



ORIGINAL RESEARCH

Assessing Low HIV Testing Rates, Stigma, and Barriers to Care among Women in the Philippines: Improving Access to HIV Prevention, Testing, and Treatment

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ABSTRACT



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The Philippines is experiencing the fastest-growing Human Immunodeficiency Virus (HIV) epidemic in the Asia-Pacific region, with new infections increasing by over 500.0% in the last decade. Despite this alarming trend, HIV testing rates among Filipino women remain critically low, and mother-to-child transmission cases are rising. The investigators of this study examined HIV knowledge, identified barriers to testing, and analyzed current HIV testing rates among women in the Philippines to inform efforts toward reaching the global goals of 95-95-95 targets and to eliminate mother-to-child transmission. A retrospective cross-sectional design was used to analyze data from 25,284 Filipino women ages 15-49, from the 2021-2022 Demographic and Health Survey Program. Univariate and bivariate analyses assessed HIV testing rates alongside knowledge, stigma, and maternal-child health variables. Only 8.9% of women had ever been tested for HIV. Significant knowledge gaps were identified, including 78.5% incorrectly believed HIV could be transmitted through shared food, and 72.4% believed mosquitoes could transmit HIV. Stigma was high, with 61.6% unwilling to purchase food from a vendor living with HIV. Among women with children, only 13.4% had been tested, and 72.6% of currently breastfeeding women had never been tested ($p \leq 0.001$). Low testing rates among Filipino women are driven by lack of testing services, inadequate knowledge, and persistent stigma. Introducing community-based saliva screening, training community health workers in HIV screening and education, integrating screening into prenatal care, and implementing education programs are essential steps toward building the HIV Continuum of Care and eliminating mother-to-child transmission in the Philippines.

Keywords: HIV/AIDS, testing, Philippines, community health, education, stigma, maternal health, mother-to-child transmission, and Continuum of Care



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Introduction

In 2024, the World Health Organization (WHO) reported an astonishing 40.8 million individuals living with Human Immunodeficiency Virus (HIV).¹ If left untreated, HIV will progress into Acquired Immunodeficiency Syndrome (AIDS), a life-threatening chronic disease. Incredible progress has been made globally as new diagnoses have decreased by 40.0% and fatality has reduced by 70.0% from 2004 to 2024. Progress is attributed to increased HIV knowledge, reduced stigma, improved access to testing, linkage to care, and the provision of medications for treatment.¹⁻³

The Joint United Nations Programme on HIV/AIDS (UNAIDS) established global targets for all countries to aim for in HIV progress. The UNAIDS standards are 95-95-95 global goals, which aim to target 95.0% of people living with HIV knowing their status, 95.0% of those diagnosed receiving antiretroviral therapy (ART), and 95.0% of those on treatment being virally suppressed. To do so, an additional 3.2 million people living with HIV need to be made aware of their HIV status.^{2,4} Coinciding with the UNAIDS 95-95-95 goals, the WHO has also established the zero mother-to-child transmission (MTCT) target. Recognizing that women and girls account for more than half (53.0%) of people living with HIV globally is a major step in achieving these global elimination targets.⁴ Building the HIV Care Continuum within communities, regions, and countries will be a vital contribution to reaching those aims.

The Southeast Asia and Pacific region have made excellent progress in the development of HIV screening and treatment. This region accounts for almost a quarter (23.0%) of annual new HIV infections globally.⁴ While they have made considerable progress towards prevention, testing, and disease management, the status of the Philippines is severely overshadowed. While most countries worldwide are experiencing declining HIV incidence rates, the Western Pacific has four nations with unexpected increases. The Philippines ranks the highest among them with an alarming increase of HIV transmission.^{4,5} The WHO and UNAIDS have expressed concern and have initiated a call for urgent action as they predict that the Philippines has the fastest-growing surge of HIV in the Asia-Pacific region.⁶

Significant risk factors for HIV in the Philippines include limited testing, human trafficking, registered female sex work, long-term migrant work, injection drug use, child marriage, and multiple sexual partners.⁷⁻⁹ The HIV/AIDS and ART registry of the Philippines reported an increase in new cases, with an approximately 500.0% rise in daily incidence over the last decade.^{6,10} Between 2010 and 2021, the Philippines Department of Health (PHDOH) recorded a substantial escalation of 315.0% in AIDS-related deaths.¹¹ However, recent studies highlight that HIV screening rates in the Filipino population remain extremely low due to limited resources, stigma, and access to testing.¹²⁻¹⁶

Even though a cure for HIV has not yet been identified, improving HIV knowledge, testing, and access to ART can lead to community viral suppression and eliminate transmission.^{17,18} Understanding HIV transmission and the distribution of disease in the Philippines can further help treatment and prevention efforts. While sexual contact has consistently been the leading mode of transmission, particularly among male-male sex (MSM), there has also been a noticeable increase in MTCT in recent years.^{7,19} Registered Filipino non-governmental organizations that conduct testing maintain a predominantly male-centered approach with a particular focus on the MSM and transgender populations.^{12,20} They have made substantial progress with HIV testing, treatment, and adherence to build the Continuum of Care within those populations. However, little has been documented about testing women in the Philippines, this missing crucial data is imperative to inform policy and practice. Globally, over half of all people living with HIV are



females, emphasizing the need to focus on women even more.²¹ The most recent PHDOH annual report highlights a 126.0% increase in new cases among infants and children under the age of 15 years old.¹⁹ An increase in HIV infections among infants has been observed throughout the country and may be associated with suboptimal HIV screening for pregnant women.^{19,20} Thus, the purpose of this study was to assess HIV knowledge, identify barriers to testing, and analyze current HIV testing rates among women in the Philippines to reduce MTCT and expand prevention efforts.

Theoretical Framework

The researchers of this study sought to understand HIV testing rates among women in the Philippines, along with identifying barriers to testing, including HIV knowledge and stigma. One of the foundational aspects of this project is based on the concept that improving HIV knowledge can be a form of prevention to increase testing.²²⁻²⁴ The overarching theoretical construct of this study was centered on identifying ways to improve testing to build the HIV Continuum of Care from the Centers for Disease Control and Prevention (CDC), which provides a model of the ideal steps that should be taken to diagnose and treat a person living with HIV.²⁵⁻²⁷ The model includes five core pillars: HIV testing and diagnosis, linkage to care, retention in care, ART, and viral suppression. Dynamics that can influence the core pillars were also addressed in the model and included, but were not limited to stigma, discrimination, poverty, marginalization, and gender inequality.

After the Continuum of Care was established as a universal model to provide context for HIV within a target population, the National Alliance of State and Territorial AIDS Directors (NASTAD) recognized the need to identify the barriers that can influence all pillars, especially testing and diagnosis.^{25, 28} The HIV Continuum of Care cannot exist, nor continue to be built if the pillar of testing is absent or falls far below global standards of practice. The Continuum of Care was reconstructed with an added bar before the bars to represent factors that influence testing, which can be seen in Figure 1.

