

PD ABU-119



# **AIDS Surveillance and Education Project**

**(492-0473)**

**U.S. Agency for International Development**  
**Manila, Philippines**

## **Final Evaluation**

**USAID/Philippines**  
**May 14, 2001**

# Final Evaluation Of the AIDS Surveillance and Education Project (ASEP)

U.S. Agency for International Development  
Manila, the Philippines

## Evaluation Team:

Dr. James Chin, Epidemiologist  
Dr. Edward Green, IEC Specialist  
Dr. Christopher Hermann, Team Leader  
Mr. Mario Taguiwalo, Sustainability Specialist

## Other Team Members:

Mr. Satoru Watanabe, Donor Coordination Division, JICA  
Ms. Kanako Tsuda, Health and Development Service, Tokyo, Japan  
Mr. Clifton Cortez, Policy Advisor, AID/W Division of HIV/AIDS

## Table of Contents

<b>Executive Summary</b>	i-iii
Acronyms	iv
<b>Section 1: Overall Impact and Results of the AIDS Surveillance and Education Project</b>	<b>1 - 9</b>
1.1 The Three Major Program Accomplishments of ASEP	1 - 4
1.2 SpO and IR Level Results	4 - 7
1.3 Activity Level Results	7 - 8
1.4 Outputs of PATH and ASEP's NGO Partners	8 - 9
<b>Section 2: HIV Sentinel Surveillance and Behavioral Surveillance Survey</b>	<b>10 - 14</b>
2.1 Background	10
2.2 Summary of Accomplishments to Date	11
2.3 Summary of Key Surveillance Finding	11-14
<b>Section 3: Information, Education and Communication Activities</b>	<b>15 - 26</b>
3.1 Raising Awareness in the General Public	15 - 16
3.2 IEC Theory and Strategy for Behavior Change	16
3.3 IEC Impact	17 - 18
3.4 Using Behavioral Surveillance Findings in IEC	18 - 19
3.5 STD Interventions	19 - 20
3.6 IEC Interventions for Individual Behavioral Change	20 - 21
3.7 Constraints to Increased Condom Use	21 - 22
3.8 Expanding Support for STD/HIV/AIDS Prevention with Religious Social Service Groups	22 - 23
3.9 Sexually Exploited Children Under Sixteen (SECUS)	23 - 24
3.10 Environmental and Structural Constraints	24 - 25
3.11 Targeting Highest Risk Groups: IDUs and MSMs	25 - 26
<b>Section 4: Sustainability and Future Directions</b>	<b>27 - 36</b>
4.1 Stakeholders for Sustainability	27 - 28
4.2 Defining the Issue of Sustainability	28 - 29
4.3 Nature and Level of Effort Appropriate for Keeping HIV/AIDS "Low and Slow" after ASEP	29 - 31
4.4 Sustaining Low HIV Prevalence After Project Completion - Future Directions	31 - 35
4.5 Institutionalization of HIV Surveillance	35 - 36
<b>Section 5: Synergy, DoH Capacity for Program Sustainability, Management Issues, and Donor Assistance</b>	<b>37 - 41</b>
5.1 Synergy	37 - 39
5.2 DOH Reorganization and Effects on Sustainability	39 - 40
5.3 Management Issues	40
5.4 Donor Assistance	41

**Annexes:**

Annex 1: Scope of Work Indicator Issues

Annex 2: The Reproductive Number (Ro) of HIV Infections

Annex 3: The Potential for Extensive HIV Epidemics in the Asia-Pacific Region

Annex 4: HIV/AIDS in Asia and the Pacific in the New Millennium

Annex 5: The Theoretical Basis for AIDS-related Behavioral Change Approaches

Annex 6: Factors Affecting the Low/Slow Pace of HIV/AIDS in the Philippines

Annex 7: Changes in IEC Strategy Before and After the 1997 Evaluation

Annex 8: People Interviewed

Annex 9: Evaluation Scope of Work

*d*

## Executive Summary

The AIDS Prevention and Education Project (ASEP) was authorized in July 1992 and implementation through a Grant with WHO/WPRO and a Cooperative Agreement with PATH began in September 1993. This Impact Evaluation was conducted between April and May 2001. ASEP's principal objective is to prevent a rapid increase of HIV/AIDS in the Philippines. ASEP is currently implemented in eight major cities of the country.

The Department of Health, USAID, PATH, NGO partners, the local government officials and staff of ASEP-assisted cities, and JICA have all made important contributions to ASEP's success. **The continued low/slow pace of the HIV/AIDS epidemic is in part due to the accomplishments of ASEP, and all participants in the project should share in this success.** Infections have been averted in the high-risk groups as a direct result of ASEP.

The two major components supported by ASEP are:

- **Surveillance** consisting of HIV Sentinel Surveillance (HSS) and the Behavioral Surveillance Survey (BSS) implemented by the Department of Health, assisted by WPRO, and local government partners.
- **Education and Policy** consisting of IEC risk reduction activities targeted on high-risk groups through a system of community outreach and peer education, and policy work with ASEP city governments to develop local support for key elements of surveillance and prevention. This component is implemented by PATH, local NGOs, and ASEP-supported city governments.

### □ Overall Impact

ASEP is a highly successful project that has accomplished a great deal at a relatively low cost, approximately \$1.5 million per year over the past eight years. ASEP has achieved three major accomplishments since its start in 1993:

- ASEP's support for surveillance determined that prevalence continues to remain at very low levels even among high-risk groups (<1 percent). However, high-risk behaviors among sex workers, male clients, men who have sex with men, and injecting drug users create the potential for a rapid increase in HIV/AIDS infections. **The risk of a rapid acceleration remains quite real, requiring continued assistance for HIV/AIDS prevention.**
- ASEP has demonstrated that local NGOs can develop effective education programs targeted on difficult to access high-risk groups. Progress is being made toward promoting risk reduction behaviors.
- ASEP has shown that local governments can be actively engaged in supporting and conducting STD/HIV/AIDS prevention programs, particularly surveillance.

## □ Surveillance

- The HSS provides a reliable basis for monitoring any changes in HIV/AIDS prevalence. The National Epidemiology Center of the DOH could support the HSS after ASEP – a clear opportunity for integration of functions. Local city health staff has sufficient experience with the HSS to continue it, and several local governments are now funding annual seroprevalence surveillance.
- Behavioral surveillance data show considerable variation among ASEP cities regarding condom use, and reported very high use needs to be verified through appropriate methods.
- Condom use data by sex workers need to be further disaggregated by partner category (regular/non-regular, paying/non-paying) to make it more useful.
- It is essential to maintain the focus of current and future prevention activities on the highest risk groups – sex workers, male clients, MSMs and IDUs – because any acceleration in infections will occur within these groups first.

Key recommendations concerning surveillance include:

- Investigate to verify high reported condom use by female sex workers.
- Investigate low reported condom use by female sex workers with non-regular partners to determine possible needed interventions.
- Disaggregate condom use data reported by female sex workers by regular/paying, regular/non-paying and non-regular/paying partners
- Integrate HIV/AIDS surveillance with the other infectious disease surveillance within the NEC as soon as possible and make associated staffing reductions and administrative changes when integration occurs.

## □ Information, Education and Communication

- PATH and partners raised on their own more than \$11 million in pro bono advertising using a wide range of media that increased awareness about HIV/AIDS infection, child prostitution, and the need to destigmatize people with HIV/AIDS. PATH's initiative (not required by USAID) proved to be very effective.
- PATH and its NGO partners use peer education approaches very effectively to communicate prevention information to difficult to reach high-risk groups.
- The impact of IEC efforts is measurable – data show that they have promoted knowledge, attitudes and practices necessary for risk reduction.
- PATH and its partners developed an excellent participatory process for using Behavioral Monitoring Systems to guide programming and engage LGUs.
- PATH and its partners – NGOs, private pharmacies and local health offices – developed a highly effective approach to providing treatment for STDs. The Triple S and Safe Pack programs definitely warrant expansion.
- An opportunity exists to expand support for and promotion of HIV/AIDS prevention by working with religious and other social service organizations.
- On-going activities in the areas of policy development, environmental and structural constraints, assistance targeted on sexually exploited children, use

of existing legislation (and funding) to discourage child prostitution are all sound activities that should be continued under ASEP.

- Education programs specifically targeted on MSMs and IDUs need greater attention if possible during the course of ASEP and in any follow-on project

The most important recommendation made in this area is that additional activities targeted on MSMs and IDUs need to be explored and started, if possible, during the remainder of ASEP. A focus on MSMs and IDUs should be part of a follow-on project.

#### □ Sustainability and Future Directions

- While there is a wide range of stakeholders from national to local levels, as a result of ASEP, the strongest capacity for future support for HIV/AIDS prevention is at the local level – i.e., ASEP assisted cities
- The most important sustainability issue is keeping the HIV/AIDS epidemic at its low/slow level. Planning for sustainability must determine what activities are essential and must be continued, and what new activities and capabilities must be developed to sustain the low/slow pace.
- Possible new activities targeted on commercial sex workers include:
  - ⇒ *An LGU-financed contract for NGOs education prevention programs.*
  - ⇒ *Planning a citywide framework for condom use promotion*
  - ⇒ *Documenting the Triple S STD project experience.*
  - ⇒ *Developing a health package for barangays in red light districts.*
- Possible elements for a “second generation” HIV/AIDS program include:
  - ⇒ *Performance-based incentive grants for LGU STD/HIV/AIDS prevention*
  - ⇒ *Applied research for STD/HIV/AIDS prevention program development to reach unserved/under-served high risk groups*
  - ⇒ *Targeted programs for MSMs and IDUs*
  - ⇒ *Applied research for promotion of additional behavioral change associated with STD/HIV/AIDS infection*
- During the remainder of ASEP, DoH needs to establish formal agreements with cooperating LGUs to assure their support for continued surveillance.

#### □ Future Assistance for STD/HIV/AIDS Prevention

- FriendlyCare clinics, Well Family Midwife clinics and the Matching Grants Program supported by USAID are possible means for expanding access to STD/HIV/AIDS information services.
- Other donors plan to integrate HIV/AIDS prevention in broader programs or cease assistance entirely.
- USAID remains at the forefront of STD/HIV/AIDS prevention and is the only donor that has developed effective programs that target on high-risk groups. **Funding for a “second generation” project is essential to: a) build on and extend the accomplishments of ASEP, and b) maintain and expand the focus on high risk groups to keep HIV/AIDS epidemic at its current low/slow pace.**

## Acronyms

ASEP	AIDS Surveillance and Education Project
AIDS	Acquired Immune Deficiency Syndrome
BLAaCP	Barangay Legal Action against Child Prostitution
BMS	Behavior Monitoring Surveys
BSS	Behavior Surveillance Survey
CDC	Centers for Disease Control
CHOW	Community Health Outreach Worker
COPE	Community Outreach and Peer Education
DOH	Department of Health
FFSW	Female Freelance Sex Worker
FETP	Field Epidemiology Training Program
FreeLAVA	Free Legal Assistance Volunteers Association, Inc.
HRG	High Risk Group
GO	Government Organization
HSS	HIV Sentinel Surveillance
HIV	Human Immuno-deficiency Virus
IDSCP	Infectious Disease Surveillance and Control Project
IDU	Injecting Drug User
IEC	Information, Education and Communication
JICA	Japan International Cooperation Agency
KAP	Knowledge, Attitudes and Practices
LGU	Local Government Unit
MSM	Men who have sex with men
NASPCP	National AIDS/STD Prevention and Control Program
NCDPC	National Center for Disease Prevention and Control
NEC	National Epidemiology Center
NGO	Non-Government Organization
PATH	Program for Appropriate Technology in Health
PE	Peer Educator
PNAC	Philippines National AIDS Council
POCOMON	Policy Compliance Monitoring
RFSW	Registered Female Sex Worker
Ro	Reproductive Number (Ro) of HIV Infection
RBG	Risk Behavior Group
STD	Sexually Transmitted Disease
USPF	The University of Southern Philippines Foundation
WHO/ WPRO	World Health Organization/Western Pacific Regional Office

## Section 1. Overall Impact and Results of the AIDS Surveillance and Education Project

This section provides a general overview and summary of the main accomplishments of the AIDS Surveillance and Education Project (ASEP) since implementation began in September 1993. Impact and results are discussed in broad terms. These issues will be discussed in greater detail in the Surveillance, Education, and Sustainability sections of the report.

### 1.1 The Three Major Program Accomplishments of ASEP

Overall, ASEP has been a highly successful undertaking. Viewed over eight years of implementation, ASEP has achieved its most important objectives. **The Department of Health, participating local governments, USAID, JICA, and the various participating partners in ASEP should be credited for contributing to this success in important ways.** Moreover, they and other organizations supporting HIV/AIDS prevention activities are all contributors to developing the capacities, institutional systems, and responses necessary to continue to prevent a rapid increase in HIV/AIDS infections.

Prior to the start of ASEP, authorized in July 1992, the extent of the epidemic in the Philippines was unknown. Nearby countries, like Thailand, were experiencing an explosive epidemic that created frightening scenarios for the region. Some eminent epidemiologists were predicting a similar explosion of HIV/AIDS infections in the Philippines, particularly in Manila. The Secretary of Health at that time speculated that infection levels could be as high as 50,000 HIV positive cases nationwide.

It was in this setting of near hysterical assertions that ASEP established the country's HIV/AIDS sentinel surveillance in 1993. Over the intervening eight years, that system spread to a total of ten cities throughout the country. Surveillance data have shown unequivocally that HIV/AIDS prevalence even within the highest risk groups remains below one percent. The total number of cases officially reported by the Department of Health (DOH) is presently 1,429, far below the wild speculations of the past. In the general population, infections are minuscule. Recent test results of 500,000 blood samples by the National Blood Bank found only one positive case. None of this was known prior to ASEP.

On the basis of the data generated by the sentinel surveillance system, the Philippines is now categorized as a low infection/slow progression epidemic. However, as the experience of other countries show, this is not an invitation for complacency. Factors promoting an accelerated spread of HIV/AIDS can suddenly come into play creating explosive epidemics. Injecting drug users (IDU) in Jakarta offer a telling example. Prevalence among IDUs had been three percent (and possibly lower). However, in just two years, it sky rocketed to above 30 percent.

While progress has been made under ASEP toward reducing the high risk behaviors that have driven the epidemic elsewhere, many Filipinos in these high risk groups engage in practices that could accelerate infection rates. The surveillance work and other activities sponsored by ASEP and other USAID activities have shown that

STDs, particularly syphilis, are at dangerously high levels that could easily facilitate a rapid increase in STD/HIV/AIDS.

While low/slow prevalence is good news for the country, continued vigilance and prevention is necessary if the Philippines is to avoid a rapid acceleration of the epidemic. Critically important is maintaining the focus of present and future assistance to prevent a rapid acceleration of the epidemic among the highest of high risk groups – female and male sex workers, injecting drug users, and men who have sex with men.

A second key accomplishment of ASEP is that it has shown that local NGOs can be mobilized to develop effective education programs targeted on high risk groups as a key intervention for preventing accelerated rates of STD/HIV/AIDS. When ASEP began, there were very few NGOs working in this area. The USAID AIDSCAP project had provided early assistance to these NGOs prior to ASEP. However, at the start of ASEP, their HIV/AIDS activities were fairly small in coverage, focused on one specific high-risk group in Manila.

Under ASEP, its partners NGOs have developed programs for multiple high-risk groups in cities throughout the country. ASEP with its implementing partner PATH has assisted some 25 NGOs in eight cities throughout the country to plan, implement and monitor education activities targeted on the high risk groups where the threat of accelerated infection is greatest. Monitoring data suggest that these programs are indeed making a difference in key areas of knowledge and practices needed to avoid infection. However, this has proven to be a difficult task with periodic setbacks and dead ends in the form of some NGOs being unable or unwilling to become effective partners.

PATH's work with NGOs in the eight ASEP focus cities shows that it takes roughly four years for an NGO to become effective at supporting STD/HIV/AIDS prevention activities. The NGO must recruit, train, supervise and retain workers who are willing and able to undertake difficult and potentially dangerous work. Understanding the organization of the community where the NGO works and gaining access to the targeted groups and individuals simply takes time. Access alone is not sufficient; the NGO workers need to establish credibility and rapport with their clients before education messages are accepted and believed. Clients often need to feel that the NGO worker is genuinely interested and concerned about her/his well being before those messages will be acted upon. All of this takes time – four years from PATH's experience – and constitutes a major investment for ASEP and its partners.

Reaching individuals for one-on-one discussions about HIV/AIDS prevention requires that workers go to where their clients work during the hours when they are active. This means going to red-light districts, sex establishments, bars, streets frequented by freelancers, etc. at night. Some key actors – mama sans, brothel owners – will resist these efforts by interfering with the worker's access to targeted clients. Certain high risk groups, particularly injecting drug users (IDU) and men who have sex with men (MSM), avoid contact because they do not want to be known. Add periodic police raids on known sex establishments and places of drug use into the equation, the NGO worker's task is even further complicated. Not surprisingly, some NGOs have had difficulty in retaining staff.

Despite these difficulties, PATH and its local partners under ASEP have established effective education programs that reach these hard to access high-risk groups. Given the success ASEP has achieved in supporting NGO education programs, and the investment of resources and time this has required, it is important that these programs be continued. The composition of the high risk groups is highly transitory – individuals enter, leave, and re-enter these groups repeatedly, often in other locations and shift between groups (e.g., from establishment based to freelance sex work). There is a constant influx of new entrants into these groups as well. The transient and changing nature of these groups requires that education efforts encouraging behavioral change must be an on-going process to prevent future acceleration of STD/HIV/AIDS.

A third key challenge for ASEP was to engage local government units (LGU) so that they would recognize the value of the surveillance and education programs, and then gradually take responsibility for supporting these activities. ASEP through PATH have demonstrated that this is achievable. For the first several years of ASEP, mayors and city councils in ASEP sites more or less watched from the sidelines as surveillance and education activities were conducted. When asked, city administrators would promise more active support through future budget allocations, but funds were not forthcoming. However, city health officials were gaining awareness about the threat that HIV/AIDS presented to their cities as positive cases were found, and the need for education activities targeted on the highest risk groups.

PATH and its NGO partners initiated a concerted policy and advocacy effort beginning in 1997/98 that led to fuller engagement of LGU officials. As a result, cities have begun allocating budget for the annual sentinel surveillance surveys, taking over a cost formally borne by ASEP. Ordinances in support of expanded STD/HIV/AIDS prevention (and treatment for STDs) have been drafted and two cities have enacted them (Angeles and General Santos). These ordinances include actions to effect environmental barriers to safe practices, such as the encouragement of 100 percent condom use in commercial sex establishments. Local AIDS Councils have also been organized to plan and support (with budgeted funds) STD/HIV/AIDS interventions. These councils are multi-sectoral in composition and include local ASEP-supported NGOs. The next major step is to encourage adequate LGU funding for the NGO education programs.

The progress ASEP and its partners have made with the LGUs is indeed very significant. From no awareness and no response, the ASEP LGUs are now taking actions that were previously not even contemplated. ASEP and its NGO partners have created new local capacities in both the public and private sectors to respond effectively to the threat of increasing STD infections and HIV/AIDS prevention. In so doing, they have helped to develop local government institutional mechanisms that are essential for implementing and sustaining programs against the spread of STDs and HIV/AIDS. ASEP partners are now working with barangay officials and council members to use existing laws and ordinances to thwart sexual exploitation of children in their communities, and to gain access to available funds for programs that will discourage entrance into sex work by minors in their community.

