

# NATIONAL HIV SENTINEL SURVEILLANCE SYSTEM

United States Agency for International  
Development, Philippines

## Final Report



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# **NATIONAL HIV SENTINEL SURVEILLANCE SYSTEM**

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Development, Philippines

## **A Final Report**

Submitted by:

**World Health Organization,  
Office for the Philippines  
Western Pacific Region, Manila**

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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AFP	Armed Forces of the Philippines
ASEP	AIDS Surveillance and Education Project
BRL	Bureau of Research and Laboratories
BSS	Behavioral Sentinel Surveillance
CFSW	Clients of Female Sex Workers
CHD	Center for Health Development
CHO	City Health Office
CUP	Condom Use Program
DOH	Department of Health
DSF	Deep Sea Fishermen
EO	Executive Order
FETP	Field Epidemiology Training Programme
FETPAFI	Field Epidemiology Training Programme Alumni Foundation, Inc.
FLSW	Freelance Female Sex Worker
GC	Government Clinic
GOP	Government of the Philippines
GPA	Global Program for AIDS
GSCEOA	General Santos City Entertainment Operators Association
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
HSS	HIV Serologic Surveillance
HW	Health Workers
IDU	Injecting Drug User
IEC	Information, Education and Communication
JICA	Japan International Cooperation Agency
LAC	Local AIDS Council
LDF	Local Dissemination Forum
LGE	Local Government Executives
LGU	Local Government Unit
LQAS	Lot Quality Assurance Sampling
MAR	Men at Risk
MCSW	Male Commercial Sex Worker
MFI	Mahintana Foundation, Inc.
MOP	Manual of Procedures
MSM	Men having Sex with Men
MSTD	Men with Sexually Transmitted Disease
MTP	Medium Term Plan
MTR	Management and Technical Review
NASPCP	National AIDS/STD Prevention and Control Program

NDF	National Dissemination Forum
NEC	National Epidemiology Center
NGO	Non-Government Organization
NHSSS	National HIV/AIDS Sentinel Surveillance System
OFW	Overseas Filipino Workers
PA	Particle Agglutination
PATH	Program for Appropriate Technology in Health
PNAC	Philippine National AIDS Council
RFSW	Registered Female Sex Worker
RI	Research Institution
RITM	Research Institute for Tropical Medicine
RPR	Rapid Plasma Reagin
SACCL	STD/AIDS Cooperative Central Laboratory
SHC	Social Hygiene Clinic
STI	Sexually Transmitted Infection
SY	Syphilis
TPPA	Treponema Pallidum Particle Agglutination
USAID	United States Agency for International Development
WB	Western Blot
WHO	World Health Organization

## EXECUTIVE SUMMARY

The National HIV Sentinel Surveillance System (NHSSS) was established in September 1993. It is a component of the AIDS Surveillance and Education Project (ASEP) which was implemented through a grant provided by the United States Agency for International Development (USAID) to World Health Organization/Western Pacific Regional Office (WHO/WPRO). The project was implemented by the Department of Health (DOH) and local government units with assistance from the WHO/WPRO until September 2003. The preparation of this Final Report was conducted from October 1 to November 27, 2003 using available data from project documents at NHSSS Office, WHO-WPRO, and WHO-Philippines.

The surveillance component has two components:

- HIV Serologic Surveillance (HSS) involves the collection of blood samples for HIV testing from designated groups at risk in strategically located geographic sites throughout the country.
- Behavioral Sentinel Surveillance (BSS) is a systematic collection of information on behavior related to HIV transmission among selected population groups believed to be vulnerable to HIV infection.

NHSSS sought to:

- define HIV prevalence among high-risk groups and serve as early warning system;
- identify HIV risk practices;
- identify other groups at risk;
- guide policy makers to arrive at informed decisions; and
- serve as a tool for program evaluation.

### Overall Accomplishments

- HSS served as a reliable basis for monitoring changes in HIV/AIDS prevalence at the national level and local sentinel sites among high-risk groups
- The results of HSS and BSS were used as basis for planning program interventions, policy advocacy and inputs to information, education and communication activities at the national and local levels.