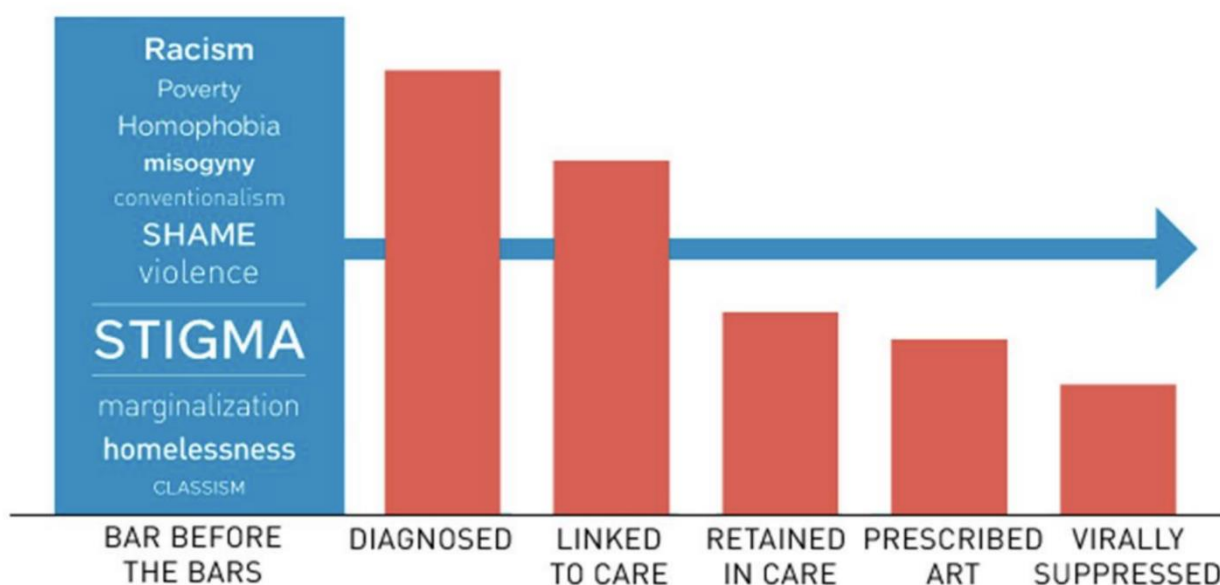


Figure 1. The Bar before the Bars. HIV Continuum of Care in red with social constructs and barriers to testing and treatment. The blue bar content can change based on the specific barriers a target population faces, but it highlights the need to address them before testing can start, and the Continuum of Care is built.^{25, 28}



The Bar before the Bars identifies social constructs that can be barriers to testing and care. By identifying the barriers within a target population, a foundation for the Continuum of care can be built, focusing on strategies to improve the effectiveness of each aspect of the bar. While the anticipated low testing rates for HIV among women in the Philippines has guided the initiation of this investigation, our group maintains the position that results will provide a positive and effective contribution to the ongoing efforts to develop a more thorough HIV Continuum of Care for people living in the Philippines. This will ultimately ensure that women are tested, linked to care, virally suppressed, and that MTCT is eliminated.

MATERIALS AND METHODS

STUDY DESIGN

This study was performed as a retrospective cross-sectional historical design that examined the rate of HIV testing among women in the Philippines and stigma-related knowledge. The design was based on univariate and bivariate analyses with a focus on one outcome variable (HIV test vs. no HIV test). The contributing variables assessed include HIV testing, knowledge, stigma, and maternal health.

The first set of analyses were designed to examine each variable independently. Appropriate descriptive analyses were utilized to understand the individual variables and the distribution. Only two maternal questions pertaining to the number of children and breastfeeding were compared in a bivariate analysis with HIV testing status. The bivariate statistical test used was a chi-square represented in bar charts in figure 10. Statistical Package for Social Sciences (SPSS, ver. 31) software was utilized for all analyses, and only those with statistical significance were considered for guiding future programs and policy.

ETHICS APPROVAL

Institutional Review Board (IRB) approval (S26-036) was completed prior to the initiation of this investigation and analyses of acquired data.

PARTICIPANT SAMPLING PROCEDURES

All participants in this study were from the Philippines and voluntarily took part in the Demographic Health Survey Program from 2021-2022 through the United States Agency for International Development. Data were collected from 27,821 women across the Philippines.²⁹ For this analysis, variables pertaining to demographics, HIV testing, HIV knowledge, HIV-related stigma, and maternal health were selected from the dataset.



Study Demographics			
		Frequency	Percent
Philippines Resident		25,284	100.0
Female		25,284	100.0
Age			
	15-19	4,973	19.7
	20-24	4,212	16.7
	25-29	3,491	13.8
	30-34	3,369	13.3
	35-39	3,134	12.4
	40-44	3,163	12.5
	45-49	2,942	11.6
Wealth Index			
	Poorest	5,329	21.1
	Poor	5,553	22.0
	Middle	4,915	19.4
	Rich	4,689	18.5
	Richest	4,798	19.0
Residence Type			
	Urban	10,577	41.8
	Rural	14,707	58.2
Education Level			
	No Education	115	0.5
	Primary	2,347	9.3
	Secondary	13,124	51.9
	Higher	9,698	38.3

Table 1. Participant demographics include residency, gender, age, socioeconomic status, location, and educational level.

Participants with missing data on HIV testing were removed from the dataset. Inclusion criteria consisted of being a female, ages of 15 - 49 years old, and currently reside in the Philippines. Eligibility was not determined by pregnancy status or ever having children. Exclusion criteria included age ranges for minors 14 and under, along with women age 50 and above. Males and non-residents of the Philippines were also excluded from the study. The variable of socioeconomic status defined as Wealth Index was stratified across



the sample population as quintiles to control for confounding factors. The overall sample for analysis decreased after removing missing cases and selecting cases based on inclusion criteria. The total sample for this study was reduced from 27,821 participants to 25,284 Filipino females, ages 15 - 49 years old. See Table 1 for the demographic characteristics of the participants in this study and Figure 2 for geographical distribution.