It is now very clear from the accomplishments of ASEP that LGU support for STD/HIV/AIDS prevention can be gained through the development of effective programs responsive to local needs. As with continued vigilance and support for surveillance and prevention, and for further NGO program development, more remains to be done to

solidify the accomplishments that have been realized by ASEP to date and to assure that full LGU support is sustained in the future.

## 1.2 Special Objective (SpO) and Intermediate Result (IR) Level Results

The preceding accomplishments of ASEP are reflected in the performance indicators that USAID has specified for the Special Objective (SpO), Intermediate Results (IR1) and IR1 Sub-Component (SC) levels. Table 1 reports the SpO, IR1 and SC indicators/measures that the mission has been using to track results under this SpO, their associated targets, and the level of achievement as of the end of 2000.

Table 1: Results for the Special Objective Framework

Indicators	Targets*	Results*
<b>SPO: Annual estimate of HIV seroprevalence for the total population</b>	< 1.0%	< 1.0%
<b>IR1. HIV seroprevalence rates among registered female commercial sex workers in HSS sites remains below 3%</b>	< 3.0%	< 1.0%

\* All Targets are for September 2002 and Results are as of December 2000 unless otherwise noted.

The table shows the low prevalence/slow progress status of the HIV/AIDS epidemic in the Philippines. Prevalence is extremely low, far below the one percent level of HIV/AIDS infections among the general population that USAID has been using as its SpO target throughout the duration of ASEP. The epidemic would have to accelerate very suddenly among high-risk groups, and then cross over and spread rapidly within the general population for infection levels to exceed this target. That is impossible during the remainder of ASEP.

The same can be concluded about the prevalence levels among high-risk groups. While USAID raised the target level from its original one percent to three percent, this was unnecessary because the prevalence of infections even within the high-risk groups still remains below one percent. This could change, however, since these groups are where any acceleration of STD/HIV/AIDS will start.

The Philippines' exceedingly good fortune of having a low/slow epidemic results from a number of factors – some known, such as absence of sexual behavior patterns that cause rapid transmission, some unknown at present, and some as yet unproved but supported by a growing body of evidence. Despite the “mysterious” complex explanation for the low/slow situation, **the DOH, USAID, ASEP partners and others working on HIV/AIDS prevention should take credit for mounting an effective response that has contributed to this low prevalence.**

Though prevention activities do not solely account for the low/slow status, these activities should be viewed as important contributing or reinforcing factors in the Philippines. Most responses to the epidemic have come too late in other countries to prevent a rapid explosion of infections, while in the Philippines, the response has preceded any rapid increase in prevalence. It is certainly true that knowledge about the risks of infection and appropriate behavioral changes are far more widespread among

high-risk groups now than before prevention programs first began, and this has very likely prevented additional infections. **The continuing challenge is to maintain and expand such activities in the coming years to keep the epidemic at its current low/slow pace.**

Table 1 (cont.)

Indicators	Targets	Results
<p><b>SC1. Knowledge: Knowledge about STD/HIV prevention among high-risk groups.</b></p> <p>Measure: Percent of high risk groups who are able to identify at least three correct ways to protect themselves from STD/HIV infection:</p>		
Registered Female Sex Workers	> 79%	72%
Freelance Female Sex Workers	> 75%	62%
Men who have Sex with Men	> 88%	66%
Injecting Drug Users	> 73%	78%*
<p><b>SC2. Attitudes: Increased perception of risk of infection by high risk group members.</b></p> <p>Measure: Percent of high risk groups who perceive themselves at risk of STD/HIV because of their behavior:</p>		
Registered Female Sex Workers	> 50%	57%
Freelance Female Sex Workers	> 45%	45%
Men who have Sex with Men	> 40%	40%
Injecting Drug Users	> 47%	N/A

\* 1999 BSS results

N/A – not available from the BSS

The Sub-Component level of IR1 focuses on promoting knowledge, attitudes and practices necessary for prevention of STD/HIV/AIDS. Knowledge about three ways to prevent infection comes close to the projected target for registered female sex workers (RFSW) in the eight ASEP surveillance cities. Results for freelance female sex workers (FFSW) fall short of the projected targets. However, progress has been made with this group – from 56 percent in 1997 to 62 percent in 2000. Most problematic has been increasing knowledge among men who have sex with men (MSM), where knowledge levels have fallen from 71 percent in 1997 to 66 percent in 2000. The clearest success has been with IDUs where results exceed the target. Failure to reach targets for RFSW, FFSW and MSMs, of course, could also reflect overly optimistic target setting.

For attitudinal changes, RFSWs, FFSWs and MSMs all report greater awareness of the risks they face from their behavior, exceeding target levels for 2000.

Consistent condom use among high-risk group members is the single most important practice that should be promoted to avert a future increase in STD/HIV/AIDS. Two indicators have been tracked regarding condom use: 1) consistent (always) condom use during the past week, and 2) condom use with non-regular partner during their last sexual intercourse.

Table 1 (continued)

Indicators	Targets	Results
<p><b>SC3.1 Practices: Increased proportion of high risk groups who report condom use with partners at risk during the past week.</b></p> <p>Measure 3.1: Percent of high risk groups who report consistent (always) condom use with partner at risk in the past week:</p> <p>Registered Female Sex Workers                      Freelance Female Sex Workers                      Men who have Sex with Men                      Injecting Drug Users</p>	<p>&gt; 50%                      &gt; 40%                      &gt; 30%                      &gt; 30%</p>	<p>42%                      39%                      20%                      15%*</p>
<p><b>SC3.2 Practices: Increase in proportion of high risk groups who report condom use during the last sexual intercourse at risk.</b></p> <p>Measure 3.2: Percent of high risk groups who report condom use during the last sexual encounter at risk – non-regular sex partner:</p> <p>Registered Female Sex Workers                      Freelance Female Sex Workers                      Men who have Sex with Men                      Injecting Drug Users</p>	<p>&gt; 92%                      &gt; 75%                      &gt; 61%                      &gt; 54%</p>	<p>69%                      72%                      28%                      56%*</p>
<p><b>SC3.3 Practices: Decrease in sharing of injection equipment by injecting drug users.</b></p> <p>Measure 3: Percent of injecting drug users who report sharing injection equipment:                      Injecting Drug Users in Cebu City</p>	<p>&lt; 40%</p>	<p>52%</p>

\* 1999 BSS results

The data show that:

- RFSWs report levels of consistent condom use approaching the projected target for 2002, but results fall far short for condom use with non-regular partners.
- FFSWs report condom use that approximated 2002 targets.
- MSMs fall short on consistent condom use and are far below the target for sex with non-regular partners.
- IDUs report somewhat better condom use, falling short of the target for consistent condom use, but exceeding the target for non-regular partners.
- Results for reducing sharing of injecting equipment among IDUs fall short of the 2002 target.

The preceding results describe the current situation in ASEP sites as a mixture of progress in some areas with the need for expanded efforts in others. Various factors contribute to this outcome.<sup>1</sup> Setting aside the question of reaching targets, the 2000

<sup>1</sup> These factors include: a) the BSS uses samples that include individuals who are not within the catchment areas of the ASEP-supported NGOs, lowering overall, aggregate results, b) some of the targets may have been unrealistically high for aggregate measures of this sort, c) considerable variation exists among ASEP cities and among the high risk groups within each city that is lost when using aggregate measures, and d) cities were "phased into" ASEP coverage; therefore, the duration of education programs varies by city, and results vary accordingly by city.

results show that considerable progress has been made toward risk reduction since the start of ASEP in 1992. Condom use by RFSWs, the largest high risk group, at roughly 70 percent overall is definite progress when compared with the very low use when ASEP started. Areas where results have fallen short of targets to define where more effort is needed during ASEP and in any subsequent assistance for HIV/AIDS prevention.

### 1.3 Activity Level Results

The Activity Level measures in USAID's SpO framework reflect outcomes and results that are directly under the control of implementing organizations. As Table 2 shows, every measure that USAID has specified for ASEP's surveillance, NGO - LGU, and policy activities have been reached or exceeded.

Table 2: Activity Level Results

Activities and Measures	Targets	Results
<b>1. HIV Sentinel Surveillance and Behavioral Surveillance Survey, and NGO program monitoring systems are coordinated and utilized by the DOH, LGUs and NGOs to monitor HIV prevalence and risk behavior among high risk groups with national and local program interventions guided by results.</b>		
1A: No. of geographic sites providing data to monitor HIV prevalence.	8	8
1B: No. of geographic sites providing data to monitor risk behavior prevalence.	8	8
1C: No. of quarterly meetings of an STD/HVI Committee involving FETP and PATH to coordinate data-related activities.	12	40
1D: Number of NGOs using behavioral data to guide program development.	20	25
<b>2. Network of NGOs, GOs and Private Commercial Sector groups delivering IEC services to STD/HIV/AIDS high-risk groups.</b>		
2A: HIV/AIDS outreach workers trained and active in STD/HIV/AIDS work	120	210
2B: Peer educators supported and active in STD/HIV/AIDS education.	1,000	1,959
2C: Private and public health care providers in HSS sites trained in improved STD management.	1,200	1,990
2D: Entertainment establishments in 2 HSS promoting 100% condom use policy.	50%	100%*
<b>3. LGUs and NGOs jointly manage and sustain effective STD/HIV/AIDS Prevention and Control Programs in their cities.</b>		
4A: Number of cities/municipalities implementing effective STD/HIV/AIDS Prevention Action Plans.	8	8
4B: Number of local STD/HIV/AIDS Multi-sectoral Committees established and actively supporting policy reforms in HSS sites.	4	7
4C: Number of LGUs and partner NGOs finance STD/HIV activities through new revenue sources in HSS sites.	4	8**
<b>4. Policy and Environmental/Structural constraints to promoting STD/HIV/AIDS prevention being analyzed, results disseminated and advocacy efforts conducted.</b>		
Measure: The number of policy, environmental, and structural constraints analyzed; results disseminated; and advocacy efforts conducted.	5	7 policy studies, 6 advocacy efforts completed

\* Being verified by NGO partners through on-going compliance monitoring.

\*\* Eight cities were sites for the Triple S STD program that was based on a new revenue source.

ASEP's extension in October 2000 continues activities through September 2002 with a focus on sustainability. Two new Activity level measures were added at that time pertaining to sustainability that are not included in the preceding table for 2000 results.

Measure 1E in the revised framework is "50 percent of ASEP LGUs provide funding for the HSS and BSS." At present, five LGUs are funding the HSS, but none are supporting the BSS. The BSS has limited utility for both the LGUs and NGO partners and is unlikely to receive support by the target date of September 2002.

Measure 1F is "At least 6 LGUs have a signed ordinance in support of STD/HIV/AIDS prevention." This indicator pertains to the policy activities PATH and its NGO partners support. To date, ordinances have been finalized and enacted in Angeles and General Santos, and ordinances have been drafted in four other cities. Signature by the mayor in these other cities is awaiting the outcome of the May 2001 elections. Cebu's mayor stated that such an ordinance would be feasible there if he is re-elected, suggesting that most ASEP cities could have enacted ordinances later in 2001.<sup>2</sup>

#### 1.4 Outputs of PATH and ASEP's NGO Partners

The following table summarizes the substantial level of outputs produced by PATH and its NGO partners over the past eight years.

(See Table 3)

Table 3 shows that a great deal of activity has been carried out by PATH and its NGO partners. While outputs do not necessarily translate directly or immediately into impact, the magnitude of these activities constitutes a significant contribution to preventing STD/HIV/AIDS through a wide range of interventions directed to high risk groups, as well as to the general population. These results are all the more impressive when compared to expenditures. On average, USAID has provided approximately \$1.5 million annually for these activities through the PATH Cooperative Agreement. Clearly, a great deal has been produced with a fairly modest amount of funding – something that the DOH and USAID should consider as another major accomplishment of its support for ASEP.

---

<sup>2</sup> Two technical issues contained in the scope of work concerning indicators are discussed in ANNEX 1

Table 3: Cumulative Results of ASEP's Education and Policy Components – 1994-2000

<b>Activities</b>	
<b>Collaborating Organizations</b>	
Number of Collaborating Private Sector Organizations and NGOs	53
<b>COPE</b>	
Number of subprojects completed	25
Number of NGO participants trained: CHOWs, PEs & Public and Private STD Service Providers	1,990
Number of first-time client contacts	317,251
Number of female sex workers contacted	> 150,000
Percent of the total number of female sex workers contacted by ASEP NGOs	> 25%
Number of repeat contacts made with all ASEP NGO clients	> 1,000,000
Number of IEC materials distributed	1.5 million
Number of condoms distributed	> 5.6 million
Average cost per client contact (no clinic)	P500
Average cost per client contact (with clinic)	P1,500
<b>Private Sector</b>	
Number of Triple S Red, Blue and Green Packs sold	3,773
Revenue generated from Triple S sales	P434,000
Number of participating Triple S pharmacies	100
Number of pharmacy staff trained to provide counseling	450
<b>100% Condom Use</b>	
Number of establishment owners supporting 100% condom use in Angeles, Cebu and General Santos.	350
Number of establishment owners partially funding peer educators to encourage and monitor 100% condom use.	90
<b>Mass Media</b>	
Number of newspaper articles published about PATH-sponsored activities	56
Value of free media time raised for STD/HIV/AIDS IEC (TV, radio, electronic billboards, cinema screen time, newspaper space, billboards, LRT signboards, magazine space, etc.)	> \$11 million
Mass media public service advertising campaigns from 1995 to 2000	5
Radio soap operas with STD/HIV/AIDS messages	1999 (50% pro bono): 2000 (100% pro bono):
on Radio Mindanao:	9 9
Awards for most creative public service announcements:	International: Local:
	1 (1999) 2 (1998/1999)
PATH professional staff awarded recognition by local organizations for their leadership in their respective areas of expertise	2
Publication clearinghouse at De La Salle University established	1
Newsletters distributed to ASEP stakeholders in eight cities	5
Number of Special Events Sponsored (workshops, training, etc.)	30
Skills-building manuals and training curricula develop for public and private sector service providers and their organizations	15

## 2. HIV Sentinel Surveillance and Behavioral Surveillance Survey

### 2.1 Background

The HIV Sentinel Surveillance System (HSS) is currently carried out annually in 10 cities to monitor HIV prevalence in selected high-risk behavior groups. The Behavioral Surveillance System (BSS) monitors high-risk behaviors among these same sentinel groups. Six target populations were initially included in the surveillance system: registered female sex workers (RFSW), freelance female sex workers (FLSW), male sex workers (MSW), men who have sex with men (MSM), male STD patients, and injecting drug users (IDU). The number of sentinel groups was reduced to four in 1997 – RFSW, FFSW, MSM, and IDU. Since 1995, during the annual HSS blood collection period, new recruits of the Armed Forces of the Philippines (AFP), have been included as a HSS target group. Blood samples collected for HSS are also tested for syphilis.

The first round of HSS was conducted in June-August 1993 in two cities (Quezon and Cebu). The initial design of HSS sites anticipated a gradual expansion to about 30 sites. However, the 1997 mid-term evaluation recommended that HSS be limited to 6-8 sites until there was more evidence of widespread HIV transmission in the Philippines. DOH elected to expand HSS to 10 cities that included - Quezon, Pasay, Angeles, Baguio, Iloilo, Cebu, Cagayan de Oro, Davao, General Santos, and Zamboanga.

ASEP has funded the direct costs of HSS – i.e., supplies and staff for the collection and testing of blood samples. This is implemented through a grant to the WHO Western Pacific Regional Office (WPRO) in Manila that established a sub-grant agreement with the New Tropical Medicine Foundation for the administration and financing of surveillance operations. WPRO has provided limited technical support for HIV surveillance activities in the Philippines. The WHO grant also serves as the mechanism for contracting with local research groups to collect behavioral data.

The National Epidemiology Center (NEC) of the DOH is now the principal unit involved with infectious disease surveillance in the Philippines and is responsible for overall management, technical guidance and field supervision of the surveillance system. ASEP currently funds five staff persons assigned to NEC to work with field site managers and staff during the HSS rounds to provide technical oversight. NEC analyzes HSS data and disseminates the results.

The Behavioral Surveillance Survey (BSS) was not initially part of ASEP's surveillance component. Some behavioral questions were included in the HSS (e.g., condom use rates). The 1995 Mid-term Evaluation recommended development of BSS and also encouraged ASEP's Education component to develop a Behavioral Monitoring System (BMS) to evaluate behavioral changes that might be attributable to its outreach and educational activities.

## 2.2 Summary of Accomplishments to Date

A total of 11 rounds of HIV sentinel surveillance (HSS) have been conducted. From 1994 through 1996, two rounds were carried out annually and since 1997, only a single round is conducted annually. At the local level, Social Hygiene Clinic staff have been trained by NEC/AIDS Unit to carry out blood sampling and data collection needed for the HSS. After completion of a surveillance round, NEC prepares and distributes a report of HSS findings to DOH managers and others (e.g., LGUs) who participate in the data collection. As of 2001, at least five ASEP cities are capable of implementing HSS with minimal technical supervision and are willing to fund the costs for HSS rounds.

The BSS started annual collection of behavioral data at HSS sites from selected high risk groups in 1997. These surveys are conducted by local research institutions. Future local support after ASEP for the BSS is very uncertain at this time.

## 2.3 Summary of Key Surveillance Findings

HIV infections of registered or freelance female sex workers have not been found in large numbers. Annual HSS samples of about 300 RFSWs from the sentinel sites have only detected occasional and sporadic HIV infections. In the Philippines, HIV prevalence in all FSW sentinel samples continues, as of 2001, to be generally well less than 1% at all sentinel sites. These findings clearly indicate that extensive HIV transmission has not occurred, even within the highest heterosexual risk behavior groups.

Table 4: HIV Prevalence rates for RFSWs in HSS rounds – 1996-2000

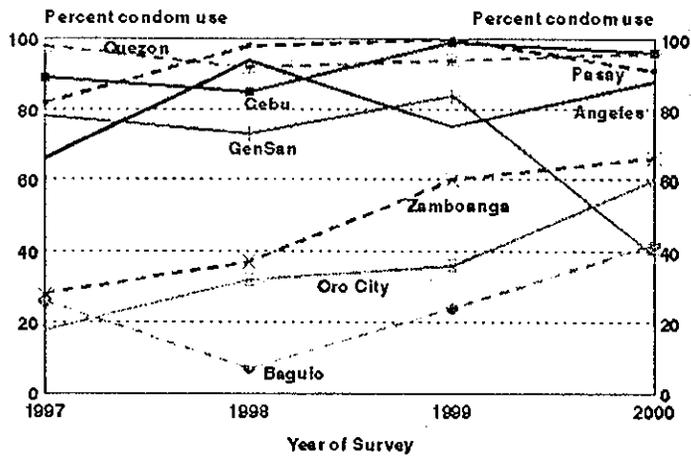
	1996	1997	1998	1999	2000
#HIV+ / #tested	2 / 3069	4 / 3028	5 / 2672	2 / 3002	4 / 3000
HIV prevalence	0.07	0.13	0.19	0.07	0.13

Relatively high seropositive rates for syphilis (<1% to 5%) have been found in the last couple of years in many of the HSS sentinel risk groups. The highest rates were generally found among FFSWs, followed by MSMs. However, in the last few years, rates among MSMs have been decreasing and rates among RFSWs have been the lowest.