- HSS and BSS sentinel sites were established and operated in 10 cities, namely: Angeles, Baguio, Cagayan de Oro, Cebu, Davao, General Santos, Iloilo, Pasay, Quezon and Zamboanga.
- Institutionalization efforts were undertaken which led to HSS and BSS being owned and institutionalized in the cities of Cagayan de Oro and Baguio since 1998 and 1999 respectively – this means that the LGUs assumed full responsibility in implementing the surveillance activities even beyond the project life. The other eight (8) LGUs started to assume full responsibility in 2002.
- Supervisory visits and Management and Technical Review (MTR) were consistently conducted which aided the sentinel sites in addressing problems related to the implementation of HSS and BSS.
- Major trainings were undertaken at the national and local levels (e.g. team preparation and team-building workshops, proficiency trainings for medical technologists and training on AIDS counseling).
- Information on HIV/AIDS was disseminated to various sectors through the National Dissemination Forum (NDF) and Local Dissemination Forum (LDF) which led to a better understanding of the disease and its social and economic ramifications. As a result, champions or advocates were gained and media people took notice of the problem and featured them in national dailies, television and radio programs.
- A three (3) volume Manual of Procedures were developed, published and circulated: (1) Setting-up an HIV Sentinel Surveillance; (2) HIV Serologic Surveillance; and (3) HIV Behavioral Surveillance. These MOPs will guide an LGU on how to establish a surveillance system and conduct surveillance activities.
- Publication of six (6) NHSSS Annual Technical Reports, from 1997–2002, which contain the results of HSS and BSS activities.
- Developed a collaborative relationship with partner LGUs, NGOs, research institutions and other organizations in the conduct of HIV/AIDS surveillance and other surveillance-related activities.
- Able to educate the high-risk groups, owners and managers of entertainment establishments, HRGs and truckers (groups usually hard to convince to attend such activities) through their attendance in LDF and other information and education activities.

## Lessons Learned

- Sustained and innovative advocacy strategies generate positive and effective responses from LGUs (e.g. institutionalization, ownership and mobilization of resources).
- Ensuring confidentiality of information is necessary in gaining the trust of study participants, as well as in creating a conducive atmosphere for participation where they become more open in their responses.
- Systematic documentation of best practices and failures will greatly help in future formulation of strategies and policies for implementation. It could be noted that there were no case studies conducted on sites which were able to institutionalize or those unable to push through the institutionalization processes.
- The MTR was an effective internal evaluation mechanism of the BSS and HSS activities because it responded to issues and problems confronting the implementors, and discussed good practices of other sites where other sites can benefit.
- A national law is effectively implemented when it is adopted as a local law or policy and guided by implementing rules and regulations which are suited and responsive to local priorities and needs.
- Exchange of experiences and accomplishments among ASEP project areas both in meetings and visits on site served as effective learning tools for LGUs in the process of setting up a more dynamic and effective HIV/AIDS and STI prevention and control program, and for other related actions and innovations. This kind of sharing also strengthens commitment and political will.

## Key Recommendations

- **On surveillance implementation:**
- The HSS Teams should support, maintain and exert all efforts to attain the desired sample size of 300 per risk group so that the HSS would be sensitive to detect the presence of HIV at the 1% level. To assist the HIV surveillance teams, the LGU should consider hiring the better performing peer educators

and community health outreach workers as contractual or volunteer workers in the CHO.

- Review and improve measures on how to ensure confidentiality of information in order to create a "safe atmosphere" for the study participants.
- The Department of Health and partner agencies should continuously provide technical support to the ten (10) ASEP sites through follow ups, logistics support, field visits, fora and other initiatives to maintain linkages. The attainment of the 100% CUP is the next level to reach and provision of anti-retroviral drugs for the HIV patients at the community level is another tall order to achieve in support of the 3x5 initiatives.

**On surveillance findings:**

- Develop strategies on how to address the wide gap between knowledge and adoption of positive behaviors.