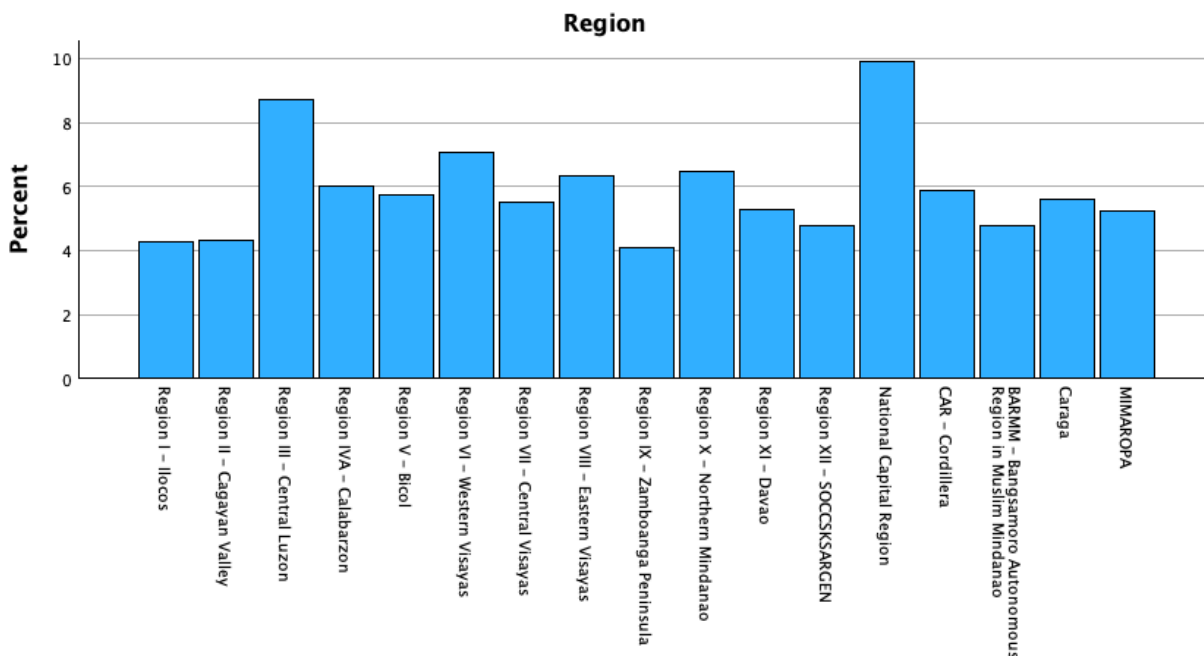


Figure 2. Participant regional distribution.

RESULTS

The design was based on univariate and bivariate analyses with a focus on one outcome variable (HIV test vs. no HIV test) and simultaneous analysis of contributing variables found in Table 2. The first set of analyses were designed to examine each variable independently. Appropriate descriptive analyses were utilized to understand the relationship of variables and if interactions and bivariate analysis were needed. Based on the literature regarding HIV testing among women in the Philippines, barriers to testing, and stigma, the following variables were analyzed.



Summary of Results			
HIV TESTING			
Ever been tested for HIV?	91.1%	8.9%	
	No	Yes	
HIV KNOWLEDGE			
Can a person with HIV look healthy?	72.2%	27.8%	
	No/DK	Yes	
Can you get HIV by sharing food?	21.5%	78.5%	
	No	Yes/DK	
Can a mosquito transmit HIV?	27.6%	72.4%	
	No	Yes/DK	
Have you heard of ARVs to treat HIV?	71.3%	28.7%	
	No/DK	Yes	
Are there drugs to avoid HIV transmission during pregnancy?	47.8%	52.2%	
	No/DK	Yes	
HIV-RELATED STIGMA			
Would you buy vegetables from a vendor with HIV?	61.6%	38.4%	
	No/DK	Yes	
Should a child with HIV be allowed to go to school?	58.1%	41.9%	
	No/DK	Yes	
MATERNAL-CHILD HEALTH			
*Women with children: Ever tested for HIV?	86.6%	13.4%	** ≤ 0.001
	No	Yes	
*Currently breastfeeding: Ever tested for HIV?	72.6%	27.4%	** ≤ 0.001
	No	Yes	

*Sample size reduced to women with children (14,631) and currently breastfeeding (2,318)

**Statistical significance, $p \leq 0.05$

Table 2. Summary of results (N = 25,284).

HIV Testing

All participants were asked if they have ever been tested for HIV. Out of 25,284 females, only 2,244 (8.9%) have ever been tested for HIV.

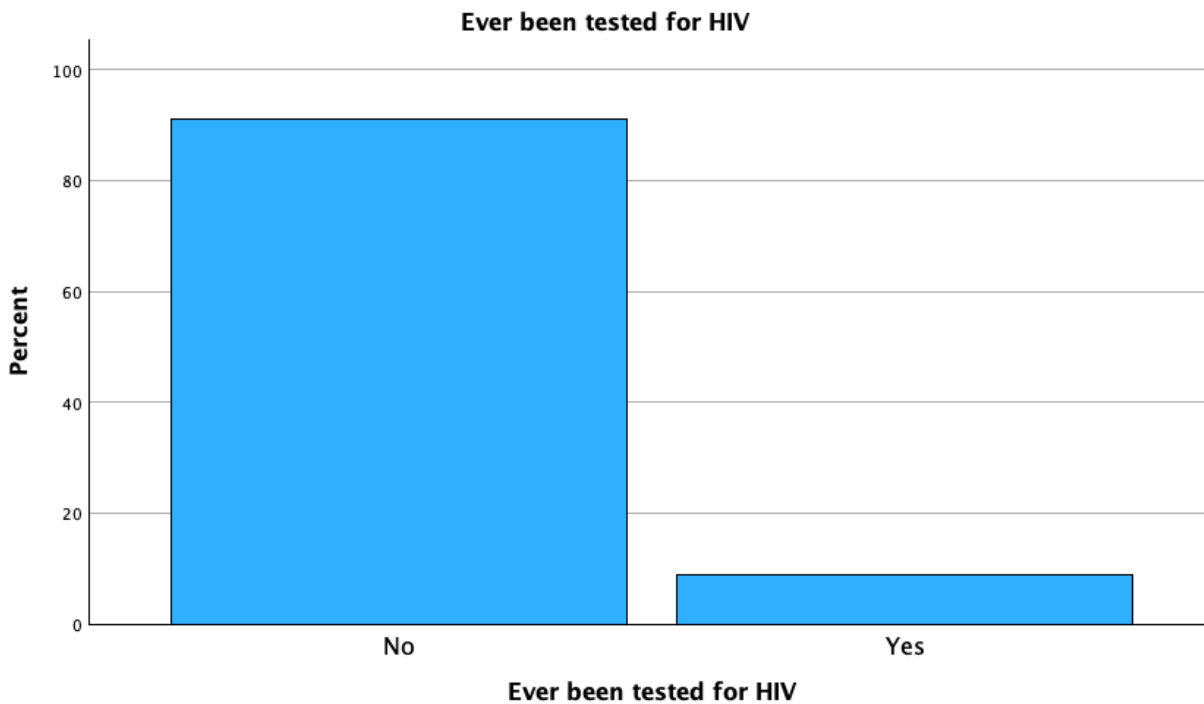


Figure 3. The percentage of women tested for HIV (8.9%).

HIV Knowledge

Participants were then asked a series of HIV-related knowledge questions to measure what they knew about the disease, transmission, and treatment. Higher levels of HIV knowledge and education were linked to higher rates of testing. All participants (100.0%) had heard of HIV/AIDS. When asked if a person living with HIV could look or appear healthy, only 27.8% of women answered correctly. Nearly three in four women answered incorrectly and did not know a person living with HIV could appear healthy (72.2%).