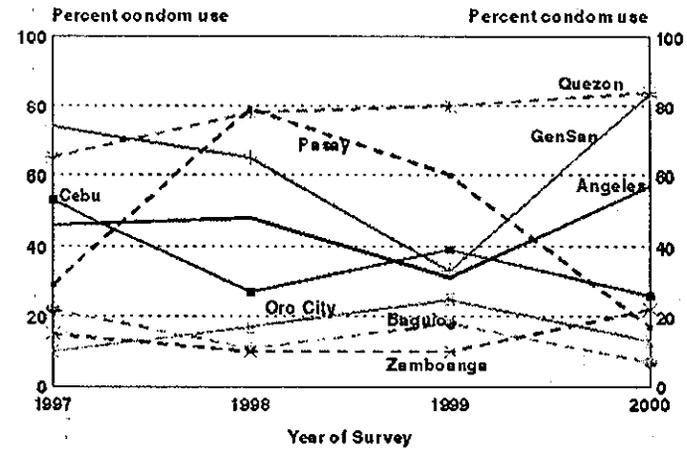
Detailed condom use data have been collected over the past several years through the HSS and BSS. However, presentation of survey results as averages across all sites has obscured important differences among the ASEP sites. In several sites (Quezon, Pasay, Cebu, and Angeles), relatively high condom use (above 90%) has been reported by RFSWs with non-regular sex partners. In Baguio and Zamboanga, increasing condom use is reported. General Santos, Davao, and Iloilo show an erratic pattern with low reported condom use (less than 50%) in 2000. Reported condom use by RFSWs with their regular sex partners is generally much lower compared to that reported with their non-regular sex partners. These trends are presented in the following graphs.

(See graphs – next page)

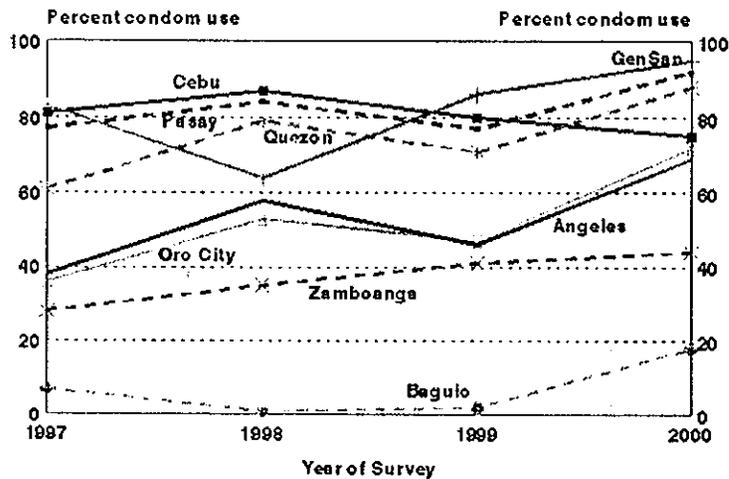
**Registered Female Sex Workers (RFSW)  
Condom Use with Last Non-Regular Sex Partner**



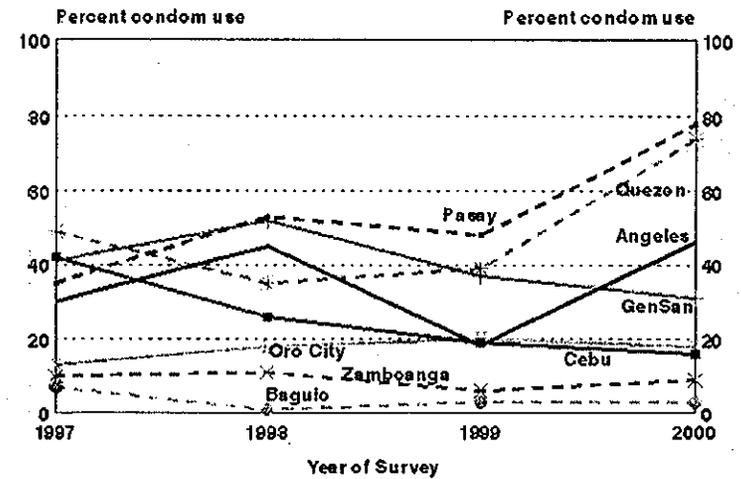
**Registered Female Sex Workers (RFSW)  
Condom Use with Last Regular Sex Partner**



**FreeLance Female Sex Workers (FLSW)  
Condom Use with Last Non-Regular Sex Partner**



**FreeLance Female Sex Workers (FLSW)  
Condom Use with Last Regular Sex Partner**



USAID/Manila has recently developed an Infectious Disease Surveillance and Control Project (IDSCP) to strengthen surveillance and control of major infectious diseases, specifically tuberculosis, dengue and malaria. This project is located in the NEC, receives assistance from a resident advisor from CDC/Atlanta, and funds nine staff positions. Its objectives and functions easily incorporate those of HIV surveillance.

- **Conclusions**

The HIV/AIDS surveillance data in the Philippines support the basic conclusion that extensive transmission of HIV has not occurred, even within the highest risk groups – MSMs, IDUs and sex workers. This low and very slow increase of HIV prevalence in the Philippines is due to the low infection rate of HIV via sexual intercourse and the generally lower prevalence of HIV risk behaviors present in the Philippines compared to other Asian countries where transmission of HIV has been extensive.<sup>3</sup>

In 1999, the Philippine Red Cross tested 500,000 blood samples and found only one HIV positive sample. These data represent a valuable source of additional HIV surveillance data and they should be reviewed on a timely basis, but as of April 2001, the blood bank's HIV findings for the year 2000 had not been received by FETP.

ASEP's support for HIV surveillance has been successfully implemented and there are favorable indications that LGUs will continue funding this activity in the future. The HSS, as designed by WHO/GPA during the late 1980s, has been a relatively reliable method for monitoring the general patterns and trends of HIV infection. The HSS can provide an early warning alert of HIV transmission in the highest risk groups.

A major problem with reported condom use by female sex workers is that such data are often unreliable. Some field studies that collected condom use data from male clients of sex workers have shown usage rates about half of that reported by the sex workers. The very high reported usage rates (at several sites > 95%) found by the BSS need to be validated through appropriate studies, such as focus group discussions. Another problem with the condom use data is that female sex workers often have regular paying clients who the women refer to as "regular" sex partners, not distinguishing them from husbands or boyfriends. Future BSS surveys should separate out condom usage data for these regular paying sex partners (regular customers) from non-paying regular sex partners (husbands or boyfriends).

It is possible to integrate the HIV/AIDS surveillance with IDSCP. The active HIV surveillance components (HSS and BSS) can be combined with surveillance of other sexually transmitted infections, but not with other infectious diseases. However, it must be realized that the HSS and BSS can only provide surveillance data on HIV and STDs. This eliminates the need for ASEP funding of five contract staff positions for HIV/AIDS surveillance.

---

<sup>3</sup> Additional details regarding the basic epidemiology of HIV in Asia and the prospects for extensive HIV transmission in most Asia-Pacific countries can be found in the Annexes.

Alternative arrangements for contracting with local research groups for BSS data collection could be used. Given the greatly diminished need for technical assistance for HIV surveillance (capacities have been developed at both national and local levels), the WHO grant will no longer be needed after this merger.

The common thread that runs through all extensive or epidemic transmission of HIV in Asia is that the primary HIV risk behavior groups affected are all socially marginalized and engaged in socially unacceptable and often illegal behaviors. Injecting drug use and multi-partnerism are difficult subjects for government agencies to address. The same is true in the Philippines. Therefore, attempting to integrate ASEP's outreach and education activities targeted on high risk groups into broader general medical or family health care programs is inappropriate. Such an attempt would result in inadequate access to and coverage of these high risk groups. This evaluation emphasizes the fundamental fact that any rapid increase in HIV/AIDS infection will occur first within these groups, and that the special, targeted interventions of ASEP are necessary to prevent that acceleration.

- **Recommendations**

- ⇒ The high reported condom use rates of RFSWs (> 80%) with non-regular sex partners should be validated.
- ⇒ Factors accounting for low reported condom use rates (< 50%) of RFSWs with non-regular sex partners should be identified and education efforts based on this information should be undertaken to increase consistent condom use.
- ⇒ Condom use data for female sex workers should be disaggregated by three categories of sex partners – i.e., regular non-paying sex partners, regular paying sex partners, and non-regular paying sex partners.
- ⇒ Blood bank data should be reviewed on a monthly basis in order to monitor HIV prevalence trends in a low HIV risk behavior population on a more timely basis.
- ⇒ BSS should continue to collect condom use data. If no funding for BSS can be provided after termination of ASEP, behavioral questions (condom use rates, etc.) should be included in HSS rounds.
- ⇒ HIV/AIDS surveillance at the national level should be integrated with national surveillance of other major infectious diseases, by September 30, 2001 if possible.
- ⇒ With the integration of surveillance functions, ASEP funding for contract staff to support the HSS and BSS should be terminated.
- ⇒ With the integration of surveillance functions, USAID/Manila should use less expensive administrative arrangements for surveillance support, such as a direct grant to the New Tropical Medicine Foundation, eliminating the need for the current grant mechanism with WPRO.

### 3. Information, Education and Communication Activities

#### 3.1 Raising Awareness in the General Public

Starting in 1995, ASEP conducted IEC activities through mass media to raise public awareness about HIV/AIDS and STDs. The mass media campaign sought to:

- increase public awareness of STD signs and symptoms and appropriate STD care-seeking behavior;
- increase public awareness of child prostitution and associated HIV risks; and
- destigmatize persons with STDs and HIV/AIDS.

In collaboration with McCann Erickson Philippines and local NGO partner ReachOut, five separate waves of public service advertising were developed and placed in the tri-media (TV, radio, print) during 1995-2000. More than US\$11 million in pro bono media time and space on TV, radio, electronic billboards, cinema screen time, newspaper space, billboard space, signboard space, and magazine space were donated.

All advertising had to clear a media censor, and so content related to condoms was excluded. However, ASEP itself paid for three waves of advertising to promote generic condom use during 1997-2000, in collaboration with DKT Philippines. In addition, nine radio soap opera (30-minute scripts) with STD/HIV prevention themes were developed, pre-tested and aired in 1999 on Radio Mindanao Network for a total of 24 hours of radio broadcast time (50 percent pro bono). Due to popular public demand, the ASEP radio soap operas were broadcast again in 2000 on Radio Mindanao Network, all pro bono. Two of ASEP's campaign waves received awards for most creative Public Service Announcement (one international award in 1999 and two local awards in 1998 and 1999).

To measure exposure and message recall on the part of the television audience, ASEP bought into a Nielson Omnibus survey in 1999. Overall, 35 percent of all TV viewers remembered seeing STD advertisements on TV, rising to 45 percent in Metro Manila. Of those who saw the STD ads, 55 percent were able to recall the ad material. Asked what they would do in case they had STD, including learning of symptoms in a sexual partner, 79 percent gave correct answers. Independent of this survey, the FHI 2000 survey of urban men in the general population found that fully 83 percent of men cited mass media as their source of information about HIV/AIDS and STDs. ASEP's mass media campaign appears to have been highly successful in achieving its objectives.

#### • **Conclusions**

PATH is to be commended for taking the initiative to raise such a substantial amount of funding for mass media communications. While mass media communications are not exclusively targeted on high-risk groups, these messages also reach these groups and contribute to raising general awareness about the risks of STD/HIV/AIDS. To the extent that PATH continues to have the staff resources to support this effort, they should be encouraged by USAID to do so.

- **Recommendation**

⇒ Raising pro bono mass media contributions should be promoted as an element in the design of future HIV/AIDS projects.

### 3.2 IEC Theory and Strategy for Behavior Change

Globally, the peer education model has served as the theoretical basis for most information, education and communication (IEC) activities and behavioral change communications targeting higher risk groups. The team agrees with the 1997 evaluation that peer education is the best IEC approach for reaching and influencing the high-risk groups. ASEP supported IEC has been primarily through local-level Community Outreach and Peer Education (COPE) programs, in which peer educators make initial contact, do basic IEC, and refer clients for counseling to Community Health Outreach Workers (CHOWs). These front line outreach workers have reached over 317,251 vulnerable people between 1994-2000. (See Table 2 for numbers of PEs and CHOWS trained.)

There are some problems with the COPE program, problems typically found in peer education programs globally. The main ones concern motivating and compensating outreach workers, and high drop-out rates. Peer educators and CHOWs earn little money for this work, and many leave the program to take better paying jobs.

As part of the COPE and the Policy Compliance Monitoring (POCOMON) programs, PATH and its partners have purposely sought to identify and work with key local opinion leaders. For example, according to *Refining the ASEP Education Strategy, 1998-2000*, "(s)everal ASEP NGOs use ethnographic observational methods to identify indigenous leaders within high-risk communities." Working with such leaders helps gain entrance into local communities and acceptance of outreach and other project initiatives. It also helps promote behavior change.

Every two years, PATH updates and revises the ASEP educational strategy, in consultation with the NEC/NASPCP (now DOH-PNAC). This revision is informed by the results of behavior monitoring surveys (BMS) and BSS, HSS, qualitative research supported by ASEP, relevant research from other sources, other monitoring and evaluation results, lessons learned from project implementation, and global findings and experience related to AIDS and STDs.

- **Conclusion**

Peer education remains the most effective IEC approach for reaching and influencing the knowledge, attitudes and practices of high-risk groups.

- **Recommendation**

⇒ ASEP should continue its support for peer education and work to ensure that LGUs appreciate the value of reaching targeted groups through outreach activities.

### 3.3 IEC Impact

#### • Findings

A major accomplishment of ASEP has been to find and work with NGOs and community based organizations that proved willing and able to reach socially marginalized groups, such as sex workers, MSMs and injecting drug users.

For program monitoring, PATH and its NGO partners developed the BMS as a tool for measuring and tracking the level of risk behavior and risk reduction practices among ASEP client groups. The BMS complements the BSS, which is conducted by the DOH to evaluate program impact. With technology transfer and sustainability as goals, PATH has trained 21 partner NGOs in the design and implementation of the BMS since 1996. By December 2000, five NGOs had completed six rounds of BMS; 16 had completed two or more rounds.

Almost all quantitative IEC targets of ASEP have been met or exceeded (see Section 1). An exception are HIV/AIDS knowledge levels, measured by being able to provide three correct methods of HIV prevention.

Since condom promotion is the primary focus of the Project's behavior change effort, rise in user levels is an important indicator. According to the BMS, condom use among FFSWs with their last commercial partner was 76 percent in 2000, up from 73 percent in 1999. BSS data from ASEP's eight sites show a comparable finding for the same year: 73 percent for FFSWs. Registered sex workers were lower (69 percent) and MSM were much lower (28 percent).

Condom use with non-regular partners varies greatly by site among RFSWs, from a low of 36 percent in Davao City to a high of 96 percent in both Cebu City and Quezon City. Consistent condom use ("always") was reported by 43 percent of RFSWs, 38 percent of FFSWs, and only 13 percent of MSMs. After the 1995 Mid-term Evaluation, ASEP gave priority to FFSWs because risk behaviors were higher among FFSWs, as was the rate of partner turnover. These recent findings in two ASEP sites argue for continuous behavioral surveillance, since rates can always change, especially with mobile changing populations.

According to DKT social marketing data, Trust condom sales in ASEP sites have increased steadily from 487,407 in 1996 to 1,098,318 in 2000 (1,012,680 in 1999). This is in spite of ASEP having fewer NGOs working on COPE in 2000 compared to 1999.

Table 5 provides further evidence of the effectiveness of IEC activities. From the BMS, respondents who have been exposed to an ASEP peer educator or a CHOW are significantly more likely to score better on various KAP indicators than respondents who have not. Even male clients of sex workers, ASEP's most elusive target group, were much more likely to report condom use with last commercial partner if they had had contact with an ASEP peer educator or CHOW versus who did not (75% versus 41%).

Table 5: Risk Recognition and Knowledge about HIV Infection by Level of Exposure to IEC

Group	Agrees at Risk for STDs		Disagrees Can Recognize HIV+	
	Less	More	Less	More
RFSW	44	53	69	76
FLSW	71	68	82	85
MSM	43	67	67	86
Clients	45	76	61	88
< 18 year old	43	50	52	78

Less – information from other source

More – information from ASEP

Source: BMS 1999

- **Conclusions**

While exposure to ASEP IEC activities marginally increased reported condom use among FFSWs during 2000, ASEP's education program significantly increased awareness about personal risk of STD infection and that physical appearance is no indication of HIV infection. Aggregate data concerning knowledge, attitudes and practices also suggest much progress has been made during the course of ASEP. From field observations of COPE activities, it was apparent that participating NGOs effectively communicate key risk reduction and behavior change messages that further reinforce these results. It is fair, therefore, to conclude that exposure to ASEP's education efforts does make a meaningful difference in knowledge, attitudes and practices among key high-risk groups.

- **Recommendation**

⇒ While ASEP should remain focused on policy and environmental/structural constraints, COPE should be continued during ASEP and expanded in future STD/HIV/AIDS prevention activities.

### 3.4 Using Behavioral Surveillance Findings in IEC

- **Findings**

Behavioral surveillance surveys, in principle, should be used to develop and refine IEC activities. With the future reliance on LGUs to support all surveillance activities, it becomes of paramount importance that this support includes behavioral surveillance. It is clear from discussions with LGU officials that the nature and need for HSS was far better understood and appreciated than the BSS or BMS. Serologic surveillance data are more readily understood by medically trained people. They have far less familiarity with behavioral data and their application in outreach programs to the same high-risk groups. This raises serious concerns about future funding for the BSS and possible BMS within NGO programs if these costs are borne totally by LGUs. (This issue is discussed further in Section 4 – Sustainability).

Prior to 2000, LGUs were merely provided with BMS findings without any active involvement in the process. ASEP recently improved its methods for systematically using its BMS findings to re-direct and fine-tune its interventions. Since 2000, the procedure is to conduct guided discussions with local NGO partners to analyze recent BMS findings and explore together the reasons behind results, especially unexpected findings. Examples of how this has translated into program action include:

- When it was found that many in target audience believed that they can recognize HIV infected sexual partners by external symptoms, IEC was fine-tuned to challenge this misconception.
- When condom use was found to be much lower among regular than occasional partners, IEC was fine-tuned to emphasize the message that condom use needs to be with all partners in order to provide adequate protection.
- **Conclusion**

ASEP's participatory procedures for analyzing and using information for program development could contribute to sustaining LGU and NGO interest in continuing and further institutionalizing behavioral change monitoring.

- **Recommendation**

⇒ ASEP's new participatory procedures for analyzing and using information for program development should be emphasized and further institutionalized during the remainder of ASEP.