**On future undertakings:**

- The DOH should consider: (1) maintaining the overseas Filipino seafarers as one of the groups for surveillance with assistance from the different manning agencies and conducting special studies among land-based OFWs; (2) Advocating for expansion of HIV surveillance in other cities, specifically those that are contiguous to the present sentinel sites; (3) Identifying data sources that will provide denominators for the HIV/AIDS Registry for it to be more informative and useful; and (4) Identifying other core or bridge-groups that have risk potentials for HIV spread and conducting special surveys to assess level of risk.
- Conduct case studies of successful and weak HSS and BSS sites In order to learn from good and failed practices in HIV/AIDS surveillance.
- 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.
- Integrate HIV/AIDS surveillance with the other infectious disease surveillance within the NEC and make associated staffing and administrative actions.
- In compliance to Republic Act 8504 (The Philippine AIDS Prevention and Control Act of 1998), the LGUs, aside from the 10 ASEP sites, should intensify HIV/AIDS education and information campaigns that focused on sub-

populations of highest risk to acquiring HIV and other STIs. Likewise, they should have ample supply of condoms and drugs for treating identified persons with STIs.

- Intensify and strengthen advocacy network to influence other LGUs in sustaining and adopting the HSS and BSS in their locality as a priority concern.

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## 1.0 INTRODUCTION

This Final Report documents the accomplishments of and implementation gaps and lessons learned in the National HIV Sentinel Surveillance System (NHSSS). This report also gives recommendations on how to improve the HIV/AIDS surveillance system in the Philippines.

The NHSSS, a component of the AIDS Surveillance and Education Project (ASEP), was made possible through a United States Agency for International Development (USAID) grant to World Health Organization/Western Pacific Regional Office (WHO/WPRO). The Department of Health (DOH), with assistance from the WHO/WPRO and local governments, implemented the project from September 1993 to September 2003.

This report contains the following: (i) project background; (ii) description of the NHSSS; (iii) implementation scheme; (iv) accomplishments; (v) summary of major accomplishments; (vi) lessons learned; and (vii) recommendations. All data are based on project documents.

## 2.0 BACKGROUND

In 1984, the death of a foreign national from pneumonia caused by AIDS attracted public attention to HIV. By mid-1995 the number of HIV-positive persons in the Philippines has reached more than 660 cases, the Philippine National AIDS Council (PNAC) reported. However, because of the weaknesses in reporting procedures, inaccessibility of diagnostic facilities, and scarcity of health workers adequately-trained to manage and monitor HIV/AIDS cases this number may only be a fraction of a larger figure (PNAC 1995). It is in this context that the ASEP, with NHSSS as one of its components, was conceptualized and implemented.

### 2.1 Policy Environment on HIV/AIDS

After the DOH classified HIV/AIDS as a notifiable disease in 1986, the HIV/AIDS Registry was established the following year. The HIV/AIDS Registry is a passive surveillance system institutionalized to consistently monitor HIV+. Before the Registry, there were no reliable data. The HIV/AIDS Registry was the only way to show with some degree of accuracy the virus' geographic spread and the population groups that it affected. Still, submitted reports on new HIV/AIDS cases had several limitations. The HIV/AIDS Registry provided little information on the current status and trends of transmission because the reports showed only past infections. Clinical and laboratory expertise

necessary for accurate diagnosis was lacking. Under-reporting, delayed reporting, and minimal coverage of HIV testing were also noted in the national passive survey area.

In 1988, the increasing number of HIV-infected persons led the government to establish the National AIDS/STD Prevention and Control Program (NASPCP) under the Department of Health (DOH). A Medium Term Plan (MTP) was developed to attain the NASPCP's objective to reduce HIV transmission, morbidity and mortality associated with HIV infection, and the impact of HIV infection and AIDS on the individual, the family, and the community (PNAC 1995:1).

In 1992, the President of the Philippines, to address the HIV/AIDS problem more fully, issued Executive Order No. 39, which mandated the creation of the Philippine National AIDS Council (PNAC), "a multi-sectoral body tasked to review and recommend policies on HIV infection and AIDS and to direct national approaches towards minimizing their spread and impact". The PNAC spearheaded the formulation of policy guidelines, the development of comprehensive strategies for HIV/AIDS prevention and control, and the delivery of a consolidated position on issues related to HIV and AIDS.

In 1998, the government passed the Philippine AIDS Prevention and Control Act or R.A. No. 8504, which defined AIDS and its gravity. The law emphasized the need for strong state action, such as promoting awareness of the causes, modes of transmission, consequences, prevention, and control of HIV/AIDS through a comprehensive nationwide educational and information campaign. It also proposed to extend support to every person suspected or known to be infected with HIV/AIDS and to fully uphold his or her human rights and civil liberties.