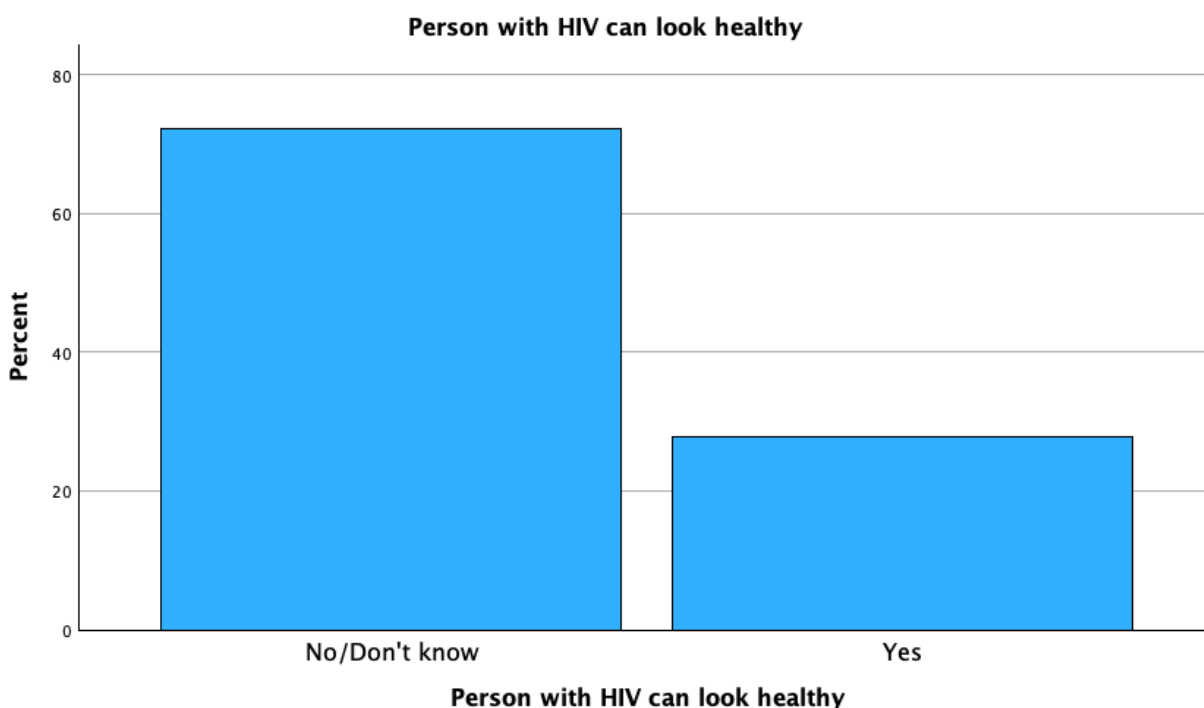


Figure 4. Knowledge distribution of asking participants if a person with HIV can look healthy.



When asked if HIV could be transmitted by sharing food, an alarming 78.5% of women answered incorrectly, highlighting a lack of knowledge. Only one in five women knew that HIV could not be spread by sharing food (21.5%). Figure 5 shows how drastic the difference is between the correct and incorrect responses.

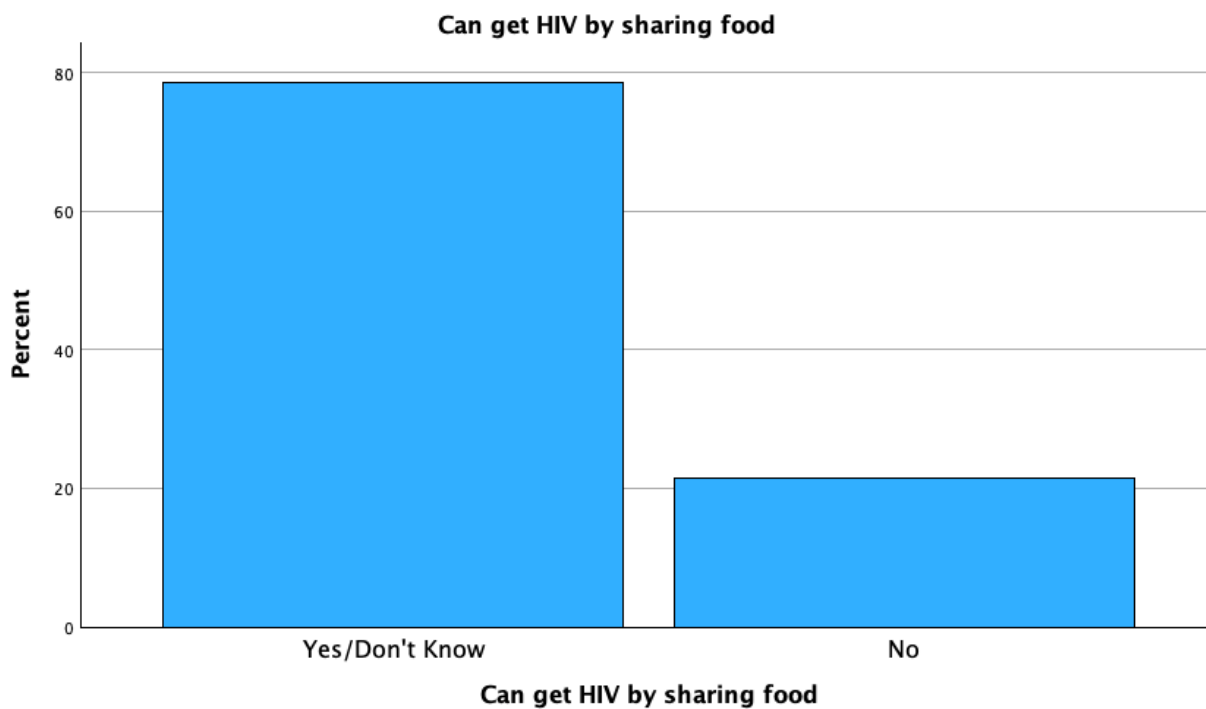


Figure 5. Knowledge distribution of participants when asked if HIV can be transmitted by food.

When asked if a person can get HIV from mosquitoes, over 72.4% of participants answered yes. This shows a significant discrepancy in HIV knowledge regarding disease transmission.