### 3.5 STD Interventions

Recent studies on STD prevalence are finding very high rates of infection, especially among female and male sex workers and their clients. In response to the growing recognition of the magnitude of STD infections in the Philippines, USAID amended PATH's Cooperative Agreement in 1996 to support skills training for improved STD case management. ASEP's LGU and NGO partners provided training in STD syndromic management, adapted from WHO, to government health care providers and private pharmacists in its eight project sites.

Irregular STD drugs supply was a serious constraint to STD management. In response, PATH initiated a social marketing strategy designed to provide effective treatment of genital discharge syndromes "Triple S" kits (Solusyon sa Sekretong Sakit), sold to customers at pharmacies in several ASEP sites. The Netherlands government provided funding for the STD drugs. A comparable "SafePack" was provided to public facilities with funding from JICA. PATH facilitated an agreement with pharmaceutical company Unilab to provide STD drugs at near actual cost, resulting in a reduced retail price. The present cost of Triple S (P300) contains only a 5% price subsidy (excluding the costs for packaging, IEC materials, and promotion). With a planned slight increase in retail price, this social marketing program can approach self-sustaining financing for the kits.

Sales in pharmacies of Triple S and distribution of SafePacks in the public sector have been good, providing a measurable indicator of syndromic management impact. Some 3,773 Triple S packs were sold in the eight ASEP sites in two years. Each Triple S pack contains two "partner notification" cards. In 1999-2000, 335 notified partners (9 percent of all sales) presented their cards and were thereby able to buy Triple S at a 50 percent discount. These results indicate that social marketing of Triple S offers a cost effective response to STD treatment and makes available an effective treatment packet that is affordable to many clients.

One constraint to effective STD services in the public sector is that social hygiene clinics are not permitted to provide services to those under 18 years of age. These clinics are also designed to service only registered sex workers. ASEP has encouraged these clinics to accept FFSWs. Screening for gonorrhea and chlamydia is now being provided to FFSWs in three ASEP sites. Despite these developments, age remains a serious barrier to STD treatment in the public sector, preventing minors from getting needed services, while access to public health facilities and services has not yet become universal.

- **Conclusions**

Placing increased emphasis on STD prevention, as the project is doing, is an effective strategy. IEC efforts targeted on high risk groups for STD prevention and treatment need to give greater emphasis to: a) dispelling common myths about STDs, and b) risks associated with STDs, particularly the potential for infertility and impotence as a result of infection.

Reaching infected STD partners and getting them treated is an important achievement of the program, and one that should be encouraged in the future. STD partner treatment can do much to limit STD and HIV transmission.

Age restrictions, and to a lesser extent, excluding FFSWs from social hygiene clinic services, are policy constraints that impede a more effective response to STDs through government facilities.

- **Recommendations**

- ⇒ ASEP should continue support for STD treatment, particularly its emphasis on raising awareness about STD risks and sequelae among high risk groups.
- ⇒ ASEP, or a follow-on project, should identify ways to remove limitations to STD services from government facilities for minors and FFSWs.

### 3.6 IEC Interventions for Individual Behavior Change

ASEP IEC strategies for HIV/AIDS prevention aim to interrupt the transmission of HIV/AIDS by changing or modifying individual behaviors among high-risk groups. Interrupting transmission among these "core transmitters" is thought to be the most cost-effective intervention, and perhaps the only one justified in a low-prevalence country

such as the Philippines. ASEP emphasizes condom use and, secondarily, appropriate treatment for STDs. Complementing the latter is a STD syndromic management program, parts of which are supported by other donors as well as USAID.

In principle, ASEP follows the ABCD approach to AIDS prevention: Abstain, Be faithful, use Condoms if A or B fail, and seek Diagnosis and appropriate treatment of STDs. When asked for details about the A and B components, however, peer educators, counselors, and local program officers seem to not believe that promotion of A and B are realistic objectives, given the nature of the groups targeted. Yet if concurrent multi-partnerism drives the major part of any HIV epidemic, and if condom user levels seem unlikely to rise quickly, then other IEC objectives should be considered.

- **Conclusions**

Partner reduction ought to be promoted as a significant risk reduction factor among target populations not engaged in commercial sex, namely men in red light districts, much of the MSM population, and some sexually exploited adolescents. In theory, this has begun, but in practice, there could be far more emphasis on this. To focus attention on partner reduction, such behavior should be monitored through ASEP. A relevant indicator is the proportion of men or women who have had sex with a non-marital, non-cohabiting partner in the last 12 months.

- **Recommendations**

- ⇒ ASEP should monitor the suggested partner reduction indicator.
- ⇒ Greater emphasis on partner reduction should be given in NGO education activities with MSMs, clients of sex workers and minors engaged in sex work.

### 3.7 Constraints to Increased Condom Use

- **Findings**

Condom use measured by last-time use with a commercial partner is fairly high for a low-prevalence country. However, consistent condom use with all partners needs to increase among high-risk target groups. Factors impeding greater use include:

- Men complain that condoms reduce sensation and pleasure;
- People do not feel at personal risk of HIV infection;
- Many customers (male and female) refuse to use them.
- Condoms are inconvenient and not always at hand.
- Condoms used with regular partners suggest mistrust or lack of affection.
- Non-branded condoms distributed by ASEP and the DOH reportedly smell unpleasant.

Cost does not seem to be a constraint to use and most condoms are obtained in pharmacies. The Catholic Church has opposed attempts at condom social marketing, such as mass media promotion through mass media and placement in public outlets, such as supermarkets and vending machines.

Another factor affecting condom use is that sex workers – particularly free-lancers – are highly mobile with many entering and leaving this work. This results in a constantly changing population with new entrants not having been exposed to infection prevention messages and the importance of condom use. Perceptions of personal risk of infection are also low among high-risk groups and this too discourages greater condom use. For many in these groups, no one seems to know anyone who has been infected and AIDS is just something that educators warn about.

- **Conclusions**

Continued and expanded promotion of condom use is very important given that this is the key behavioral change in any effort to prevent a rapid increase in STD/HIV/AIDS infections within the highest risk groups. Surveillance of prevalence and high-risk behaviors must continue and guide IEC and related interventions.

- **Recommendation**

⇒ During the remainder of ASEP and in any future STD/HIV/AIDS prevention project, IEC activities designed to increase condom use among female sex workers, MSMs and IDUs should be a priority objective.

### 3.8 Expanding Support for STD/HIV/AIDS Prevention with Religious Social Service Groups

A common element of programs directed to sexually exploited children is helping them to return to school or to receive vocational training. This type of intervention is often sponsored by religious organizations working to prevent child prostitution and is becoming a more widely used approach in HIV/AIDS prevention programs.

In ASEP sites, Caritas and the Salvation Army are providing educational opportunities and vocational training to help sex workers, especially adolescents, interested in leaving sex work. There is some limited cooperation already occurring between religious groups. For example, one foreign priest working in a red light barangay in Cebu City distributes condoms as part of his group's social service work.

The Catholic Church strongly opposes promotion of contraceptives of any kind, including condoms, and its opposition constrains condom social marketing. While the Church has not directly opposed the work of local NGOs and government agencies engaged in STD/HIV/AIDS prevention, elected officials must remain sensitive to the influence of the Church in affecting the views of their constituents.

However, it is highly unlikely that the church's position constrains condom use among high risk groups. It is difficult to conceive of a sex worker engaged in this activity who refuses to use a condom because of religious proscription. Moreover, only two percent of the men in a recent survey cited religion as a reason to not use condom.

The conservative influence of religion in the Philippines must be credited for influencing many in the general public to follow relatively conservative sexual behaviors.

Keeping multi-partnerism levels low and median age of sexual debut high contributes to the low/slow pace of HIV/AIDS in the Philippines.

Because of the contentious condom issue, Catholic leaders have not yet participated in the Philippines National AIDS Council or local AIDS councils (with one exception). Yet the Catholic Church is said to be supportive of every aspect of HIV and STD prevention *except* condoms. Other denominations might be even more supportive.

- **Conclusions**

The opportunity for engaging religious organizations in ASEP activities seems possible and should be explored. A starting point is to find acceptable areas of HIV/AIDS prevention in which religious social service groups are comfortable working in and then build upon those areas of cooperation. One obvious opportunity is to encourage representation of these organizations on local AIDS councils. This involvement can help sustain prevention activities, promote public health issues and approaches among religious groups, and reduce obstacles to program success.

- **Recommendation**

⇒ ASEP and its partners, as well as the National AIDS Program, should explore possibilities for engaging religious social service groups of all denominations more broadly in their HIV/AIDS prevention programs.

### 3.9 Sexually Exploited Children Under Sixteen (SECUS)

- **Findings**

ASEP began its SECUS activities following recommendations of the 1997 evaluation and recent BMS findings showing that this group is at special risk for STD/HIV/AIDS. ASEP first conducted studies that provided information for strategy and program development to address the special problem of SECUS. A number of ASEP partner NGOs now have a SECUS component in their IEC programs. The IEC approach is similar to that directed toward other sex workers, but with the additional message of the dangers of multiple partners. Since the majority of SECUS clients are freelance sex workers, it is fair to view this program as a specialized intervention for adolescent freelance sex workers (female and male).

There has also been awareness raising about the sexual exploitation of children through TV public service announcements. This is a key concern of religious groups, local government agencies, other local organizations and of the Barangay Legal Action against Child Prostitution (BLAaCP) that ASEP has initiated.

- **Conclusions**

SECUS is an important activity that directly contributes to the goal of preventing a rapid increase of HIV/AIDS among the highest risk groups. While fairly limited in coverage at this time, it establishes a clear model that can be expanded in the future. By targeting on underage sex workers, it also creates the opportunity for engaging

other social service organizations concerned with the welfare of youth in HIV/AIDS prevention.

- **Recommendation**

⇒ PATH and its NGO partners should continue SECUS through the remainder of ASEP and this program should be included in future HIV/AIDS prevention initiatives.

### 3.10 Environmental and Structural Constraints

ASEP is addressing structural and environmental factors that affect high-risk behaviors. NGOs have begun engaging gatekeepers, such as sex establishment managers and owners, mama-sans, pimps and other procurers, in efforts to reduce high-risk behaviors involving IEC and condom distribution. The 100 percent condom use policy targets establishment managers and owners in Angeles, Cebu and General Santos. Over 350 establishment owners now support a “solidarity” policy for 100 percent condom use. In Cebu, 90 establishment owners provided partial payment for peer educators to encourage and monitor compliance with condom use in their establishments. These are measures of program success.

Another initiative targets city health officers and city officials with IEC and policy education. These efforts have helped to develop local AIDS councils, establish and work toward common risk-reduction goals, pass ordinances related to the entertainment industry, and enhance the potential for sustainability of activities in the future. Through these activities, ASEP has facilitated cooperation among various local stakeholders – city health officials, police, church groups, and barangay leaders – regarding NGO programs to reach high-risk groups.

The BLAaCP and SECUS are both working on environmental and structural constraints that pertain to ASEP’s focus on direct HIV prevention. BLAaCP is still in a developmental stage, but by the end of ASEP, barangays confronting the problems associated with the local sex industry, particularly the involvement of minors in sex work, will be better able to access funding for local responses that they wish to undertake.

- **Conclusions**

The response by PATH and its partners to addressing environmental and structural constraints has been well conceived and is effectively implemented. These activities have the potential for making important changes in the “ground rules” that can contribute to preventing an increase in HIV/AIDS.

- **Recommendation**

⇒ PATH and its NGO partners should continue all of their on-going efforts to address policy, environmental and structural constraints affecting HIV/AIDS prevention among high-risk groups.

### 3.11 Targeting Highest Risk Groups: IDUs and MSMs

ASEP stopped funding a number of NGOs in 1999 and 2000 for a number of reasons, including LGU sustainability considerations, financial mismanagement by some NGOs, program ineffectiveness, unwillingness to cooperate with local government agencies, and other unacceptable actions by NGO staff.

Though not the explicit purpose of these reductions, assistance directed to MSMs, IDUs and RFSWs were reduced. MSMs are still being reached as part of COPE programs, but they are not currently being targeted as a special group. Male sex workers have in effect been folded into activities directed to all freelance sex workers – male or female. Work with IDUs continues but on a relatively limited scale. No current programs reach MSMs in the general public with the exception of the Triple S and Safe Pack programs through which a number of MSMs continue to be reached with STD information and treatment.

The current program directs greater support to female freelance sex workers; men in red light districts (clients); young female sex workers; and policy, environmental and structural constraints (i.e., POCOMON, SECUS, BLAaCP). The new focus on young female sex workers is especially warranted in light of their having the highest partner turnover (3.78 clients per week) and the lowest level of recent condom use (44 percent) in 2000 among all categories of female sex workers.

While the current focus on these groups and activities is sound, the limited attention directed to IDUs and MSMs is troubling.<sup>4</sup> The potential for a rapid increase in HIV/AIDS infections among IDUs is probably greatest among all high-risk groups. Injecting drug use in the Philippines is principally concentrated in Cebu City and among deep sea fishermen based in General Santos City. While the problem is currently fairly small and localized, the potential for increased use of injectable drugs exists and could rapidly occur as it has in other nearby countries.<sup>5</sup> High risk behaviors are widespread among IDU who often share injecting equipment, do not clean equipment adequately have sexual contact with women and possibly men in the sex industry, and report low condom use.

A special group of IDUs deserving attention is seafarers and deep-sea fishermen. The DOH reported that 25 percent of all reported HIV cases are said to be among these groups and injecting drug use is reportedly increasing among deep sea fishermen. They also celebrate return to land and getting paid with visits to sex workers; their reported use of condom is very low. In response, ASEP has begun outreach activities for this group in General Santos City.

---

<sup>4</sup> A notable exception is the IDU program conducted by the University of Southern Philippines Foundation (USPF), an ASEP-supported NGO. Peer education involves teaching about the risk of sharing injecting equipment and how to clean equipment correctly before sharing. Safer sex and condom use is also promoted. USPF's pilot harm reduction program provides IDUs with a kit containing a clean syringe, a topical antibiotic, condoms, and educational material. The kits are re-supplied as needed. This program is conducted in a very low-profile way in order not to provoke legal action or public denunciation. USPF has explained to the police and the barangay captain that its program is only a pilot project intended to prevent HIV/AIDS within the community.

<sup>5</sup> The IDU community in Kamagayan Barangay, Cebu City is now estimated to be 2,000. The number of IDU users among deep sea fishermen in General Santos is unknown, but it is said to be growing.

Second to IDUs, MSMs also have a high likelihood for where HIV/AIDS could rise quickly, and MSMs are a far larger group than IDUs. They constitute a significant segment of Philippines society, if occasional bisexuals are added to homosexuals. Homosexual and bisexual transmission currently accounts for 27 percent of all reported HIV cases. Since men may be reluctant to report MSM behaviors, the actual contribution of MSMs might be higher. MSMs:

- are practicing anal receptive intercourse far more often than previously assumed based on information collected by the evaluation team,
- have significant sexual links with women and men in the general population, forming multiple potential bridges leading from this core group,
- do not use condoms often, and
- are the least likely among high-risk groups in believing they are at personal risk for HIV infection

As ASEP ends and responsibility for AIDS prevention is turned over to city governments and city health departments, preventive interventions directed toward commercial sex workers are more likely to be continued than activities directed to IDUs and MSMs. Local government officials expressed less enthusiasm about supporting interventions with MSMs and IDUs. As a telling example during the evaluation, one city health official informed the team that MSMs and IDUs have “already been covered,” as if interventions for these groups were no longer needed.

- **Conclusions**

High percentages of IDUs and MSMs continue to engage in very dangerous high-risk behaviors. Both groups present problems of access, but education programs for risk reduction through behavioral change directed specifically to these groups are essential in the future to keep the epidemic at its low/slow level. Given the comparatively small numbers of IDUs, small financial investments in prevention among IDUs could go a long way toward preventing a rapid increase in HIV/AIDS.

- **Recommendation**

⇒ ASEP should explore opportunities for expanding risk reduction programs for IDUs and MSMs that are possible either during the remainder of ASEP (if funds and time permit) or for a follow-on HIV/AIDS prevention project.

## 4. Sustainability and Future Directions

ASEP has been the single largest and longest running investment project in HIV/AIDS prevention in the Philippines. As discussed elsewhere, the project has made a substantial, and possibly crucial, contribution to the country's response to the epidemic. ASEP is ending in September 2002, making the sustainability of this contribution an increasingly important issue in the future response to the HIV/AIDS epidemic in the country. This section presents findings, conclusions and recommendations regarding the various dimensions of sustainability of ASEP's contribution to this response.

### 4.1 Stakeholders for Sustainability

- **Findings**

The evaluation team found that important elements of national and local government recognized the importance of sustaining the project's activities. There is a varied range of stakeholders for project sustainability that includes the top leadership of the DOH, units within the DOH responsible for disease surveillance and control, the Philippine National AIDS Council, and various parts of local governments at project sites, including the respective mayors, city council members, city health officers, and city health officials responsible for STD/HIV/AIDS control.

A key group of stakeholders for sustainability that had not been given much prominence in the past emerged during this assessment. These stakeholders include the leaders of barangays in the red light districts of the localities where the project has been implemented. As would be expected, the local NGOs involved in project implementation are also active stakeholders for sustainability.

Although these various stakeholders for sustainability are not the ones most vulnerable to HIV infection, they have recognized most clearly the potential threat of a larger HIV epidemic and genuinely accepted the need to forestall such a threat by sustained action. Even as many of these stakeholders recognize other important health problems aside from HIV/AIDS, they have given due attention to preventing the further spread of HIV/AIDS as one of the country's priority health objectives.

Among these stakeholders, however, the ones closest to the communities where the risks of HIV/AIDS are greatest seem to have the greatest stake in sustaining the project activities. Leaders of entertainment enterprises associations, social hygiene clinic personnel, barangay leaders, city health officials, and city government officials have the greatest interest and stake in the continued effectiveness of HIV prevention. While local groups have the greatest stake in sustainability, they have limited ability on their own to coordinate with other localities similarly interested in sustaining the project activities. Thus, the national level leadership and participation of the DOH and PNAC is also essential to galvanize local governments to act in a concerted manner.

- **Conclusions**

These stakeholders need to have much greater ownership of interventions designed to prevent the spread of HIV/AIDS beyond the life of ASEP. They need to recognize that while ASEP has initially assisted in their being able to confront the problem, the real challenge is the community's since risky behavior in the local community is the main driving force behind the spread of HIV/AIDS, and that local people engaged in these risky behaviors will be the main beneficiaries in preventing the further spread of infections.

In the remaining life of the project, ASEP's implementing organizations – i.e., DOH-WHO for the surveillance component and PATH for the education component – need to engage local stakeholders in planning for sustainability. Particular attention should be given to officials from barangays in red light districts, city government officials, newly elected or re-elected after the May 14, 2001 elections, city health officials, and the local NGOs involved in project activities.

- **Recommendation**

⇒ The DOH and ASEP should engage local stakeholders in sustainability planning.

#### 4.2 Defining the Issue of Sustainability

The evaluation team found that at the national and local levels, the issue of sustainability is well recognized and important decisions for substantive action have been taken in this regard. All three local governments visited by the team are absorbing the costs of conducting the HSS. At the national level, the DOH has made provisions to sustain some of the project activities under the National Epidemiology Center and the National Infectious Disease Control and Prevention Center.