## **2.2 AIDS Surveillance and Education Project (ASEP)**

The AIDS Surveillance and Education Project (ASEP) was launched on September 1993 through a grant from the US Agency of International Development (USAID). Surveillance and education were the two major components of ASEP. "Surveillance" was granted to WHO and implemented by the National Epidemiology Center (NEC) of the Department of Health (DOH), while "education" was granted to the Program for Appropriate Technology in Health (PATH). Some non-governmental organizations (NGO), research institutions, and the Japan International Cooperation Agency (JICA) helped to implement the project. ASEP's goal is to control the transmission of HIV in the

Philippines through the establishment of public and private sector mechanisms that would monitor the prevalence and transmission of HIV and encourage behavior that reduces the risk transmitting the disease.

The DOH established an active surveillance system to keep track of HIV/AIDS. The NHSSS was created in response to the HIV/AIDS Registry's limitations. It has two components: HIV Serologic Surveillance (HSS) and Behavioral Sentinel Surveillance (BSS). The HSS collected blood samples from risk groups in strategically located areas in the country for testing, while the BSS systematically collected information on behavior related to HIV transmission from population groups deemed vulnerable to HIV infection.

To educate and promote awareness, risk-reduction activities focused on high-risk groups were launched through community outreach, peer education, and policy work with city governments. They were also aimed to develop local support for key elements of surveillance and prevention. The project supported mass media and community-based communication and public relations programs which encourage behavior that reduce the risk of HIV transmission. The target audience includes the HRGs, locations indicated by the HIV Sentinel Surveillance, and the general population as well. The IEC program was implemented by PATH, local NGOs and ASEP-supported city governments.

### 3.0 DESCRIPTION OF NHSSS<sup>1</sup>

This section summarizes the NHSSS' overall goal, specific objectives, components, planned activities, and expected output.

#### 3.1 Overall Goal

The NHSSS aimed to implement a nationwide HIV sentinel surveillance system that would monitor HIV seroprevalence among HRGs.

#### 3.2 Project Objectives

The NHSSS' main objective was to detect HIV infection among members of known population groups vulnerable to AIDS. Specifically, the project aimed to:

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<sup>1</sup> The data for the description of NHSSS, i.e., overall goal, specific objectives, components, planned activities and expected outputs were taken from the document, "AIDS Surveillance and Education Project Amplified Project Description; and National HIV Sentinel Surveillance System (AIDS Surveillance and Education Project)".

- define HIV prevalence among high-risk groups and serve as an early warning system;
- identify HIV risk practices;
- identify other groups at risk;
- guide policy makers to arrive at informed decisions; and
- serve as a tool for program evaluation.

### 3.3 Components and Planned Activities

#### 3.3.1 HIV Serologic Surveillance (HSS)

HIV Serologic Surveillance (HSS) is a systematic collection, analysis, interpretation, and dissemination of information on HIV prevalence among selected high-risk population groups. It is a monitoring tool that could provide baseline appraisals of HIV prevalence among potential risk groups, determine the HIV infection trends, identify surveillance groups and sites with high and/or lower rates of infection and, to a limited extent, provide information on prevailing HIV risk behaviors. The HSS' main objective is to give early warnings on dangerous levels of HIV infection, when 1% HIV prevalence is breached.

##### ➤ Activities

- Preparatory activities, such as constitution and orientation of the surveillance staff, selection of surveillance sites through mapping and systematic selection, production and pre-coding of survey instruments, preparation of laboratory supplies and other logistic requirements, and coordination and networking with groups that could facilitate access to the HRGs for surveillance;
- Data/blood collection;
- Data processing and analysis;
- Preparation and dissemination of surveillance results and recommendations for local government officials, national and regional health agencies in charge of HIV/AIDS prevention and control programs, local NGOs involved in HIV/AIDS prevention work, sectors in the academe doing studies in HIV/AIDS, and at-risk population groups to include advocacy activities; and
- Evaluation of the conducted surveillance round and planning for the next HSS.