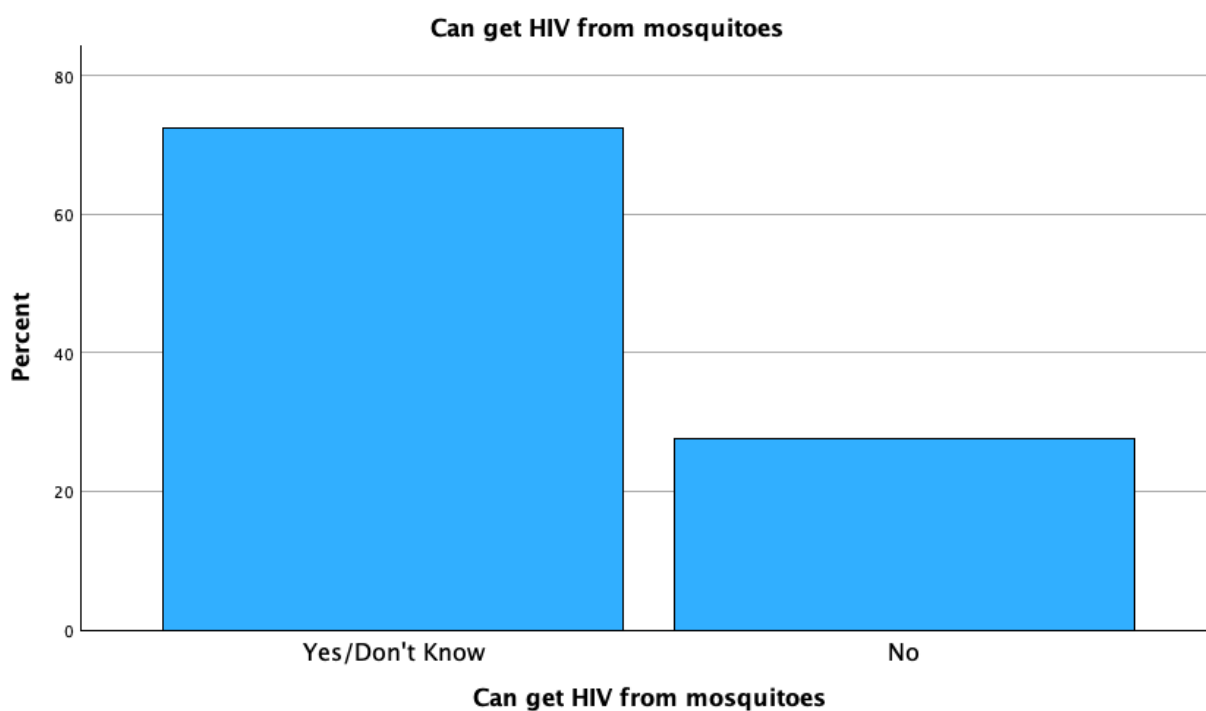


Figure 6. Response distribution of participants when asked if HIV can be transmitted by mosquitoes.



Another knowledge question asked was pertaining to the treatment of HIV with antiretrovirals. Even though almost half of the women knew treatment exists to prevent transmission during pregnancy, only 28.7% knew that antiretrovirals were available for anyone diagnosed with the disease. This could suggest that women are more familiar with the term treatment over ARVs and that they are more likely to hear it during pregnancy-related appointments.

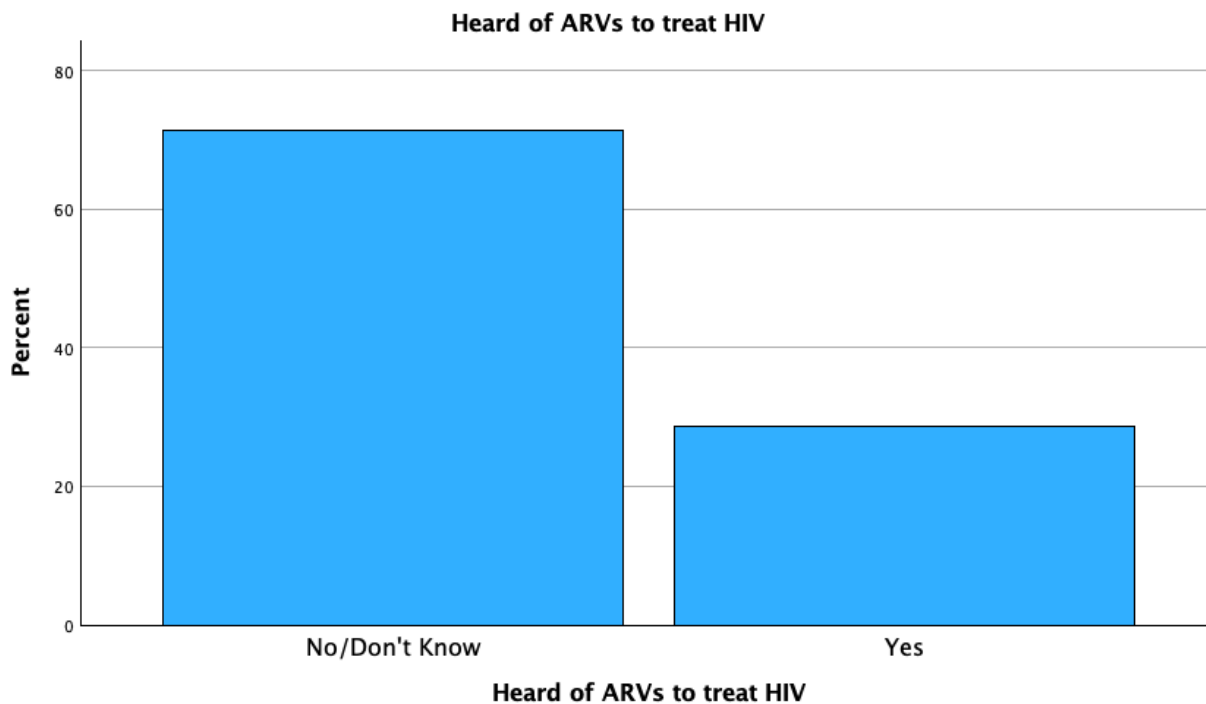


Figure 7. Participant responses when asked if they had ever heard of ARVs to treat HIV.

HIV-Related Stigma

Women were then asked a series of questions pertaining to HIV-related stigma. The questions alluded to their perception of people living with HIV and how to treat them. When asked about purchasing vegetables from a vendor diagnosed with HIV, only 38.4% of women answered that they would. The remaining majority (61.6%) stated that they would not purchase vegetables from a vendor with HIV or they did not know. If a participant would not purchase vegetables from a vendor living with HIV, it is possible that they would have fears of being rejected if they were diagnosed. HIV-related stigma was high within this variable, which may contribute to the low testing rates.