However, current thinking is primarily focused on simply continuing activities initiated by ASEP without any substantial changes. Planning for sustainability is proceeding along the same lines as ASEP's current organization – surveillance and education. LGUs have already decided to sustain surveillance through the city health office and are currently considering possible mechanisms for sustaining NGO preventive education programs. The DOH is preparing to sustain the surveillance activities with which it has worked most directly, but it has not yet assumed responsibility for sustaining the education activities supported by ASEP.

In on-going considerations about sustainability, there is growing recognition of the critical capacities important to preventing spread of HIV. This includes sustaining the capacity of the DOH to manage and direct a nationwide network of surveillance sites, the capacity of NGOs to reach important high risk groups in the community, the capacity of city health offices to conduct serological surveillance activities in their localities, and the capacity of local networks of interested parties to jointly analyze serological and behavioral data and then to use such analysis to guide concerted preventive education.

There is need to go beyond merely sustaining activities as designed and implemented by ASEP and the capacities created by ASEP. **The most important**

**dimension of sustainability is the sustainability of the conditions of and benefits from continued low prevalence of HIV. What should be the most important sustainability issue is the sustainability of low HIV prevalence after ASEP.**

The nature, scope and level of effort undertaken by ASEP were determined by the concurrent level of knowledge about the epidemic over the past eight years. It can be assumed that, since HIV prevalence has remained low while ASEP has carried out its activities, it is highly possible that HIV prevalence will remain low in the future while activities similar to those undertaken by ASEP are continued.

But this assumption should be examined carefully. Will the Philippines face significantly increased risks of a higher HIV prevalence if activities undertaken by ASEP stop completely after project ends in 2002? Will simple continuation of ASEP activities after 2002 be sufficient to forestall a much higher HIV prevalence? Will preventing a much higher HIV prevalence require new activities in addition to sustaining the activities undertaken by ASEP?

- **Conclusions**

In addition to planning the continuation of activities and capacities supported by ASEP, planning for sustainability should include determination of the appropriate level of effort needed to keep HIV prevalence low in the period following ASEP. Such planning for sustainability should indicate to what extent continued low HIV prevalence and its benefits depend on: (a) essential continuation (or tolerable reduction) of activities and capacities supported by ASEP, or (b) additional or new activities and different capacities that need to be supported.

- **Recommendation**

⇒ During the remaining time of ASEP, USAID should undertake the above planning exercise in preparation for the possibility of future funding for STD/HIV/AIDS prevention in the Philippines.

#### 4.3 Nature and Level of Effort Appropriate for Keeping HIV/AIDS “Low and Slow” after ASEP

- **Findings**

The evaluation team recognized the critical contributions of ASEP to preventing the rapid increase of HIV/AIDS through the following activities:

*a. Increasing knowledge for understanding the course of the epidemic:* ASEP contributed to generating data and information on:

- the prevalence of HIV/AIDS, the extent of highest risk behaviors that are most likely to transmit HIV/AIDS,
- the size and current networks of groups practicing risky behavior, and,
- the knowledge, attitudes and practices of high risk group members.

*b. Demonstrating reliable ways of reaching high risk groups:* ASEP demonstrated that some local NGOs have the ability to access project funds, use these funds to expand their access to high risk group members, and provide information and education relevant to the behavior of high risk individuals. One important facilitating factor is that local authorities have adopted a health service approach to commercial sex, instead of a law enforcement approach, to what remains a prohibited illegal activity.

*c. Influencing the reduction of highest risk behavior:* ASEP has shown that peer education and community health outreach work in red light district communities, and regular liaison with commercial sex establishments can increase condom use, improve promptness and effectiveness of STD diagnosis and treatment, and introduce harm reduction measures among injecting drug users.

ASEP has not had uniform success in these three aspects equally among all high-risk groups with whom it works. ASEP has been most successful in the first two categories of actions (understanding the epidemic and reaching high risk groups), but after initial gains, stalled in the further reduction of high-risk behavior, such as condom use and STD treatment. ASEP had been most successful in all three categories of action among commercial sex workers and clients, but has been less successful among men who have sex with men, and least successful among injecting drug users. It might be that the local communities where ASEP has been implemented are much more willing to confront the health issues associated with commercial sex, but much less for MSMs and IDUs.

- **Conclusions**

It is very likely that an appropriate response to HIV/AIDS beyond ASEP will entail the same three categories of actions that were undertaken under ASEP. It might be possible that after ASEP's completion in September 2002, the local governments of former ASEP sites might be willing and able to sustain on their own all three categories of action in relation to risk groups associated with commercial sex. It is, however, very unlikely that local governments at non-ASEP project sites would be able to undertake the same actions even with respect to high-risk populations involved with commercial sex. It is also unlikely that without external assistance, even those local governments in ASEP project sites would be able to extend the benefits of these three categories of action to other high-risk groups, specifically MSMs and IDUs.

In the area of HIV/AIDS prevention among persons involved with commercial sex where LGU interest is highest, greater LGU support and involvement in the three categories of preventive action might be generated through the following types of pilot programs during the remainder of ASEP:

*a. An LGU-financed contract for NGOs implementing ASEP activities to provide preventive education to people involved in commercial sex.* A pilot might be undertaken immediately after the newly elected or re-elected local officials assume office in July 2001. The pilot might involve LGUs taking over some portion of activities within the current contracts between PATH and the local NGOs. Engaging in such a pilot would clarify issues and problems with LGUs supporting NGO-implemented COPE activities.

**b. Planning a citywide framework for condom use promotion.** Promotion of condom use is an appropriate action for reducing risky behavior. Alternative social marketing strategies designed to encourage condom use among different segments of the population could be tried on a city-wide basis, including promotion of greater condom use by clients of government facilities, e.g., social hygiene clinics.

**c. Documenting the Triple-S project experiences.** Under the context of a city-wide condom use promotion effort, a supplementary effort to provide prompt and effective STD treatment should be another priority ASEP activity to be sustained. The experiences with the Triple S program in the ASEP project sites should be documented for use by local governments and the DOH in designing follow-on efforts.

**d. Designing a health service package for barangays in red light districts.** Cebu's Barangay Kamagayan and Angeles' Barangays Balibago and Sta. Teresita offer opportunities for designing a modified barangay health station that can provide standard health services, but with the important addition of STD diagnosis and treatment, HIV/AIDS prevention counseling, and even harm reduction for IDUs where this is a major problem. Operation of such red light health stations could be contracted out to NGOs with appropriately trained, experienced staff (especially for STD and HIV/AIDS services) as an alternative regular government staffing. ASEP could help to prepare draft TORs and SOWs that could be used by the DOH and LGUs in contracting out red light health stations.

- **Recommendation**

⇒ Prior to project completion, ASEP should give priority to getting the local governments it has assisted to assume a greater share of the responsibility for the three categories of action to prevent HIV/AIDS among those involved with commercial sex, exploring the possibilities suggested above.

#### 4.4 Sustaining Low HIV Prevalence After Project Completion – Future Directions

- **Findings**

Assuming that ASEP-assisted LGUs carry out their expressed intentions to sustain activities after the project ends, the major sources of risks for higher HIV prevalence in the future might be those groups involved in commercial sex in non-ASEP localities, and among MSMs and IDUs in localities with sizable numbers of these high risk groups.

By the end of the project, it is likely that the following conditions will prevail:

- HIV prevalence is low, even as high-risk behavior continues among certain groups.
- NGO capacity to reach groups with high-risk behavior is well established in ASEP project sites.
- Capacity and commitment of the LGUs to continue the HSS will be in place.
- Capacity of the DOH to coordinate HSS activities among at least 10 sites will be established.

- Documentation for easy adoption of the following prototype local responses shall have been prepared and disseminated:
  - ✓ HSS and BSS surveillance
  - ✓ Condom promotion through COPE
  - ✓ STD case management through Triple-S
  - ✓ Coordination of local responses through local AIDS councils and local ordinances.

For the country to secure the benefits of continued low HIV prevalence in the future, it will be essential that the following conditions be created:

- Wider coverage of education programs targeted on the highest risk groups – i.e., sex workers, male clients, MSMs, and IDUs.
- Further increases in condom use rates
- Wider coverage of prompt and effective treatment of STDs
- Availability of current surveillance data on HIV prevalence
- Availability of current data on the prevalence of behaviors related to HIV/AIDS transmission and the size and composition of groups defined as high risk.
- Effective national and local government support for STD/HIV/AIDS prevention programs.

Perhaps the greatest challenge for the future to maintain the low/slow pace of the epidemic is to expand prevention activities beyond the eight ASEP sites to locations that also have large high risk groups. A problem cited by city officials is the difficulty of implementing prevention programs in their city when neighboring localities do not support such efforts. For example, efforts to encourage 100 percent condom use are undercut by the fact that sex workers and their clients can simply go to a nearby city or municipality that has no HIV/AIDS programs (nor even the awareness of the need for such). The same is true when one major red light area – e.g., Kamagayan in Cebu City – is the focus of interventions while an equally high risk area – e.g., Ermita – goes unattended. The problem is that meaningful geographic coverage is necessary to implement prevention measures effectively.

## • Conclusions

Future assistance designed to keep the HIV/AIDS epidemic in the Philippines at its present low/slow pace will need to take new forms and directions. Effective prevention in the future will require different responses from merely continuing existing activities in current ASEP sites.

ASEP has developed and tested components for a comprehensive package of interventions to prevent an increase in the rate of infections among high-risk groups. The challenge is to sustain these activities in present ASEP-assisted LGUs in the future and to extend these interventions to additional localities that contain large high-risk groups either near ASEP cities, or to entirely new locations. Compared to the development nature of ASEP, lower cost, more rapid approaches to introducing and sustaining prevention activities in new locations will be needed. From a long-term perspective on the response to the epidemic, ASEP has been a very successful “testing and

development" phase. What is now tested and known to be effective needs to be marketed to additional localities where the threat of HIV/AIDS is significant.

The following are possible elements of a "second generation" response to the HIV/AIDS epidemic in the Philippines.

□ **Incentive Grants Program for LGU STD/HIV/AIDS Prevention.**

A performance-based grant program to LGUs could be developed for both current ASEP cities and for new localities with large populations of high-risk groups. Participating LGUs would be required to demonstrate commitment to reducing the risk of HIV/AIDS infection by contributing some portion of the funding for prevention activities. Annual performance targets for selected key indicators, including support to local NGOs conducting HIV/AIDS prevention activities with high-risk groups, would be set. Success in meeting the indicators and targets would lead to continued funding in the following year with a revised set of targets.

Performance could focus on indicators related to condom use (self-reported condom use, condom sales and take-up, and STD infection rates) detailed in the framework for citywide condom use promotion and adaptation of the Triple-S project described above. Such a grant program could also include provisions for LGU contracting of NGOs to undertake preventive education of high-risk groups including operating red light barangay health stations, also described above.

For the current ASEP cities, the program would be the means by which USAID funding for prevention activities would be gradually reduced and ended while LGU funding would correspondingly increase. ASEP cities appear likely to assume costs of seroprevalence surveillance; therefore, the focus of this program would be on gradually increasing LGU funding for behavioral surveillance and/or NGO education programs. Some cities might choose to use the monitoring surveys of their funded NGOs to generate the behavioral data currently collected through the DOH's BSS. In general, each year of participation in the program would result in an increasing share of costs borne by the LGU until USAID funding is completely phased out.

For new localities, many of the technical interventions can be drawn from ASEP experience. These, plus new activities that are more responsive to local needs, would be presented to interested cities and municipalities as a package of interventions to choose from. In effect, the program for new localities would be an accelerated version of ASEP. In the first year of the program, USAID could cover all start-up costs of selected activities as an inducement to get started and begin building local support and NGO capacities. Satisfactory achievement of first year performance targets would be the basis for continued assistance. As with the ASEP cities, indicators and targets would serve as the criteria for continued funding to the new localities. The gradual phase-out would commence in the second year so that the participating LGU would bear all costs before the end to the project.

In response to the problem of undercutting prevention measures because of neighboring localities not supporting the same measures, the focus for new localities might initially be those secondary cities and municipalities surrounding the current ASEP cities. This "hub" approach could be used to encourage surrounding LGUs to join with

the central city in implementing STD/HIV/AIDS prevention activities to create effective "prevention zones".

□ **Applied research for STD/HIV/AIDS prevention program development to reach previously unserved/under-served high-risk groups.**

A small grants sub-project could be established to carry behavioral research into the high risk behaviors of previously unserved and under-served high-risk groups. The results of the research would be aid in the development of programs targeted on these groups and using approaches that are most appropriate to reach group members with risk reduction messages. Deep sea fishermen in General Santos is one example of the types of groups that would be a target of this activity. The principal users of this funding would be local NGOs, but it is possible that university groups working with a NGO or local government agencies might also use such funding for program development.

□ **Targeted Assistance for MSMs and IDUs.**

As has been emphasized throughout the evaluation, it is essential to reach the highest risk groups where the potential for accelerated HIV/AIDS prevention is greatest in the coming years. Complacency is unwarranted and difficulties in gaining access to these groups must be overcome. Future assistance should re-double efforts to develop effective program that reach these groups.

ASEP has had limited success in working with MSMs and IDUs despite efforts to do so for various reasons. As observed above, these groups have not been a top priority for LGUs. A major problem has been too few NGOs to work with to develop effective programs for MSMs and IDUs and/or an unwillingness of existing organizations to coordinate with local government agencies.

If partner organizations cannot be identified or they remain unwilling to deal with local government, it might become necessary to try to develop alternative organizations and channels to reach MSMs and IDUs. For example, self-help groups might be organized and supported for this purpose. NGOs willing to try to develop new programs for these two groups might also be possible. In short, targeted funding could help to fully exploit opportunities for preventing a breakout of HIV infection among these groups.

□ **Funding for applied research for promotion of additional behavioral change associated with HIV infection**

While the core of educational efforts have been increasing awareness of risk and key measures to prevent infection, survey data show that several associated behavioral changes are not well understood nor followed. Applied research to test and develop special interventions to promote these related behavioral changes could be funded by a future project. This includes:

- promotion of condom use for casual sex (not just commercial sex),
- postponement of sexual debut,
- reduction of pre-marital and extra-marital sex, and
- reduction in number of concurrent sexual partners.

For some of these behaviors, the follow-on HIV/AIDS program might be able to work with partners that have not been previously involved, such as the Catholic Church, other religious organizations, "influentials" for adolescents (e.g., singers, movie actors, athletes), and educators.

- **Recommendation**

⇒ If and when funding for a "second generation" HIV/AIDS program in the Philippines becomes likely, USAID should explore the feasibility of the above possibilities for a new project.

#### 4.5 Institutionalization of HIV Surveillance

- **Findings**

All LGUs assisted by ASEP have undertaken HIV surveillance through repeated rounds, and by 2001, most will have assumed the local costs of these surveys. They state that they now recognize the importance of this information and are committed to continuing its collection for the foreseeable future. The DOH, however, has not yet made explicit provisions to absorb the central costs of the HSS, but has expressed its willingness to do so before the end of the project. The prospects of sustaining the HSS, therefore, appear good.

Apart from continuing regular annual HSS rounds, there are a number of issues, which WHO-WPRO and the DOH need to address with respect to sustainability. The first issue is the need to formalize the mutual commitments of participating LGUs and the DOH in a nationally coordinated network of HIV surveillance sites. While all the parties seem to have agreed to continue doing HIV surveillance, no legal or administrative instrument currently exists that formalizes this agreement.

The second issue has to do with the "clients" or "stakeholders" of HIV surveillance data. Social hygiene staff of LGUs will continue to undertake the surveillance activities and the National Epidemiology Center of DOH will coordinate the nationwide surveillance. However, it is important that those who need to act on the basis of the data be clearly defined and given the opportunity to participate in decisions about the direction and conduct of the surveys to assure its continued relevance and maximum usefulness to end-users.

The third issue concerns the behavioral research aspects of surveillance. It has become clear that reliable estimation of condom use and more informative data on how to promote condom use are going to become increasingly important to efforts to reduce risk from commercial and casual sex. This gives greater importance to guiding behavioral surveillance in ways that are most useful and constructive for local program development.

- **Conclusion**

The remaining 15 months of ASEP is sufficient time to get in place necessary agreements and arrangements that will help to assure continuation of behavioral surveys and to make such surveys of maximum utility to program managers in government or in NGOs.

- **Recommendations**

- ⇒ Negotiate and sign a national agreement by the DOH and participating LGUs that commits all parties to the conduct of regular annual HIV surveillance rounds under the technical direction of the DOH and with the support and participation of the LGUs.
- ⇒ In this agreement, the end users of surveillance data at national and local levels need to be identified and given appropriate roles in order to ensure the usefulness and relevance of the surveillance effort.
- ⇒ A detailed technical plan for revising and enhancing the behavioral aspects of surveillance activities should be prepared. The plan should provide for reliable summative data on condom use rates, as well as formative data useful for improving efforts to increase condom use.

## 5. Synergy, DOH Capacity for Program Sustainability, Management Issues, and Donor Assistance

### 5.1 Synergy

As the USAID portfolio downsides and re-structures, it is important to explore all possibilities to reduce management requirements accordingly. USAID directed the evaluation team to explore possibilities for integrating ASEP activities into other on-going activities in its health and population portfolio. This section discusses possibilities for this, but also emphasizes the necessity of continuing activities targeted on high-risk groups to prevent a rapid acceleration of STD/HIV/AIDS.

- **Findings**

- **Integration**

Two clear opportunities for integrating elements of ASEP into the IR2 – Infectious Disease activities exist:

- **Skills Upgrading and Quality Improvement of Laboratory Testing**

Under USAID Infectious Disease activities, skills upgrading of laboratory staff and quality improvement of testing procedures at local levels are supported. This directly benefits the HSS system, assuring better quality testing of blood samples and fewer inaccurate results. In the future, USAID will not need to provide assistance in these areas through a future HIV/AIDS project as it is possible that JICA might continue its support to reference laboratories in some form.

- **Infectious Disease Surveillance**

A clear opportunity for integrating of surveillance functions under ASEP with those supported by the Infectious Disease Surveillance and Control Project assisting the NEC have been discussed in Section 2 – Surveillance. Integration is strongly recommended.

- **Extension of HIV/AIDS Activities to Other Projects**

The evaluation team identify three potential areas where STD/HIV/AIDS prevention and related services could be added to on-going USAID-funded projects:

- **STD counseling, testing and treatment; HIV/AIDS education; and marketing of services to sex workers by FriendlyCare clinics**

One possibility for expanding access to STD diagnosis, treatment and testing, and to HIV/AIDS prevention education is to develop these services in the FriendlyCare Clinics as they become more established. The FriendlyCare Clinics principally target the broad low to middle income market segment in major cities. Compared to government facilities, however, quality in Friendly Care Clinics is much higher. It is possible that at

least some high-risk group individuals will use these clinics. The manager of the Cebu FriendlyCare Clinic told the evaluation team that when operations stabilize, he plans to try to market the clinic's services to sex workers in the surrounding communities.

- **STD counseling, testing and treatment, HIV/AIDS education, and later marketing of services to sex workers by Well Family Midwife Clinics**

Similar to the FriendlyCare Clinics, the Well Family Midwife Clinics offer a second opportunity for expanding access to STD services and HIV/AIDS education. These services could become part of the 250 midwife clinics over time, expanding access to information and services nationwide. However, just as with the FriendlyCare Clinics, it is unlikely that the many high-risk group individuals will use these clinics given their focus on the traditional clients of midwives – women and their children principally for pregnancy related services and early child care.