### 3.3.2 Behavioral Sentinel Surveillance (BSS)

Behavioral Sentinel Surveillance (BSS) is a systematic collection of information on behavior related to HIV transmission gathered from selected population groups deemed vulnerable to HIV infection. It is a monitoring tool that provides data on the level of knowledge and risk behaviors of selected population groups, the prevalence and trends of behavior that increase or decrease risks of HIV infection, and the overall picture of the vulnerability of groups to HIV. Its objectives include: monitoring the level of knowledge and risky behavior patterns of population groups considered at risk for HIV; provide timely and relevant information for prioritizing, targeting, and evaluating HIV/AIDS prevention and control programs; and monitor risk-reduction practices and treatment-seeking behavior among vulnerable groups.

#### ↳ Activities

- Preparatory activities, such as the constitution of the surveillance staff, selection of private research group, selection of surveillance sites through mapping and systematic selection, production and pre-coding of survey instruments, preparation of logistical requirements, coordination with groups involved in surveillance, and recruitment and training of interviewers;
- Data collection/interviews;
- Data processing and analysis;
- Preparation and dissemination of surveillance results and recommendations for local government officials, national and regional health agencies in charge of HIV/AIDS prevention and control programs, local NGOs involved in HIV/AIDS prevention work, sectors in the academe studying HIV/AIDS, and at-risk population groups; and
- Evaluation of the surveillance round conducted and planning for the next BSS.

### 3.4 Expected Output

The project is expected to:

- Initiate a national sentinel surveillance system for HIV infection. The plan was to initiate the project in four sites, gradually cover 30 sites, and activate every six months for the duration of the grant.
- Make available statistically reliable time series data on HIV seroprevalence and its geographic distribution throughout the country in order to track changes in HIV seropositivity, monitor progression of the AIDS epidemic in the Philippines, and target preventive intervention in the most cost-effective manner.
- Establish policies, criteria, and procedures for selecting and adding new sentinel sites.
- Establish policies for expanding sentinel groups from currently identified HRGs to other groups.
- Develop standard procedures for HIV blood screening, confirmatory testing, and quality assurance programs.
- Publish within the grant's duration quarterly reports which present HIV prevalence data generated from each round of sentinel surveillance.
- Hold Annual National AIDS Workshops which would present comprehensive yearly updates on the epidemiology of HIV infection in the Philippines.
- Institutionalize a national HIV surveillance system.
- Increase local awareness of HIV.
- Identify other HRGs and possible expansion of the existing coverage area.
- Comply with standard procedure for quality assurance maintenance (training, upgrading, and equipment).

#### **4.0 IMPLEMENTATION**

The Department of Health, with funding support from the USAID and technical assistance from the WHO/WPRO, implemented the project from 1993-2003. Originally, the NHSSS was to operate from September 1993-1999 only, but was extended without additional cost in October 2000 to run until September 2003 so that its maintenance and institutionalization may be ensured.

This section briefly describes the implementation scheme for its two phases, participating agencies and key personnel, sites and population groups, and financial resources.

#### 4.1 First Phase, 1993–1997

The HIV serologic surveillance (HSS) started in June 1993. The BSS was added in 1997.

Surveillance rounds were conducted every 6 months from 1993–1996. In 1997, frequency of the rounds was reduced to once a year. Syphilis (SY) testing was included in 1994. The following year, serologic tests were conducted among Armed Forces of the Philippines recruits as a surrogate for the general male population. Until 2001, HSS among recruits were annually conducted. Because there were no dramatic changes, the frequency of HSS on AFP recruits was reduced to every other year. Cebu City and Quezon City were the initial sites of the NHSSS in 1993. Then the coverage gradually expanded to 10 cities in the Philippines: Angeles, Baguio, Cagayan de Oro, Cebu, Davao, General Santos, Iloilo, Pasay, Quezon and Zamboanga.

Sentinel surveillance data facilitated the depiction of infection trends and the monitoring of changes in risk behavior patterns. It also served as a tool for planning and assessing public health programs and interventions, particularly for HIV/AIDS prevention and control.

#### 4.2 Extension Phase, 1997–2003

The project was extended for three years from October 1997 to September 2000. After this, it was again extended at no cost from October 2000 to September 2002. The surveillance component officially ended in September 2003. The project was extended to enhance local commitment and ensure continuity in monitoring HIV prevalence and behavioral trends. Moreover, the extension aimed to maintain NHSSS by institutionalizing it at the national and local levels. It also sought to:

- Produce statistically reliable time series data on HIV seroprevalence and behavior through HSS and BSS;
- Maintain quality of surveillance activities and data;
- Strengthen and institutionalize the NHSSS; and
- Increase local awareness of and advocacy against HIV.