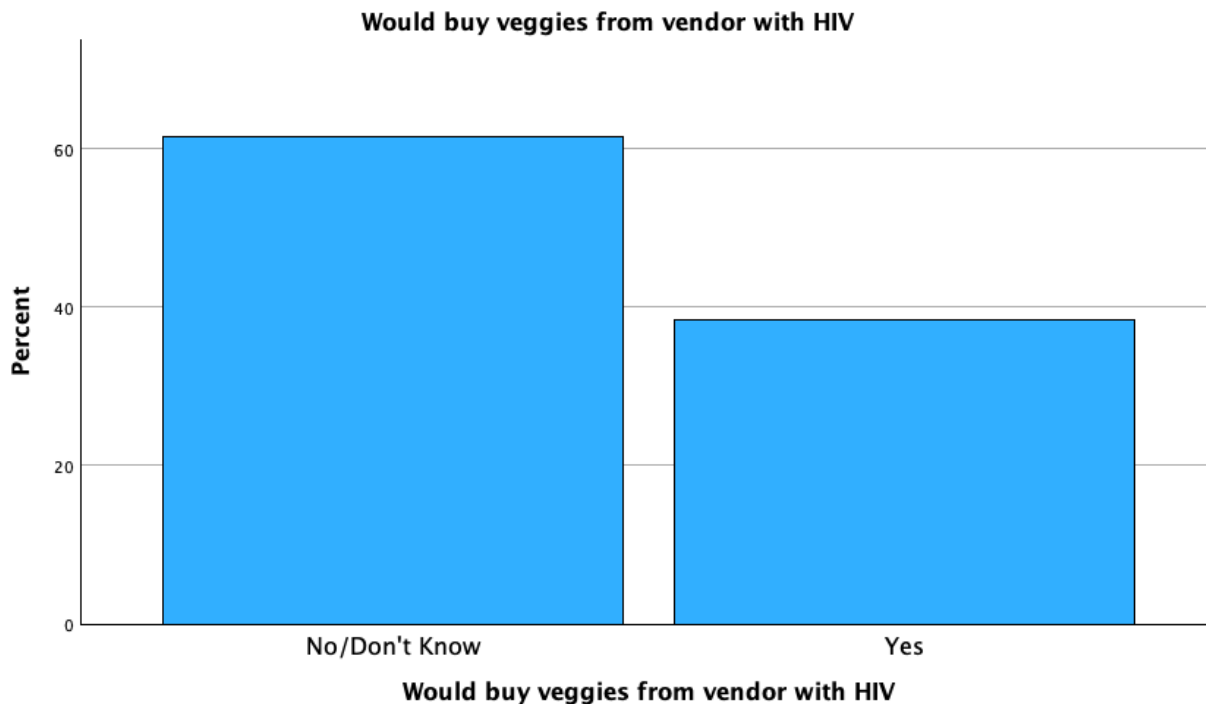


Figure 8. Participant distribution when asked if they would buy vegetables from a vendor with HIV.

Women in this sample were asked if children with HIV should be allowed to go to school. More than half (58.1%) said no or were unsure, while only 41.9% said yes. This highlights deeper levels of stigma with an HIV diagnosis and societal norms associated with the disease.

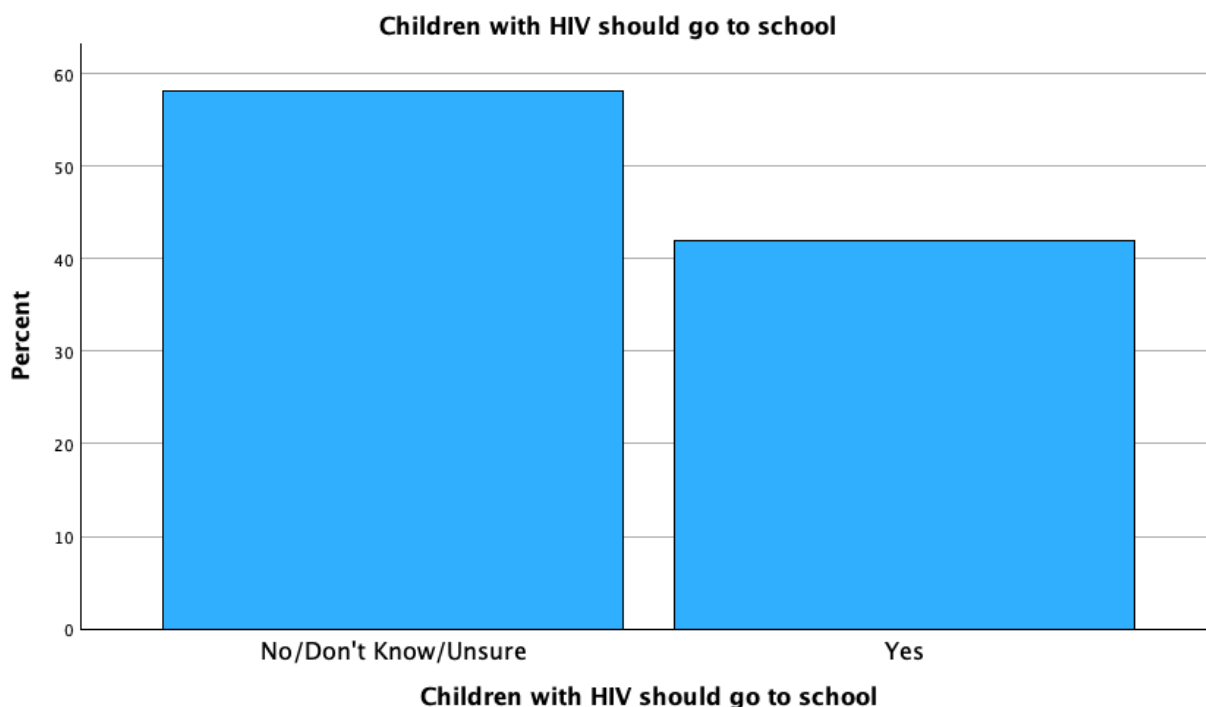


Figure 9. Participant distribution of whether they think a child living with HIV should go to school.

Maternal-Child Health

The lack of testing among women and new cases among infants is alarming. Data were stratified by women with children and analyzed by HIV testing rates. If women have children, they should have gone through



prenatal appointments and delivery with some form of healthcare. HIV testing should have been conducted with each pregnancy. Data were also stratified to analyze women currently breastfeeding and whether they were tested for HIV. Breastfeeding is a direct risk of transmission, so it is crucial that all women pregnant and breastfeeding know their status to protect their babies.

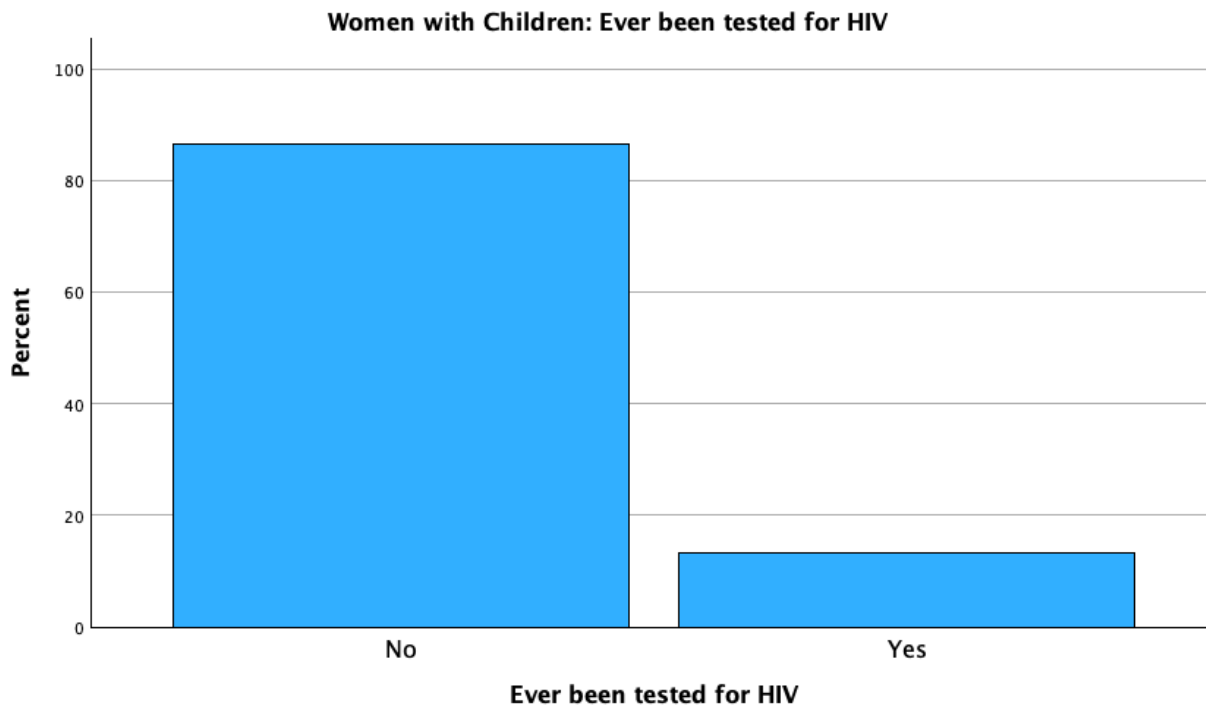


Figure 10. The distribution of women with children and their HIV testing status.