- **Incorporation of STD/HIV/AIDS prevention activities into the MGP indicators for municipalities.**

A third possibility for expanding support for STD/HIV/AIDS prevention is to incorporate indicators and targets into the performance agreements MGP enters into with its partner LGUs. For example, a participating LGU could commit to promoting 100 percent condom use in its local sex establishments. Means for measuring such performance indicators and associated targets would have to be established. It is likely, however, that the LGU would require external assistance, perhaps through a future HIV/AIDS program, to plan and implement such actions. This suggests the possibility for a future linkage between MGP and a "second generation" HIV/AIDS project if they worked in the same localities.

- **Conclusions**

There are several opportunities for integrating ASEP activities into other USAID funded activities and to extend STD/HIV/AIDS information and services through new channels being developed by USAID programs. To some extent, it is likely that these new channels – FriendlyCare Clinics, Well Family Midwife Clinics and the MGP – could reach some individuals in high-risk groups. However, the majority are unlikely to make extensive use of FriendlyCare and Well Family clinics that are targeted on higher income and/or mainstream population segments. While integration and expansion could contribute to HIV/AIDS prevention, expanding services and information through these channels alone will not be sufficient to prevent an acceleration of HIV/AIDS among the highest risk groups.

ASEP has shown that one-on-one communication by accepted peer educators is the most effective way to reach high-risk groups. Broad mass media efforts are not particularly effective in this regard when behavioral change is the ultimate goal. If USAID is to continue its important assistance in keeping the epidemic at its low/slow pace, programs targeted on the highest risk groups will still be needed – specifically for sex workers, MSMs, and IDUs. Without such a focus, support for the main objective of preventing a rapid increase in infections will effectively cease.

- **Recommendations**

(See Section 2 – Surveillance for recommendations concerning integration of surveillance functions)

- ⇒ USAID should begin exploring the full feasibility of and schedule for extending STD/HIV/AIDS prevention information and services to its other on-going health and population projects as suggested above.
- ⇒ Even with integration and expansion, in any future assistance for STD/HIV/AIDS prevention, USAID should continue to support special education/prevention programs focused on the highest risk groups – sex workers, MSMs and IDUs.

## 5.2 DOH Reorganization and Effects on Sustainability

- **Findings**

The DOH's response to the HIV/AIDS epidemic must be viewed in the broader context of its on-going reorganization under Executive Order 10 that radically reduces the number of organizational units and staffing at the national level.

Recent legislation created a new agency attached to the DOH – the Philippine National AIDS Council (PNAC) – that is mandated to guide the country's response to the HIV/AIDS epidemic. PNAC is responsible for mobilizing a multi-sectoral response to the epidemic, including participation by LGUs. Two DOH units have responsibility for important elements of a national HIV/AIDS response: the NEC is tasked to absorb STD/HIV/AIDS surveillance developed under ASEP and the National Center for Disease Prevention and Control (NCDPC). These two units share responsibility for sustaining and expanding activities for STD/HIV/AIDS prevention initiated by ASEP. However, both lack sufficient numbers of regular (permanent) staff to do so.

New leadership assumed direction of the DOH in February 2001 with a change of administrations. A genuine asset that will assist in sustaining HIV/AIDS prevention activities is the current Secretary of Health. The Secretary was the Chief of the FETP when early responses to the HIV/AIDS epidemic started in the mid-1980s, and then later with the start of ASEP activities. He has a full understanding and appreciation of the nature of the problem and what must be done to mount an effective response.

- **Conclusions**

Severe staffing limitations for PNAC, NEC and NCDPC limit the DOH's ability to support ASEP activities after the end of ASEP. These limitations could be mitigated by using budget resources for contractual staff. With such resources, the DOH is likely to be able to sustain HIV/AIDS prevention programs given the Secretary's appreciation of the continuing risks of higher HIV/AIDS prevalence. However, even with contractual staff for HIV/AIDS programs, strong and effective LGU support becomes only more critical.

As part of this assessment, the DOH must determine which activities it can sustain, modify, or cease given its available staff resources and budget in this area. The

three DOH agencies responsible for the national response – PNAC, NEC and NCDPC – should develop a joint sustainability plan designed to maintain the low/slow status of the epidemic.

- **Recommendation**

⇒ The DOH must determine the appropriate level of response it must make to help in the effort to keep the rate of HIV/AIDS at its current low/slow level.

### 5.3 Management Issues

- **Findings**

During the course of the evaluation, no major management issues involving USAID, the DOH, and ASEP partners in recent years were identified that greatly reduced the overall performance and results of the project. The main mechanisms used to implement ASEP – the grant to WHO to support surveillance activities, the Cooperative Agreement to PATH for the education and policy component – worked relatively smoothly.

PATH's management of its activities under the Cooperative Agreement has been particularly laudable. Considerable effort was made to strengthen the administrative, financial and program capacities of partner NGOs. Visits to partner NGOs are frequent and follow-up consistent. Good relations were maintained even in the face of difficulties and setbacks. PATH helped its NGOs institute the BMS and make very good use of results for program planning. In fact, attention to monitoring and evaluation has been exemplary by PATH and its NGO partners.

Perhaps the clearest demonstration of resolve on PATH's part to maintain standards and follow sound management practices was in ceasing support to NGOs that violated financial management requirements, were unwilling to cooperate with local government agencies, had programs that were performing poorly, or whose staff engaged in unacceptable actions. Considerable investment in time and staff resources was made in these NGOs and stopping work with them was not an easy task, but one that was necessary.

- **Conclusions**

Overall management of ASEP has been very sound and reflects cooperation and commitment to the goals of the project by all participating organizations. No additional recommendations are warranted concerning management arrangements.

### 5.4 Donor Assistance

- **Findings**

The following organizations were visited to learn about their current and future plans to support HIV/AIDS prevention activities:

- JICA and the Embassy of Japan – Anticipates ending current funding for HIV/AIDS activities with a new focus on tuberculosis, further assistance is unclear at this time.
- UNICEF – Plans to include HIV/AIDS messages in its program to encourage healthy behaviors among youth in five locations in the Philippines.
- UNFPA – Plans limited future involvement in HIV/AIDS prevention other than including prevention messages in their programs.
- European Union – Due to program funding reductions to the Philippines, all HIV/AIDS activities have ceased and no new activities are anticipated.
- UNAIDS – Manages \$100,000 in funding for eight selected NGOs, or approximately \$12,500 per NGO; selection is being finalized.

These meetings also reflected the need for better communication among agencies supporting HIV/AIDS prevention. Regular meetings involving UN agencies, the DOH, bilateral donors, social service organizations and NGOs could be helpful. An electronic bulletin board or website on HIV/AIDS in the Philippines might be helpful.

- **Conclusions**

It is clear from these meeting and discussions that USAID has been and will remain the leading donor agency in the Philippines for HIV/AIDS prevention. This makes a follow-on project after ASEP all the more important. USAID is the only donor that supports interventions targeted on the highest risk groups which is essential to prevent a rapid acceleration of HIV/AIDS infections in the future.

However, USAID/Philippines does not control allocation decisions for HIV/AIDS funding earmarked by Congress. These decisions are made by AID/Washington and are based on various factors. Those earmarked funds also carry special requirements that may make the Philippines a less suitable country for such funds. In short, the DOH **should not** assume that the Philippines Mission will automatically receive, nor that it controls, future funding to the Philippines for HIV/AIDS prevention.

- **Recommendations**

- ⇒ If funding becomes available to USAID/Philippines for HIV/AIDS prevention after ASEP, a “second generation” program as described earlier should be undertaken.
- ⇒ USAID should continue discussions with other donors regarding support for HIV/AIDS prevention and encourage better communication among all concerned agencies.

## ANNEX 1: Scope of Work Indicator Issues (Section IV.A – Impact Assessment)

### 1. Are the indicators appropriate for measuring the results ASEP wants to achieve?

#### • Findings

The SpO Framework offers a sufficient range of measures to capture the key elements of activities supported by ASEP. The Sub-Component (SC) indicators are measures widely used as international standards and they do provide a rough approximation of overall results as discussed above. They are sufficient for general reporting purposes (e.g., for the R4). However, the actual situation is more varied and complicated than the aggregate indicator results can show. Viewing results in the aggregate across all eight cities distorts what is actually occurring with changes in knowledge, attitudes and practices in each ASEP site. USAID managers need to have ready access to more precise information of this sort. Concern about the feasibility of some of the targets for the SC indicators was noted in Section 1.

While the Mission met with its partners about revisions to indicators and targets for the extension period, some measures and targets could use further updating. At the Activity level, all targets have been achieved as of 2000. It could be helpful for program monitoring and reporting to revise these targets upward. Also, the Activity level measures do not cover PATH's important work on STD prevention.

Increased condom use is the most important behavioral prevention measure and refinement to the current indicators is recommended in Section 2 – Surveillance. After condom use, partner reduction is perhaps the second most important behavioral change for risk reduction. While partner reduction has not been a highly effective message directed to commercial sex workers in prevention programs, this is a useful measure for monitoring behavioral patterns among high risk groups.

#### • Conclusions

Given that ASEP ends in September 2002, revisions to existing indicators and targets should be kept to a minimum and made only where revisions would serve useful monitoring and reporting purposes. An indicator on partner exchange rates would contribute to monitoring an important dimension of behavioral change for risk reduction.

#### • Recommendations

- ⇒ The KAP indicators and targets should remain as currently stated, but a composite table showing results disaggregated by city should be produced by the USAID project manager for internal mission use.
- ⇒ Add an indicator on partner exchange rates and use PATH's estimates to set realistic targets for the end of ASEP in 2002, recognizing its likely limited applicability to commercial sex workers.
- ⇒ Activity level targets should be revised by USAID, NEC/AIDS Unit and PATH, and add one readily available indicator for the STD program.

2. Are the 2002 targets for the number of active NGO front-line workers realistic in terms of the level of coverage needed to control and prevent STD/HIV in the ASEP sites?

- **Findings**

The current target for trained **and** active for Peer Educators (PE) and Community Health Outreach Workers (CHOW) in the SpO Framework is 1,000 by 2002.

NGOs report mixed experiences in being able to retain trained PEs, while none mentioned that the turnover of CHOWs was as problematic. This varied widely among the NGOs; for example, FreeLava reported that it has retained most of its PEs. Others reported high turnover of PEs resulting from the PEs taking a full time job.

PATH reported that a total 2,169 CHOWs and PEs have been trained as of 2000, but that only 404 were currently active, reflecting the turnover of PEs. With the approach of the previous September 30, 2000 termination date of ASEP, PATH understandably began to scale back its activities from the levels reached in 1998 and 1999 in preparation for project closure. They reversed those efforts when USAID committed to extending the project until 2002 with additional funding. ASEP then scaled back up, but overall outputs (e.g., number of first client contacts, repeat contacts, IEC materials disseminated, etc.) for 2000 were below those of 1999 and 1998.

With ASEP's extension, greater emphasis is now directed to policy and related sustainability activities. Ceasing assistance to selected NGOs in 1999/2000 further reduced educational activities, contributing to a reduction in the number of active PEs and CHOWs.

With respect to the issue of adequate coverage, the need for expanded educational efforts directed to MSMs and IDUs is discussed later in the report. An important problem city officials report pertaining to coverage is that no prevention efforts are being made in surrounding municipalities of ASEP cities where there are high risk districts. This undercuts the efforts of ASEP cities to implement preventive measures effectively, such as 100% condom use. Sex workers (and their clients) relocate to the surrounding areas to work where there are no such policies, but continue to reside in the ASEP city, and in time, resume work there. Reaching additional surrounding areas is clearly beyond ASEP's available resources. Furthermore, with only 15 months remaining in ASEP and no assurance of a follow-on activity to continue these efforts, expansion at this time is impractical.

- **Conclusions**

Whether a target of 1,000 trained and active PEs and CHOWs is sufficient to assure prevention against an acceleration of the epidemic requires first delineating what coverage is needed to accomplish this objective. The size and distribution of populations at high risk should determine how many NGOs and workers are sufficient. First, all high

risk areas in ASEP sites that warrant education and prevention programs must be identified. Then, the size of the high risk populations in these areas would have to be estimated. That would begin to answer the question of how many NGO workers would be needed, but to do so with any accuracy would require a special study just for this purpose.

A rough estimate from site visits is that at least a doubling of areas in ASEP sites would be needed for complete coverage. Therefore, 1,000 PEs and CHOWs might be a reasonable approximation for this, given 404 at present. But expansion of education programs needing more PEs and CHOWs at this point in ASEP is impractical.

Regarding the current indicator and target, the number of NGOs currently participating in ASEP and their respective capacities to implement programs determines how many frontline workers should be trained **and** active. Decisions have been made by USAID and PATH that scaled back the number of participating NGOs and re-focused ASEP on sustainability issues. This, plus the high turnover of frontline NGO workers, account for the 404 trained **and** active PEs and CHOWs. By counting only trained **and** active workers misses an important accomplishment in this area, which is the total number of workers that have participated in ASEP activities throughout the life of the project.

- **Recommendations**

⇒ Keep the current measure, delete the condition of "active", and increase the target to reflect more accurately the total training efforts of PATH and its NGO partners.

## ANNEX 2: The Reproductive Number ( $R_0$ ) of HIV Infections

The past, present, and future prevalence of HIV infection can be understood more clearly by utilizing the concept of the reproductive number of an infectious disease agent—designated  $R_0$ . This relatively simple epidemiological concept describes, in a single value, the epidemic potential of an infectious agent. When on average one infected person infects more than one other person,  $R_0$  is greater than 1 and the result will be sustained or epidemic spread of the agent. However, when, on average, one infected person does not infect more than one other person,  $R_0$  is either 1 or  $<1$  and epidemic spread does not occur. When  $R_0$  is 1 or  $<1$ , the infectious agent will either disappear or maintain itself in the population with zero or limited growth and become endemic.

Examples of the spread of an infectious agent where  $R_0$  is much greater than 1 are influenza and measles epidemics in a largely susceptible population. In such situations, one infected person at the start of an epidemic can easily infect scores of persons who in turn infect scores more so that  $R_0$  is very high. Infected persons who recover are then immune to re-infection with the same infectious agent. As the epidemic continues, the number of persons who were infected and became immune increases while the number of susceptible persons decrease. Thus,  $R_0$  in these examples decreases over time and eventually becomes less than 1 and the infectious agent either becomes endemic or dies out depending on how rapidly new susceptible persons become available. The epidemiological dynamics of HIV infection are different because not everyone is at equal risk for HIV infection, and extensive transmission of HIV requires specific patterns and networks of persons engaged in HIV risk behaviour(s).

With regard to HIV transmission,  $R_0$  among participants who engaged in sex partner exchange activities in gay bathhouses and among injecting drug users in “shooting galleries” during the early 1980s was probably on the order of 5-6.  $R_0$  for HIV in male haemophilia patients (also for most other adults who received HIV-infected blood or blood products) and their steady sex partners have been substantially below 1.  $R_0$  for FSW and their male clients can be either  $<1$  or  $>1$ , and its value depends on sex partner exchange rates and the presence or absence of many facilitating or inhibitory factors.

The concept of  $R_0$  and HIV transmission in different HIV risk behavior groups (RBG) whose prevalence of HIV risk behaviors differs can be illustrated by reviewing HIV trends in Thailand from 1989 to 1999. The Thai HIV sentinel surveillance data show very clearly that extensive HIV transmission was essentially limited to the highest HIV RBG and to some of their regular sex partners. After explosive increases in HIV prevalence among IDU and FSW groups during the late 1980s and early 1990s, some limited transmission from infected male clients of FSW and HIV-infected male IDU to some of their regular sex partners occurred. However, since the mid-1990s, HIV prevalence levels among antenatal females in Thailand have been slowly decreasing—from over 2% in 1994-1995 to 1.5% in 1998. This decrease cannot be totally attributed to the 100% condom use programme that was implemented among FSW and their clients because no marked increase in condom use with their wives and steady girl friends has been documented among Thai males. At least part of this decrease is more likely due to the fact that  $R_0$  between HIV infected Thai males and their steady sex partners is less than 1.

### ANNEX 3: The Potential for Extensive HIV Epidemics in the Asia-Pacific Region

The gathering or impending storm analogy for AIDS in Asian Pacific countries may not be an accurate description of the probable future scenario of HIV/AIDS in this region. A better example or a more appropriate analogy may be to consider the potential for large-scale HIV epidemics in this region, as one would evaluate the potential for a large forest fire. Using such an analogy--with the dryness or wetness of the trees in a forest equated with the patterns and prevalence of heterosexual HIV-risk behaviors in a large population--the potential for extensive or epidemic HIV spread in Asian Pacific countries can be better understood.

The spread of HIV in human populations can be illustrated by reviewing all the factors needed for a forest fire. The basic ingredients for a forest fire and its counterpart(s) for epidemic or self-sustained HIV transmission include:

Forest Fire	Epidemic Transmission of HIV
1. A source - some spark, lightning, a match, a discarded cigarette, etc	1. Importation of an HIV infected person(s), or importation of HIV infected blood products.
2. Kindling, dry bushes, etc., to ignite the surrounding trees	2. Extensive HIV spread in the highest HIV-risk behavior groups – FSW and IDU
3. Location/spacing and amount of very dry kindling and bushes	3. Patterns, prevalence and the social dynamics of sexual or IDU networks
4. Forest fire potential – are most of the trees wet or dry?	4. Pattern and prevalence of HIV-risk behaviour in the population, dry = high, wet = low
5. Wind and other factors such as total neglect until the fire is out of control!	5. Facilitating factors such as proportion of recent infections, concurrent STD, “dry sex”, lack of male circumcision, etc

It appears that in most Asian-Pacific populations, it is very difficult to get a “generalized” HIV epidemic (a large forest fire) started. This is because the patterns and prevalence of heterosexual risk behaviors in the general or total heterosexual population are insufficient to sustain any extensive HIV transmission outside of the highest HIV-risk behavior groups such as FSW and IDU. Or to use the forest fire analogy, the trees are mostly wet.

In most Asian-Pacific populations, in addition to a general lower prevalence of heterosexual HIV-risk behaviors (i.e., the forest is wet), most of the factors that facilitate sexual transmission of HIV are either not present or present in relatively small amounts. In some raging forest fires, the intense heat generated by the fire will consume some “wet” trees that ordinarily would be difficult to ignite. Many persons with lower heterosexual risk behaviors might get infected in an African HIV epidemic situation because of the high prevalence of HIV infections and a high proportion of very recent and therefore very infectious HIV infections. Persons with identical heterosexual risk behaviors would probably not get infected in the typical Asian-Pacific HIV transmission environment because of the very low prevalence of HIV found in most Asian-Pacific countries.

