following virtual approaches does your clinic use to support your HIV testing efforts? Select all that apply.

- Online appointment booking for HIV testing or HIV self-testing
- Home delivery of HIV self-test kits
- Virtual channel to assist clients to administer the HIV self-test and understand the result (video or audio call)
- Follow-up call with clients after they access an HIV self-test, to support linkage to confirmation testing
- Online or virtual notifications sent to clients when their HIV test results are ready (such as when sending blood sample to lab for testing)
- Online portal for clients to refer other people for HIV testing (such as for contact tracing, partner notification, or normal client referrals)
- Automated Chatbots to respond to client questions/concerns on Viber/WhatsApp/Telegram/other messaging app

- None
- Other (specify) _____

Section 3: Treatment and care

10. Which of the following treatment approaches does your facility use? Please select all that apply.

- Multi-month ARV refill: giving 3- or 6-months worth of supply to a client at a time to clients who are stable on ART
- Fast-track ARV refill: dispensing ARV to a client who is stable on ART without undergoing a consultation with a physician for some facility visits
- Same-day ART initiation
- Rapid ART initiation: ART initiation within 7 days of diagnosis
- None of the above
- Other (specify) _____

11. Aside from visiting your facility, what other ways can your clients access ART refills? Please select all that apply.

- Home delivery via courier service
- Through patient groups
- Through key population drop-in centers
- Through pharmacies
- Other local access points for ART refill
- None of the above
- Other (specify) _____

12. Which of the following virtual approaches does your clinic use to facilitate the provider's support to patients? Please select all that apply.

- Online appointment booking for virtual consultations with providers
- Virtual consultations between provider and patient (video or audio)
- Virtual screening, review of symptoms, and diagnosis between provider and patient (video)
- Virtual method for provider to prescribe/order medications for patients
- None of the above
- Other (specify) _____

13. Which of the following virtual approaches do you use to keep your clients engaged and provide follow up care? Select all that apply.

- Case Managers or Peer Navigators use virtual channels to keep in contact with clients in long-term care, such as clients on ART or PrEP (virtual case management)
- Case Managers or Peer Navigators use an electronic or client management software to keep track of the clients within their ART or PrEP cohort
- PLHIV support group meetings held virtually
- Online appointment booking for ART or PrEP refills

- Online appointment booking and for diagnostic services for clients on ART or PrEP (such as viral load testing, HIV/STI testing)
- Online or virtual notification sent to clients when their viral load test results are ready (such as when sending blood sample to lab for testing)
- Automated virtual notifications sent to clients in ART or PrEP care to support retention
- Collection of client feedback and complaints on service access using online or electronic survey tool
- None of the above
- Other (specify) _____

Primary care and other services

14. What laboratory services does your facility offer and carry out within the facility? Please select all that apply.

- Viral load testing
- CD4 count testing
- Complete blood count
- Blood chemistry
- None of the above
- Other (specify) _____

15. If one or more of the above laboratory tests are not available at your facility, how do your clients access those services?

- Specimen is collected and sent by our facility to a partner laboratory
- Client is referred to a laboratory within our service delivery network
- Client proceeds to their laboratory of choice
- Other (specify) _____

16. What health conditions does your facility offer primary care level screening services for? Please select all that apply.

- Viral hepatitis (B and/or C)
- Other STI
- TB
- Cardiovascular disease
- Diabetes
- Cervical cancer
- Colorectal cancer
- Depression
- Anxiety

17. What health conditions does your facility offer primary care level management? Please select all that apply.

- Viral hepatitis (B and/or C)

- Other STI
- TB
- Cardiovascular disease
- Diabetes
- Cervical cancer
- Colorectal cancer
- Depression
- Anxiety

18. What kind of virtual HIV interventions do you think will be most important for your facility/site to implement in the future? _____

19.(Optional) Who can we contact with follow up questions about your facility/site's use of virtual channels to support HIV service delivery? Please indicate the contact person's name, title, and email.

[END]