Only 13.4% of women with children have ever been tested for HIV. That implies that the maternal healthcare systems are missing over 86.0% of women who need to be tested to prevent mother-to-child transmission. This is likely contributing to the increased number of infant cases. Additionally, 72.6% of women currently breastfeeding have never been tested for HIV ($p \leq 0.001$). This highlights the direct risk that most infants face without all mothers being tested.

DISCUSSION

This study identifies significant gaps in HIV testing and care for women in the Philippines. The findings suggest that HIV-related stigma, lower levels of HIV knowledge, and lack of resources are key barriers that prevent women from getting tested. Addressing the issue of inadequate access to testing is important because, if left unaddressed, it will restrict women's ability to know their status and continue the unnecessary spread of disease. Therefore, based on this study's findings and current health programs in the Philippines, we will discuss recommendations to improve the HIV Continuum of Care system so that it is more equitable for women. Key actions to enhance the current system include expanding HIV education across both public and private healthcare sectors, adopting saliva-based testing options, increasing testing hubs for women, improving access to care after diagnosis, and integrating HIV testing and treatment into current prenatal care. Together, these actions can help strengthen the current systems and make HIV testing and care services more accessible to women across the country.^{1-3, 25, 28}



HIV KNOWLEDGE

The incidence of HIV in the Philippines has resulted in a sharp escalation in the past decade, making it one of the fastest rates of growth in the Western Pacific.⁷ Contributing factors leading to this increase are social stigma, challenging sociopolitical circumstances, and significant barriers to healthcare access. Evidence of HIV related stigma is reflected in women's attitudes towards individuals living with HIV. In this study, 61.6% of women reported that they would not purchase vegetables from a vendor with HIV, and when asked if children with HIV should be permitted to attend school, 58.1% said no, or they did not know. This suggests persistent social exclusion associated with HIV. Stigma shapes perception and contributes to barriers in testing.

All study participants had heard of HIV/AIDS; however, there were some significant gaps in knowledge demonstrated in the results. When asking women if HIV could be transmitted through sharing food, an alarming 78.5% responded yes, or they did not know. Widespread misconceptions about disease transmission and treatment were further displayed in only 27.8% of women correctly identifying that a person with HIV could appear healthy, and more than 72.4% incorrectly reported that it could spread through mosquito bites. Treatment knowledge was limited; only 28.7% of women knew that ART is available for anyone living with HIV. These misconceptions may contribute to ongoing stigma and discourage individuals from seeking testing, preventive measures, and treatment. Addressing the stigma and low HIV education levels may increase engagement in testing and treatment services.

Limited access to testing creates barriers across the Continuum of Care. In the Philippines, testing services outside of public hospitals are largely concentrated on sites that serve the MSM and transgender populations, thereby reducing testing access for women.²⁰ Expanding HIV testing access and increasing education resources are imperative to ensure women can learn their status and promptly be linked to care. The implementation of saliva testing may enhance testing by providing a less invasive and more accessible alternative to blood-based screening. An increase in testing rates among women is important to prevent MCTC. Nearly 90% of women in this study have access to a cell phone, which will strengthen linkage to care.

BUILDING THE CONTINUUM OF CARE

Improving HIV knowledge, reducing stigma, and increasing access to testing remain the most critical components of building an effective and standardized Continuum of Care for the Philippines. The WHO estimates that 62.0% of people living with HIV in the Philippines know their status.³⁰ Discrepancies exist between the estimate, incidence growth, and low percentage of testing. It is unclear how the 62.0% estimate was calculated, but the incidence of HIV infections has been increasing rapidly over the last decade and now spans over 500.0%.^{6, 10} At the same time, testing rates remain extremely low, especially among women (8.9%). With the rate of HIV incidences increasing at alarming rates in a substantially small portion of the population, it stands to reason that increased accessibility to testing, especially among women at risk, will dramatically increase these incidence rates, thereby revealing the true nature of HIV prevalence in this population. This estimate needs to be reconsidered and revised to capture the true prevalence of this disease. We anticipate a continued growth in incidence rate as risk factors are present and women remain largely untested.



HIV Knowledge and Stigma

HIV education needs to be integrated into public and private healthcare systems, along with community-based programs. When HIV knowledge improves, stigma is reduced and testing increases. It is vital that people are given the tools through education to assess their own risk factors and make informed health behavior choices. If transmission is misunderstood, such as those in this study believing HIV can spread through food (78.5%), fear will continue to deter testing. If advances in treatment and ART are misunderstood (71.3%), the hope of living a full lifespan and not transmitting the disease will never be known. Our team strongly recommends training public, private, and community-based care facilities with HIV education models utilizing the Health Belief Model as the theoretical framework to increase uptake in testing.^{15,16,31-33} The first bar of testing in the Continuum of Care cannot be built without a plan to increase HIV knowledge and reduce stigma.

Increasing HIV Testing

With the rise in HIV infections worldwide, the WHO is encouraging countries to adopt low-cost prequalified HIV rapid tests (blood or saliva).³⁴ Salivary fluid-based testing is safe, private, quick, and is therefore an effective way to expand access to an HIV diagnosis. With oral HIV saliva testing, the collection and analysis of the saliva do not require extensive training nor certification for practitioners to collect, allowing for community workers and the like to easily be trained. Additionally, the inclusion of salivary-based testing methods substantially reduces the exposure of technicians to blood, lowering the risk for healthcare workers and minimizes the risk of viral transmission to technicians.³⁵ Therefore, integrating saliva testing with clinical care will be a reasonable task that will immeasurably impact the current state of mother-to-child transmission of HIV in the Philippines.

Discrete results and reduced stigma are among the benefits of saliva testing. By incorporating WHO-approved salivary testing methodologies, this will arguably increase the ability to test a greater number of people and at a far greater capacity than is currently being practiced. HIV education and stigma reduction programs need to be established alongside testing programs. This is particularly important among maternal-child health settings to prevent MTCT. Integrating HIV education and testing within prenatal appointments will help normalize the process and reduce stigma.

Training Community Health Workers (CHW) in salivary testing, HIV education, and community outreach will expand capacity to increase testing efforts. The model of utilizing local CHWs reduces stigma by eliminating the need to build rapport among community members. A higher volume of CHWs can be easily trained in saliva testing procedures to reach untested communities.