The forest fire analogy and epidemiological observations of HIV prevalence trends in Thailand over the past 15 years can be used to describe the past, present, and future of HIV/AIDS in Thailand. It can be concluded that although much of the dry brush and kindling (IDU and FSW) in Thailand have burned and some of the surrounding forest has been singed, no generalized forest fire has occurred primarily because most of the forest is wet! The Thai HIV sentinel surveillance data show very clearly that extensive HIV transmission has essentially been limited to their highest HIV-risk behavior groups (RBG) and from these RBG to some of their regular sex partners. However, since the mid-1990s, HIV prevalence trends in heterosexuals outside of the highest RBG has been steadily decreasing. This indicates that HIV can and does spread to a limited extent from infected male clients of FSW to their regular sex partners and from infected IDU to their regular sex partners, but not much further. In countries such as the Philippines and Indonesia, despite the presence of thousands of HIV infected persons during the past decade, the dry bushes and kindling (IDU and FSW) in these countries have not yet ignited into flames, but continue to smolder.

The potential for extensive HIV spread to suddenly erupt in the highest RBG (in Asian-Pacific countries they are IDUs and FSW and their male clients) is constantly present. Therefore, as with any good fire protection program, such potentials should be reduced as much as possible before these dry bushes and kindling burst into flames! Full implementation of risk and harm reduction programs in countries with current low HIV prevalence can assure that brush fires can be prevented and this would assure that no generalized forest fire would occur, even if most of the trees were dry!

The forest fire analogy can also be used to help make some very difficult policy decisions. In some forest fire situations, a few trees are intentionally "sacrificed" to save a larger portion of the forest. With limited HIV prevention resources, it may be more prudent to focus virtually all public health resources in preventing HIV infections in the highest HIV-risk behavior groups (FSW and IDU) rather than to dilute such efforts by spending a large proportion of the prevention dollars on the general public.

#### ANNEX 4: HIV/AIDS in Asia and the Pacific in the New Millennium

The future of HIV/AIDS in Asia is clear if the paramount importance of the patterns and prevalence of human risk behaviors needed for epidemic or self-sustaining transmission of HIV are better understood and accepted. HIV is primarily a sexually transmitted infection (STI) that has a relatively low infection rate for any single episode of anal or vaginal intercourse. What has not been fully appreciated is that for extensive or epidemic sexual transmission of HIV to occur, specific patterns and networks of high heterosexual HIV risk behaviors (multiple and concurrent sex partners, high frequency of sex partner exchange along with high prevalence of such behaviors) need to be present. HIV/AIDS programs and policies in Asia have been driven primarily by the belief that in Asian countries with current low HIV prevalence, epidemic HIV transmission into most of these general populations is inevitable, i.e., it is only a matter of time. However, based on epidemiological observations in this region over the past 15 years an alternative scenario is that HIV has, to a great extent, already spread as much as it can in most Asian-Pacific populations according to the prevailing patterns and prevalence of HIV risk behaviors.

According to this new HIV/AIDS paradigm for Asia, the general patterns and prevalence of heterosexual HIV-risk behaviors in most Asian populations are insufficient to fuel any extensive or sustained spread of HIV outside of those population groups with the highest HIV-risk behaviors. In the few Asian countries where extensive HIV transmission has occurred during the past decade (Cambodia, Myanmar, Thailand, and parts of India), the most recent HIV surveillance data indicate that HIV prevalence peaked in these countries during the mid-to-late 1990s. However, during the coming decade, HIV prevalence in these countries is not expected to decrease rapidly but will likely persist at around 2-3% because HIV transmission from infected FSW and infected male clients of FSW to their regular sex partners will continue to occur at a slow but steady pace.

In Asia-Pacific countries where extensive HIV spread has occurred primarily in IDU populations (China, Malaysia, Pakistan, Vietnam, Nepal, Indonesia, and parts of India), this HIV pattern is projected to continue with little change during this decade. Public health interventions, directed at minimizing HIV transmission among IDU groups, can only be effective if these interventions are fully supported by national governments, and such official support continues to be elusive. However, HIV sentinel surveillance focused on FSW and STD patients in these countries should be sufficient to provide adequate warning should extensive heterosexual HIV transmission begin. In the absence of extensive heterosexual transmission, HIV prevalence in the total 15-49 year old populations of these countries are not expected to increase to much more than about 0.5%.

The exact dynamics, quantitative aspects, and mix of epidemiological parameters (patterns and prevalence of sex partner exchange, temporal presence or absence of facilitating factors, etc.), needed to ignite extensive heterosexual transmission of HIV or to determine how high HIV prevalence may reach, are not known with any degree of

certainty. In Asian countries where no extensive heterosexual transmission of HIV has occurred, but where pockets of high heterosexual HIV-risk behaviors exist, some extensive HIV transmission may occur, when and if, a sufficient number of HIV infections are permitted to accumulate. In addition, in countries where the patterns and prevalence of sexual risk behaviors are increasing, the potential for extensive heterosexual HIV transmission will also increase. Therefore, HIV/AIDS will continue to pose an immense challenge to public health workers throughout the region because all of the major HIV risk behaviors are present in virtually all Asia-Pacific countries, albeit in significantly varying degrees.

Regardless of what the future growth potential of HIV/AIDS may be in the Asia-Pacific region, the only responsible public health action to take involves focusing HIV/AIDS interventions on the highest HIV risk behavior groups (RBG). From all the HIV/AIDS epidemics that have occurred in Asia-Pacific countries, it is clear that sustained heterosexual HIV transmission will only occur in those populations with sufficient heterosexual risk behaviors. In addition, it is also clear that the first evidence of extensive heterosexual transmission of HIV will be found among FSW and STD patients and current HIV surveillance systems in most Asia-Pacific countries are capable of detecting HIV prevalence rates when they reach 1% or more in these RBGs.

To assure that extensive HIV transmission will not occur or will not continue to occur in Asia-Pacific countries, public health programs must fully implement the 100% condom program for all commercial and casual sex encounters. Such programs are urgently needed in current high HIV prevalence countries and in present low HIV prevalence countries before HIV prevalence rises to detectable levels. The 100% condom intervention effectively focuses on all commercial and casual sex encounters, and has been estimated to have prevented several million HIV infections in Thailand during the 1990s. However, in current high HIV prevalence countries, there is also an urgent need to address the slow but continuing problem of HIV transmission from infected FSW and/or infected male clients to their regular sex partners, since the "100% condom program" does not target regular sex partners. Similarly, where HIV prevalence is high or still low among IDU populations, public health programs should aggressively implement or at least fully support harm reduction programs for IDU groups to prevent HIV transmission in this very vulnerable RBG.

To what extent current national HIV prevalence levels in Asia-Pacific countries may increase in the new millennium will depend on how effective national AIDS programs will be in implementing risk and harm reduction interventions in FSW and IDU populations. In the absence of effective public health interventions, HIV prevalence will rise to the general levels permitted by the existing patterns and prevalence of HIV-risk behaviors.

## ANNEX 5: The Theoretical Basis for AIDS-related Behavioral Change Approaches

Globally, the peer education model as applied in AIDS prevention grew out of Diffusion of Innovation Theory of Everett Rogers, Social Influence or Social Inoculation Model, and Social Network Theory. In the first, "...there are four essential elements: the innovation, its communication, the social system and time... The theory posits that people are most likely to adopt new behaviors based on favorable evaluations of the idea communicated to them by other members whom they respect." "...Behavioral changes can be initiated when enough key opinion leaders adopt and endorse behavioral changes, influence others to do the same and eventually diffuse the new norm widely within peer networks" (UNAIDS 1999:9). The social influence model "...is based on the concept that young people engage in behaviors including early sexual activity partly because of general societal influences but more specifically from their peers." Resulting programs usually rely on "...teenagers slightly older than program participants to present factual information, identify pressures, role-play responses to pressures, teach assertiveness skills and discuss problem situations."

Social network theory focuses on social norms as behavior determinants, and believes these are best understood at the level of social network. This model provides the concept of "bridge" populations that form a link between high and low prevalence groups (cf. Chin, Bennett and Mills 1998). Globally, the peer education model has served as the theoretical basis for most IEC and BCC targeting higher risk groups such as street youth, military and police, dock workers, students, taxi drivers, factory workers, sex workers, drug users, traditional healers, prisoners, and others (UNAIDS 1999:15).

## ANNEX 6: Factors Affecting the Low/Slow Pace of HIV/AIDS in the Philippines

HIV sero-prevalence in the Philippines is very low and it seems likely to remain that way for the foreseeable future. Prevalence is even low among the highest risk groups: IDU, MSM, CSW, in fact probably <1%, although it is stated as <3% by the DOH. Background factors keeping seroprevalence "low and slow" (cf. Michael Tan 2000) include a relatively high age of sexual debut (18.8 for males, somewhat higher for females), the relatively small proportion of males who visit CSWs, male circumcision, and low average number of partners per sex worker (2-3 per week).<sup>6</sup> The influence of the Catholic Church must be credited with influencing sexual behavior in general, and among the general population, whatever struggles there may have been over the issue of condom promotion.

To summarize the factors contributing to the "low and slow" pattern of HIV transmission:

- Low levels of multi-partnerism among great majority of people.
- High age of sexual debut (average age of 18.8 for men; somewhat higher for women).
- Low proportion of men exposed to commercial sex core groups.
- Low levels of ulcerative STDs in high-risk populations.
- Relatively low level of CSW customer turnover (average of 2-3 per week).
- Near-universal male circumcision prior to age of sexual debut.
- Low level "bridging" between core groups and the general population (except for MSM, which appears relatively high).
- Few IDUs (although high risk behaviors found among this group).

---

<sup>6</sup> However, more recent data gathered by PATH and NGO partners in 1999 and 2000 documented rates of new partner exchange in CSW groups ranging from 3.5 to 6.4 per week, with street-based sex workers reporting the highest rates.

## ANNEX 7: Changes in IEC Strategy before and after the 1997 Evaluation

The evaluation Scope of Work posed a number of questions about modifications in IEC as a result of the 1997 evaluation, "To what extent have PATH and partner NGOs implemented the recommendations from the 1997 Assessment? What are the outputs and results of implementing these recommendations?"

Answers to these question are summarized in the following table.

Activities in IEC	Before 1997	After 1997
1. Target	<ul style="list-style-type: none"> <li>➤ 1995 CSW (Registered &amp; Freelance), MSM, male STD patient, sex partner of the above (these were identified by the Surveillance component as the population subgroup at primary risk of HIV)</li> <li>➤ After 1995 Mid-term Evaluation, we prioritized female freelance sex workers (FSW), MSM, IDU and their partners which were described then to be the "highest of the high-risk groups."</li> <li>➤ Results of BMS conducted by PATH and partners during 1996 –1997 showed 20% of FSW were under age 18 (minor freelance sex workers).</li> </ul>	<ul style="list-style-type: none"> <li>➤ Same target groups but because of 1997 Assessment recommendation, we intensified efforts to reach minor FSW (&lt;18 years), whom we referred to as "child and youth sex workers (CYSW)".</li> <li>➤ Added gate keepers—pimps, establishment owners and managers, others as a new target audience for advocacy efforts e.g., 100% condom use</li> <li>➤ Added local executives, policy makers and entertainment industry leaders as target audiences for social mobilization (creation of multisectoral AIDS council) and policy advocacy efforts (100% condom use), and policy compliance monitoring (POCOMON)</li> <li>➤ Added barangay captains, community leaders and parents as target audiences for legal literacy training and advocacy efforts to address child prostitution in barangays surrounding red light districts (BLAaCP).</li> <li>➤ In late 1999 scaled back the number of NGO projects targeting RSW and MSM because of anticipated closure of ASEP in Sept 2000. Prioritized freelance sex workers (minors and adults) because findings from NGO and HSS surveys showed they had the highest partner change rates and syphilis prevalence rates. Also, in some sites, freelancers engage in risky injecting practices.</li> </ul>

2

<p>2. IEC Theory &amp; Strategy</p> <p>Community Outreach &amp; Peer Education (COPE) through:</p> <ul style="list-style-type: none"> <li>- Community Health Outreach Workers (CHOW)</li> <li>- Peer Educators (PE)</li> </ul>	<p>Before 1997</p> <ul style="list-style-type: none"> <li>➤ Developed ASEP Education Strategy (1994) with strong emphasis on AIDS education (basic information—what is HIV/AIDS, routes of transmission, measures to prevent it, clarifying myths &amp; misconceptions).</li> <li>➤ Training for NGOs focused on following capacity building <ul style="list-style-type: none"> <li>• Behavior change communication</li> <li>• Counseling</li> <li>• Condom promotion/access</li> <li>• COPE strategy and systems development</li> </ul> </li> <li>➤ Results of BMS conducted by PATH and partners during 1995-1996 showed ASEP sentinel groups had low self-perception for HIV risk but relatively high self-perception for STD risk.</li> <li>➤ ASEP Education Strategy was revised (1996) to place greater emphasis on STD messages (including HIV) and on increasing target groups self-perception of STD risk and prevention practices.</li> <li>➤ NGO output reports indicated that condom access was a constraint in some sites.</li> </ul>	<p>After 1997</p> <ul style="list-style-type: none"> <li>➤ Continued COPE &amp; peer education activities</li> <li>➤ Other training inputs focused on strengthening the capacity of CHOW to conduct more personalized counseling using the Risk Reduction Counseling strategy (RRC), STD Preventive Case Management (PCM) approach &amp; Group Guided Interaction (GGI) approach to encourage and reinforce positive behavior change.</li> <li>➤ Skills on condom negotiation were emphasized during the training activities for Peer Educators.</li> <li>➤ All NGO partners handling FLSW were trained on Harm Reduction Program</li> <li>➤ Project on 100% condom use was piloted in 2 sites (Angeles &amp; Gen. San). Other sites continued to actively promote condom use.</li> <li>➤ Availability and accessibility of condoms was enhanced by expanding the reach of condom social marketing to sari-sari stores and cigarette vendors in red light districts in ASEP sites.</li> <li>➤ Coordinated with Association of Gatekeepers (in Cebu, Angeles, Gen. San, Iloilo)</li> </ul>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

	Before 1997	After 1997
3. IEC Media	<ul style="list-style-type: none"> <li>➤ Developed small media for high risk groups that incorporated basic information about HIV/AIDS.</li> <li>➤ Utilized mass media and public service advertising (PSA) approaches</li> <li>➤ Two media waves focusing on HIV/AIDS were placed in the tri-media (TV, radio, print). Approximately US\$5 million in free media time and space contributed by national and local broadcasters</li> </ul>	<ul style="list-style-type: none"> <li>➤ Contents of small media were the same but added               <ol style="list-style-type: none"> <li>1. Strong link of STI to risk of HIV</li> <li>2. Message that people with HIV infection could appear healthy or asymptomatic</li> <li>3. Simple instruction on correct condom usage and reminders to use it consistently regardless of partner-type</li> </ol> </li> <li>4. Messages on STD syndromes and appropriate care-seeking.               <ul style="list-style-type: none"> <li>➤ Improved quality of illustrations, use of more appropriate graphics and visuals</li> <li>➤ Materials underwent more thorough process of pre-testing with the target group before final production &amp; distribution.</li> <li>➤ Materials developed depict specific characteristics and behaviors of target audiences e.g., more target group specific.</li> <li>➤ Posters, stickers, leaflets on condom promotion was developed and posted on strategic locations.</li> </ul> </li> <li>➤ Contents of mass media and PSA messages aimed to               <ul style="list-style-type: none"> <li>• increase public awareness of STD signs and symptoms and appropriate STD care-seeking</li> <li>• increase public awareness of child prostitution and associated HIV risks</li> <li>• Destigmatize persons with STD and HIV</li> </ul> </li> <li>➤ Three media waves placed in the tri-media. Approximately US\$6 million in free media time and space contributed by national and local broadcasters.</li> </ul>

## ANNEX 7: People Interviewed

### □ Department of Health

Dr. Manuel Dayrit, Secretary of Health  
Dr. Maria Consorcia Lim-Quizon, Head Executive Assistant  
Dr. Mariquita Mantala, Director, National Center for Disease Prevention and Control  
Dr. Maria Ofelia Ocana-Alcantra, Director, Bureau of International Health Cooperation  
Dr. Eric Tayag, Director, Center for Infectious and Degenerative Diseases  
Dr. Loreto Roquero, Director, Philippine National AIDS Council Secretariat  
Ms. Edna Lopez, Nurse IV, National Epidemiology Center  
Dr. Ricardo Mateo, Resident Advisor Surveillance  
Ms. Ana Liza Carillo, Sentinel Nurse  
Mr. Noel Palaypayon, Sentinel Nurse

### □ United States Agency for International Development

Ms. Patricia K. Buckles, Mission Director  
Ms. Carina Stover, Chief, Office of Population, Health and Nutrition  
Mr. Jed Meline, Deputy Chief, Office of Population, Health and Nutrition  
Dr. Corazon Manaloto, Team Leader, HIV/AIDS/Infectious Diseases Special Objective

### □ PATH

Dr. Carmina Aquino, Project Manager  
Dr. Renato Linsangan, Deputy Director  
Dr. Joan Castro, STD Program Officer  
Ms. Rhona Montebon, Consultant, BMS  
Dr. Ma. Elena F. Borromeo, Consultant, ASEP  
Ms. Leona de Agnes, Technical Director

### □ Quezon City

*Kabalik ng Pamilyang Pilipino*  
Mr. Oliver Tayo, Deputy Director

### □ General Santos City

#### *Local Government*

Mr. Rodrigo Salangsang, City Administrator  
Ms. Florentina Congson, Vice Mayor  
Jose Marie Natividad, Councilor and Chair, Committee on Health  
Dr. Fidel Penamante, City Health Officer  
Dr. Mely Lastimoso, Social Hygiene Clinic Physician

***Social Health Environment and Development Foundation, Inc (SHED)***

Dr. Domingo Non, Executive Director  
Mr. Wilfred Bidad, Project Manager  
Ms. Evelyn Ginete, CHOW, COPE  
Ms. Ligaya Guiampaca, CHOW, COPE  
Ms. Magdalene Pairat, CHOW, COPE  
Ms. Shiela Sampang, CHOW, COPE  
Mr. Ernesto Jontilano, CHOW, BLAaCP  
Ms. Liwayway Sumagaysay, CHOW, BLAaCP

***Mahintana Foundation, Inc.***

Mr. Bienvenido Perez, Program Manager  
Ms. Eva Gallo, Program Officer  
Ms. Marihyl Guivone, Program Officer

***General Santos Entertainment Operators Association (GSEOA)***

Mr. Flaviano Roxas, President  
Mr. Danny Villaruel, Pier 8 Night Club  
Ms. Zorayda Aller, Arthur Massage Parlor

***General Santos AIDS Council***

Mr. Rodrigo Salangang, City Administrator  
Dr. Fidel Penamante, City Health Officer  
Dr. Mely Lastimoso, Social Hygiene Clinic Physician  
Dr. Domingo Non, Executive Director, SHED  
Mr. Bienvenido Perez, Program Manager, Mahintana Fnd  
Mr. Flaviano Roxas, President, GSEOA  
Reps of Col. Conrado Laza, Chief of Police

***Philippine Health Insurance***

Mr. Ramon Aristoza Jr., Regional Manager  
Dr. Antoniette Ladio, Head Accreditation and QA Unit  
Dr. Frances Hernaez, Medical Officer IV  
Ms. Maricris Caberoy, Training Specialist  
Ms. Emily Facelo, Health Insurance Officer

***Pharmacies***

Ms. Amelita Plete, Project Coordinator, Triple S  
Ms. Dominga Espina, Pharmacist, Rose Pharmacy