Linkage and Retention in Care

After a positive test result is confirmed, it is critical that women are linked to care immediately. This step will ensure that ART is initiated and labs are completed to monitor progress. Adapting the Hub and Spoke Model is a suggested approach to effectively link patients to care and work within local systems.³⁶ Utilizing DOH approved HIV treatment centers (hub) in collaboration with public and private clinics (spokes) will optimize this process. CHWs are also imperative to connect patients to care, follow-up, and monitor medication adherence. Unity between government, private, and local levels of care leads to improved quality care and reduced barriers for follow-up. Ultimately, when patients are cared for in holistic systems,



they will be more likely to reach viral suppression, reducing overall transmission. This process will provide a framework for the Philippines to reach the 95-95-95 targets from UNAIDS.^{4, 25, 28}

SYSTEM IMPROVEMENT

Current systems for HIV testing require a week-long training for medical technologists to get certified in HIV rapid blood screening. Due to the cost, eligibility, and length of training, scaling this to widespread practice has been a challenge. This is a barrier to enhance access to testing as limited personnel have been trained. Shifting to saliva-based screening conducted by CHWs would reduce training time to one day. Medical certification and qualifications would not be required to participate, which would improve capacity. The cost of training would be drastically reduced, allowing resources to be allocated to CHWs and more test kits. The overall increase in capacity, personnel trained, and test kits would expand HIV screening to all women at risk.

Saliva-Based Testing

Current methodological and technological advancements in salivary analytics have greatly increased the popularity and volume of testing for a variety of biofluid-based measures. For example, Al Hobobe et al.³⁷ reported that the implementation of procedures that utilize saliva as an easily obtainable biofluid of minimal cost have been growing in popularity. Most specifically, salivary testing measures are patient-friendly and non-invasive. Collection and analysis are not painful and removes the barrier of fear of needles and blood. The process of collecting saliva does not require extensive training and minimizes the risk of viral transmission to CHWs. Thus, the sheer practicality of implementing widespread and high volumetric testing far surpasses the traditional model of hospital or clinical blood-based assessments. Instead of bringing the community to the hospital or clinical lab for testing, CHWs can widely implement salivary testing by bringing the lab to the community. Furthermore, the inclusion of salivary-based testing methods substantially removes the potential exposure to blood, should direct exposure occur. While the presence of HIV (i.e., RNA, infected cellular content, and proviral DNA) is observable in salivary samples, Vohra et al.³⁵ reported that oral transmissibility is potentially non-existent. By incorporating WHO-approved salivary testing methodologies, this will very likely increase the ability to test a greater number of people and in a far greater capacity than is currently being practiced.

With the rapid increases of HIV incidence, it is imperative that the PHDOH and community-based organizations meet this growing need by combining their efforts to build more testing capacity. As it stands, many islands in the Philippines have recently experienced an increase in infant cases of HIV due to lack of female testing and MTCT. Integrating HIV saliva testing within private and public clinic services for women will reduce HIV-related stigma and increase testing rates.³³ Collaborating with the PHDOH to implement oral HIV testing practices will provide higher rates of testing and will provide data to calculate more accurate prevalence rates for the region. Ultimately, it will assist in building the Continuum of Care and reducing transmission to achieve the 95-95-95 global goals.^{4, 25, 28}

GOVERNMENT REGULATORY SUPPORT

Addressing the HIV epidemic remains a top priority for the Philippine government. The current HIV policy in the Philippines is represented in Republic Act No. 11166.³⁸ This act reaffirms the global and national goals of reaching 95-95-95 through prevention, treatment, care, and support of those indirectly and directly



affected by HIV or AIDS.^{2,4} As part of their ongoing commitment to do so, the PHDOH has shifted strategies to strengthen case finding, enhance testing capacity, expand the number of HIV treatment hubs, and increase the number of Certified Rapid HIV Diagnostic Algorithm (rHIVda) Confirmatory Laboratories.³⁹ According to Article III Section 25, the PHDOH will establish a program to help prevent MTCT. To increase the expansion of maternity care, PhilHealth recently developed policies influencing health facility engagement, schedules for maternal care, responsibilities of a care coordinator, and regulations for claims. While these policies were developed largely for structural improvement, they help highlight the importance of collaboration for providing more accessible care.⁴⁰ The Philippines has created testing policies surrounding the HIV epidemic; however, resources, test kits, training, and capacity has not yet been expanded. There has been little to no assistance from other countries. It is imperative that WHO and other countries support the Philippines immediately to expand training, implement saliva-based testing, equip more CHWs, and retain patients in care. The tools to end this epidemic exist, but unity and collaboration are required to make progress.

Limitations

The researchers of this study acknowledge that there are a few limitations. First, this study's major limitation is its retrospective cross-sectional design, which relies on self-reported secondary data obtained from the Demographic and Health Survey Program, rather than data directly collected by the research team. As a result, the analyses conducted were limited to variables available within this data set. Nevertheless, the Demographic and Health Survey Program remains a credible tool consistently used worldwide by health departments and the United States Agency for International Development. Therefore, this study's analysis is still valuable, despite the data coming from a secondary source. Second, this study only uses data from women (ages 15 - 49) living in the Philippines. Consequently, the results may only be generalizable to similar population groups in the Philippines. However, the analysis of this data specifically focusing on the women's population in the Philippines cannot be found elsewhere, therefore it is incredibly valuable that this study analyzed the data of this specific population subgroup. Third, language barriers were another limitation of this study. The participants from whom the data were collected did not all speak the same language, as there are multiple languages spoken among the population. To address the language barrier issue, the surveys were administered in the different languages spoken by the participants and translators were present. Fourth, the data set is from 2021 to 2022. However, it is still the most current data available.

CONCLUSION

Globally, HIV has transitioned from a death sentence to a manageable chronic illness due to advances in treatment, with most countries making significant progress, while the Philippines has been left behind. This study identified substantial gaps in HIV testing, knowledge, and stigma among women ages 15 - 49 in the Philippines. Among 25,284 women, only 8.9% reported ever being tested for HIV, despite global awareness of HIV/AIDS. Significant misconceptions were identified, including the belief that HIV can be transmitted through shared food (78.5%) or mosquitoes (72.4%), while only 28.7% were aware of antiretroviral treatment. HIV-related stigma was also noted, with 61.6% unwilling to purchase food from a vendor living with HIV. Maternal-child health findings were particularly concerning, as only 13.4% of women with children had ever been tested and 72.6% of currently breastfeeding women had never been tested. These findings demonstrate the need to address the knowledge, stigma, and access barriers that occur before the HIV



Continuum of Care can be built.

Strengthening HIV prevention and care among women in the Philippines will require an integrated approach that expands HIV education, reduces stigma, and increases access to testing. Community health workers can be trained to provide HIV education, counseling, and non-invasive saliva-based screening. HIV screening should also be incorporated into prenatal and maternal-child healthcare services. Following a positive result, timely confirmatory testing, linkage to care, antiretroviral treatment, and retention in care are essential to prevent transmission and improve health outcomes. Although this study is limited by its retrospective cross-sectional design and the use of secondary data from 2021-2022, it provides important evidence of the need to strengthen HIV services for Filipino women. Addressing these barriers can help build the foundation of the HIV Continuum of Care and support progress toward the UNAIDS 95-95-95 targets and elimination of mother-to-child transmission in the Philippines. These efforts cannot be made by the Philippines alone but will require global support and resources to enhance their current systems.

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