***Barangay North***

Mr. Willian Go, Barangay Kagawad & Community Volunteer (CV)  
Ms. Antonieth Almonia, Barangay Kagawad, Labangan & CV  
Ms. Linda Taporco, Barangay Kagawad, West & CV  
Ms. Basilia Tobongbanua, Street Educator Barangay Fatima & CV  
Ms. Freda Den Sanico, Street Educator, Barangay San Isidro & CV

Ms. Justine Beato, Street Educator Barangay North & CV  
Ms. Eveleen Ganila, Street Educator Barangay Apopong & CV  
Ms. Clemencia Bantoto, Street Educator Barangay South & CV  
Ms. Estelita Paradero, Street Educator Barangay Calumpang & CV  
Ms. Arceline Castanares, Street Educator Barangay West & CV

□ Cebu City

***Local Government***

Hon. Alvin Garcia, City Mayor  
Dr. Felicitas Manaloto, City Health Officer  
Dr. Ilya Abellanosa -Tac-an, Physician Social Hygiene Clinic and  
Team Leader, HIV Surveillance System Cebu City

***FreeLava***

Mr. Cris Amper, Project Manager, COPE  
Mr. Geronimo Jacalan, Project Manager, BLAaCP  
Mr. Lester Libre, Community Health Outreach Worker (CHOW)  
Mr. Ric Ledesma, Outreach worker  
Mr. Redentor Betito, Outreach Worker

***Bidlisiw***

Dr. Debra Maria Catulong, Program Manager  
Dr. Cristopher Samson, Clinic Physician & Triple S Focal Person  
Ms. Emmanuela Lumapas, CHOW

***Broadway Outreach Post***

Mr. Julie Generalao, CHOW  
Ms. Amy Bagtong, Peer Educator (PE)  
Ms. Leah Mongaya, PE  
Mr. Christoper Dungog, Thrifty Lodge Owner (gatekeeper)

***Sawang Center Outreach Post***

Ms. Emmy Lou Amores, CHOW  
Mr. John Cariat, PE  
Ms. Dolores Galicha, PE  
Mr. Raffy, SECUS  
Mr. Henry, SECUS  
Mr. Kevin, MSW

***Kamagayan Outreach Post***

Mr. Mansueto Avila, Barangay Captain  
Ms. Elsa Juranas, Barangay Kagawad and Chair, Committee on Health  
Mr. Roland Sonsona, Barangay Kagawad and Chair, Committee on Education  
Mr. Ernesto Diaz, Barangay Kagawad and Chair, Committee on Peace & Order

**University of Southern Philippines Foundation (USPF)**  
Ms. Lourdes Jereza, Project Director, Harm Reduction Program

- **Cebu Family Planning Organization Inc. (CFPOI)**  
Ms. Bing de la Cruz, Program Manager  
Ms. Nazarena Daria, Well Family Midwife Clinic Manager  
Mr. Alberto Reboquo, Field Supervisor

**FriendlyCare Clinic**  
Dr. Tomas Fernandez, Area Service Center Director

- **Angeles City**

**Local Government**  
Hon. Carmelo Lazatin, City Mayor  
Dr. Joven Esguerra, City Health Officer  
Dr. Teresita Esguerra, Physician-- Reproductive Health & Wellness Center  
(formerly Social Hygiene Clinic)  
Ms. Lynn Velasco, Nurse, Reproductive Health & Wellness Center

**PSBI (Pearl S. Buck, Inc)**  
Ms. Jocelyn Bonilla, Program Manager  
Mr. Binero Dayao, Project Coor, COPE  
Mr. Rufino Canlas, Project Coor, BLaACP  
Mr. Dexter Garcia, Project Coor, POCOMON  
Ms. Eleanor Niebres, CHOW  
Ms. Eva Abad, CHOW  
Mr. Kevin Powell, PE  
Mr. David de Leon, PE

**Angeles City AIDS Council**  
Mr. Bernie Chavez, Executive Director  
Mr. Gladison Quesada, Dept of Interior and Local Government  
Ms. Julieta Bautista, Office of City Civil Registrar  
Ms. Ester Dating, City Social Welfare and Development  
Ms. Ivy Lingad, Philippine Employment Service Organization  
Ms. Adelina Deocales, Philippine Employment Service Organization  
Ms. Flora Cortado, League Angeles City Entertainers and Managers  
Dr. Teresita Esguerra, SHC Physician

**Crossing Outreach Post**  
Ms. Eva Abad, CHOW, COPE  
Ms. Nenath Piangco, CHOW, COPE

**Rajah Motel Outreach Post**

Ms. Lyn Velasco, SHC staff  
Ms. Joan, FFSW

- **Family Health International**  
Dr. Joan MacNeil, Senior Technical Officer  
Dr. Teodora Wi, Resident Advisor
- **Management Sciences for Health**  
Dr. Robert Timmons, Deputy Chief of Party/Technical Director
- **The Futures Group**  
Ms. Ester Isberto, Country Deputy Director
- **Donor Organizations**
  - **Embassy of Japan**  
Dr. Kuniaki Miyake, First Secretary
  - **European Union**  
Ms. Athena Baquizal-Adan, Project Officer
  - **Japan International Cooperation Agency**  
Ms. Yuko Arimoto, Assistant Resident Representative  
Mr. Tomoyoda Yoshido, Assistant Resident Representative
  - **United Nations Children Fund**  
Dr. Gepke Hingst, Health and Nutrition Officer  
Mr. Leopoldo Moselina, Chief, Child Protection Section & UNAIDS
  - **United Nations Fund for Population Assistance**  
Dr. Uyen Luong
  - **United Nations Development Program**  
Mr. Terence Jones, Resident Representative
  - **Joint United Nations Programme on HIV/AIDS**  
Dr. Arthur Jaucian, Country Program Advisor
  - **World Health Organization**  
Ms. Gaik Gui Ong, Technical Officer  
Dr. Nguyen thi Thanh Thuy, Epidemiologist  
Dr. Gilles Pomerol, Regional Advisor in Sexually Transmitted Infections

## Scope of Work

### AIDS Surveillance and Education Project (ASEP) Evaluation April 2001

#### I. Background and Program Description

Two priority areas for the Mission's Special Objective (SpO1): "The Threat of HIV/AIDS and Other Selected Infectious Diseases Reduced" are aimed at preventing an explosive epidemic of HIV/AIDS and controlling other leading infectious diseases in the Philippines.

In order to achieve these purposes, two intermediate results have been developed under SpO1. Intermediate Result 1 (IR1), "Rapid Increase of HIV/AIDS Prevented", is aimed at preventing the rapid spread of HIV/AIDS within the Philippine population by institutionalizing public and private sector mechanisms for monitoring HIV prevalence and risk behavior and encouraging behaviors that reduce individual risk for contracting and transmitting HIV. Intermediate Result 2 (IR2), "The Capacity to Identify and Reduce the Threat of Leading Infectious Diseases is Strengthened", is aimed at reducing the burden of leading infectious diseases by establishing effective links between epidemiological surveillance systems and high quality disease control and prevention programs and by strengthening the capacity of LGUs to identify and reduce the threat of leading infectious diseases

#### **IR1: Rapid Increase of HIV/AIDS Prevented**

The AIDS Surveillance and Education Project (ASEP) is the main vehicle for which activities supporting IR1 are implemented. Authorized in July 1992, the project was to (1) establish an HIV surveillance system in strategically located geographic sites throughout the country to detect HIV infection among high risk groups and (2) support mass media and community-based education, communication and public relations programs aimed at preventing the spread of HIV/AIDS. Both the surveillance and education programs target the following high-risk groups: registered female commercial sex workers (RFCSWs), freelance female commercial sex workers (FFCSWs), male sex workers, injecting drug users (IDUs), men who have sex with men (MSMs), and patients at sexually transmitted disease (STD) clinics.

The surveillance component of ASEP is implemented by the Department of Health-Field Epidemiology Training Program (DOH-FETP) through a Grant to the World Health Organization/Western Pacific Regional Office (WHO/WPRO) and consists of HIV sentinel surveillance (HSS) and behavioral sentinel surveillance (BSS) systems. The ASEP education programs are implemented through a cooperative agreement with Program for Appropriate Technology in Health (PATH) working with selected non-governmental organizations (NGOs) that have access to high-risk groups. Education activities are implemented in the 8 cities where HSS surveillance activities are being implemented.

A mid-term assessment of the ASEP was undertaken in February 1995. Based on the recommendations of that assessment, a new strategic framework was developed. Under the USAID re-engineering efforts that were underway at that time, ASEP was transformed into a Special Objective (SpO1) with the stated goal of "Rapid Increase of HIV/AIDS Prevented." Furthermore, in line with the Mission's strategic planning period, the original Completion Date of ASEP was extended from September 30, 1997 to September 30, 2000, and the authorized funding level was increased from \$10.0 million to \$15.0 million.

An assessment of the SpO1 in January/February 1997 reviewed the progress and results achieved towards the SpO1 targets. The assessment found that there has been no "explosion" of HIV infections thus far in the Philippines. HIV prevalence is generally low (<1%) in almost all of the HSS sites. However, high-risk behaviors are widespread among those groups where the potential for STD/HIV infection is greatest. The assessment also provided recommendations to improve HIV surveillance systems and HIV/AIDS prevention and education activities.

## **II. Purpose of the Evaluation**

The evaluation will focus primarily on the activities implemented under ASEP and shall have the following purposes:

1. **Impact Assessment**
  - measure the extent to which ASEP achieved its purpose level objectives as articulated in the SpO1 results framework
2. **Design and Implementation**
  - determine the appropriateness of the project strategies and activities for meeting the objectives
  - determine the effectiveness of the DOH's, USAID's and implementing partners' management and implementation of the activities
3. **Sustainability and Future Direction**
  - ascertain the plans of the DOH and LGUs for sustaining the systems and measures developed under the project when USAID assistance terminates on September 30, 2002
  - determine sustainability issues faced by the LGUs and determine appropriate strategies to address these sustainability issues
  - determine needs, gaps and opportunities and recommend strategies on the future directions of HIV/AIDS prevention activities in the Philippines
4. **Synergy**
  - identify areas of synergy with other health programs (FP/MCH) and recommend possible strategies for integration of HIV/AIDS into other health programs

- determine the effectiveness of US-Japan collaboration under the Common Agenda Initiatives on enhancing the impact of HIV/AIDS surveillance and prevention activities and provide recommendations to improve US-Japan collaboration

### III. Statement of the Services

The assessment team shall work under the overall guidance of the OPHN Chief. They should analyze key documents, including 1) 1999 Revised Mission Strategy; 2) SpOI Results Framework (1999); 3) SpOI Assessment (1997); 4) DOH-HIV/AIDS 2000-2004 Medium Term Plan; 5) HIV/AIDS Project Workplans. Key documents will be air-shipped to assessment team members prior to their departure for the Philippines and or provided at the beginning of the assessment process.

The members of the team must interview key staff of the DOH, LGUs, and Cooperating agencies including WHO/WPRO, PATH, FHI, (SpOI key partners); local NGO, and other donor officials. Site visits will be made to 3 cities (Davao or Zamboanga, Cebu or Iloilo and General Santos or Angeles) to observe HIV surveillance and IEC.

The assessment work will be conducted over a period of three weeks beginning on/about the 3<sup>rd</sup> week of April 2001. The members will work over a six-day workweek without premium pay.

Proposed Approach: At the beginning of the work period, the team members shall spend two days for "team building", interviewing USAID officials and studying the basic reference documents. During this period, the team must reach common agreement among themselves on specifics of the task and how to proceed and which team members have responsibilities for which components of the SOW. The following period will be spent carrying out the assessment activities and preparing a consolidated report providing the team's findings and recommendations.

After completion of a draft report, the team shall brief USAID, DOH and other key entities. Presentation of draft evaluation findings will lead to finalization of the evaluation report. The final report will be submitted to the OPHN Chief at the end of the third week prior to the departure of the team leader. The evaluation, writing of the report and debriefings is outlined in the tentative schedule below:

#### Tentative schedule:

April 15	Arrival
April 16	Meeting with USAID, DOH officials
April 17	Review of background documents, Team building
April 18-27	Field works
April 30	Submission of Draft Evaluation/Assessment Report
May 1-3	Debriefings/Presentations
May 4	Submission of Final Evaluation/Assessment Report

May 5

Departure from Manila

Secretarial and logistics support will be the responsibility of the team members. The contractors should bring or have on hand a Personal Computer with Word Processor (MSWord) or hire typist(s).

#### **IV. Team Composition and Detailed job Description:**

The Evaluation team will include four technical experts: one Project Analyst as Team Leader; a surveillance analyst/epidemiologist; an IEC/health program specialist; and an organizational/policy expert. Following is a description of tasks and responsibilities:

##### **A. Project Analyst**

- Acts as team leader (TL) and provides overall coordination with USAID, DOH and other members of the team; oversee that the evaluation/assessment work is completed including submission to USAID of the Evaluation/Assessment Report.
- Review SpO1 Results Framework, and refine IR1 target indicators if necessary
- Recommend strategies for future HIV/AIDS activities that will include possible integration of HIV/AIDS with other health programs
- Identify areas for synergy with other health programs.

##### **B. Surveillance Analyst/Epidemiologist**

- Assess the National HIV surveillance systems and determine the feasibility of integrating HIV/AIDS surveillance with other infectious diseases surveillance systems; recommend appropriate strategies to integrate surveillance systems as necessary.
- Address issues, concerns and questions pertaining to the surveillance component

##### **C. IEC/MCH/Health Advisor**

- Assess the HIV/AIDS education component and recommend strategies to integrate HIV/AIDS education activities with other appropriate IEC components of other health services;
- Address issues, concerns and questions pertaining to the education component

##### **D. Sustainability/Organizational/Policy Specialist**

- Assess LGU/NGO collaboration and HIV/AIDS organizational policies infrastructure/management systems;
- Assess the extent to which WHO/WPRO and PATH are accomplishing their planned targets for sustainability
- Address issues, concerns and questions on implementation and sustainability

The team will address (but not limited to) the following:

### **A. Impact Assessment**

1. Did ASEP meet its purpose level objectives? What are the reasons for meeting or not meeting its objectives?
2. Are the indicators still appropriate for measuring the results ASEP wants to achieve? If not, what indicators are appropriate (could be refinements to existing indicators or entirely new indicators)?
3. Do the outputs of the surveillance and education components complement each other? Taken together, do they contribute to the achievement of the ASEP objectives?
4. To what extent has PATH and partner NGOs delivered the results anticipated for each activity benchmark in USAID's Results Framework?
5. Are the 2002 targets for the number of active NGO frontline workers (PE and CHOW) realistic in terms of the level of coverage needed to control and prevent STD/HIV in ASEP sites?

### **B. Design and Implementation**

#### **1. Surveillance**

- a. To what extent have the recommendations from the 1997 Assessment been implemented by the DOH? What are the results and how have they been used to improve the prevention effectiveness of ASEP?

Recommendations of the 1997 assessment:

- a.1. "The DOH must add a question on condom usage to the HSS and BSS that will obtain the same data that are currently collected by the NGOs."
- a.2. "Both the NGO and DOH questionnaires should collect information on condom use for the last commercial sex partner, as well as condom usage with the last sexual encounter with a spouse, boyfriend or "steady/regular partner"
- b. Have DOH/FETP and PATH demonstrated any effort to work jointly on the analysis of the same condom use data mentioned above? If so, what are the results of the joint analysis? Do they support the conclusion that ASEP is helping to mitigate rapid increase of HIV/AIDS in urban Philippines?
- c. If USAID assistance is warranted to continue, should it keep its focus on current "high risk" groups in assumed "hot spot" areas? Should the focus be narrowed? Broadened? What are the DOH plans?

## 2. Education/IEC

- a. To what extent have PATH and partner NGOs implemented the following recommendations from the 1997 Assessment? What are the outputs and results of implementing these recommendations?

Recommendations of the 1997 assessment:

a.1 Targeted IEC Interventions

“Additional target groups that should be added to include child sex workers, gatekeepers, such as sex establishment managers and owners; and policy makers, such as City health officers and LGU political leaders.”

a.2. IEC theory and strategy

“Continue emphasis on peer education. Training should be provided on interpersonal counseling to address: personalized risk assessment, condom negotiation and safer injecting drug use skills, outcome expectations and behavioral impacts on social networks and family.”

a.3 IEC media

“Small media should be enhanced to better meet the needs of the target audiences and there should be more copies of small media produced, pre-tested and distributed”.

a.4 Monitoring and evaluation

“Add outcome indicators on psychosocial correlates of risk. Coordinate outcome measures with the BSS. Evaluate programs on an annual basis. Use surveillance findings more effectively for planning NGO program activities”.

a.5 Child Sex Workers

“Identify the extent and location of child sex workers (<16 years) and the factors that are promoting child sex work. Develop a specialized prevention strategy for child sex workers and incorporate this strategy into all programs targeted on CSWs. Conduct training on the strategy with all NGOs working with CSWs”.

### 3. Implementation

- a. What is the management structures under ASEP? How effective are these management structures? How can these structures be further streamlined?
- b. What is the potential impact of the DOH reorganization, including new leadership, on project implementation? What measures can be instituted to mitigate possible negative impact/s?

### **C. Sustainability and Future Directions**

1. For activities that involve the participation of local communities/LGUs, what processes are effective and ineffective in terms of: a) obtaining and sustaining community participation; and b) getting an outside entity/organization (like ASEP and its consultants) to be accepted?
2. Have the DOH/LGUs and PATH followed through with the following technical assistance recommendations? If so, how have the inputs enhanced the sustainability of ASEP interventions?

“ To further STD/HIV/AIDS control and prevention, ASEP technical assistance for LGUs/NGOs must support a) creation of networks that are eventually made official by the LGU; b) financial sustainability measures to fund NGO programs and local government health services related to STD/HIV prevention and control need to be explored; c) implementing guidelines for the Sanitation Code of 1976 at the LGU level.

3. What else needs to be done that has not yet been addressed by existing programs? Are there opportunities that USAID can focus on to further increase the impact of its programs?

### **D. Synergy**

1. Do the programs of USAID, the GOP and other donors complement each other?
2. What are possible areas of integration between the HIV/AIDS program and other health programs (e.g., reproductive health program, and infectious diseases program)? What is the feasibility and timetable for doing this integration?
3. Are activities under the US-Japan Common Agenda enhancing the impact of HIV/AIDS surveillance and prevention activities? What more can be done to improve the effectiveness of these collaboration efforts?

## V. Reporting Requirements

The Evaluation Team is required to submit the final evaluation report following the outline given below:

### Evaluation Report:

The evaluation report must adequately address all areas contained in the scope of work (Sections II and IV). It should include:

1. Data Sheet
2. Executive Summary stating the findings, conclusions, and recommendations.
3. Table of Contents
4. Body of the Report (which include a brief project description, the environment in which the project operates, a statement of the methodology used, major findings, conclusions and recommendations, and achievement of project purposes.
5. Annexes  
The entire report (exclusive of annexes) should not exceed 50 pages. Annexes to be attached to the final assessment report include:
  - a. The scope of work
  - b. A list of persons consulted
  - c. Supplemental background materials useful for a fuller understanding of the report.