The extended project components include:

- Collecting and analyzing data on HIV prevalence and behaviors;

- Reinforcing local and national capacity to assume management of surveillance activities;
- Ensuring the commitment of local and central levels for HIV surveillance; and
- Improving the quality of surveillance.

The NHSSS covered and monitored ten cities during the extension phase. These were Angeles, Baguio, Cebu, Cagayan de Oro, Davao, General Santos, Iloilo, Pasay, Quezon and Zamboanga.

### 4.3 Implementing Agencies, Key Personnel and Management

The US Agency for International Development (USAID) provided the grant to WHO-Global Program for AIDS (GPA) for ASEP's surveillance component. WHO-GPA, a special program coordinated by the WHO and funded by multilateral and bilateral donor agencies, assisted the DOH in implementing the NHSSS. WHO-GPA, through the WHO-WPRO, implemented ASEP's surveillance component in its entirety by working with director of the Field Epidemiology Training Program (FETP). It provided technical, logistical and financial support necessary to implement the project. The WHO-WPRO worked closely with their DOH counterparts in utilizing additional GPA resources to ensure the institutionalization of sentinel surveillance activities.

The DOH held overall responsibility for the implementation of project activities within the organization and administration framework of the NASPCP. It organized, trained and provided technical and logistical support, and managed the surveillance system. It also worked with City Health Officers as field site managers. The staff of the City Health Offices which include Social Hygiene Clinics (SHCs) composed the local surveillance teams for both serologic and behavioral surveillance.

DOH officials and units involved in the project include the FETP (which later was integrated with the National Epidemiology Center), AIDS Unit of the NASPCP, PNAC, Research Institute for Tropical Medicine (RITM), Bureau of Research and Laboratories or BRL (which was later replaced by SACCL), DOH Regional Health Laboratories and Regional Field Offices, and Local Surveillance Units (City Health Offices). The DOH project staff was composed of the Resident Advisor, Project Administrator, Surveillance Nurses, Administrative Assistant, Driver, and two other staff supporting PNAC.

Both the BRL and RITM were responsible for HIV testing of blood samples collected from the various sentinel surveillance sites, but RITM was

the supervising laboratory and implementor of the laboratory quality assurance program. In the latter part of 2000, BRL was closed and replaced by SACCL, which became responsible for the supervision and implementation of quality assurance program for HIV/AIDS.

The DOH was re-engineering its structural organizational unit and people were assigned and re-assigned to the newly created offices. By this time, the FETP was already under the NEC. BRL was phased out, but SACCL took over the function of a reference laboratory for HIV/AIDS. Local implementation by LGUs and partners like RI and NGOs continued. Other DOH offices like the NASPCP and PNAC continued its support.

The NASPCP determined the information required from the NHSSS and provided program support and advice to FETP. The technical officer provided technical support to surveillance activities. The NEC managed resources including personnel, supplies, and equipments, defined the technical aspects of HIV surveillance, and completed reporting requirements to the WHO. The Resident Advisor was tasked to work with the FETP to provide an overall coordinative focus within the DOH for the NHSSS activities and to participate in the overall planning, organization, implementation, monitoring, and evaluation. A GPA Technical Officer, in partnership with the Resident Advisor, supervised the implementation of the project.

In the LGUs, the City Health Offices, the Social Hygiene Clinic, the local surveillance units and surveillance technical team, with local NGO partners and research institutions, were responsible for the implementation of the HSS and BSS.

During the extension phase, the NEC-DOH, the principal unit involved in infectious disease surveillance in the country, was responsible for over-all management, technical guidance, and field supervision of the surveillance system. It was in charge of analyzing data and disseminating the results. The RIs conducted the BSS activities, while the STD teams of City Health Offices implemented the HSS activities. The WHO, meanwhile, provided the necessary technical and administrative support.

#### **4.4 Sites and Population Groups**

As mentioned, in 1993 the initial sites were Cebu City and Quezon City. The following year, the cities of Pasay, Angeles, Iloilo and Davao were added. General Santos and Cagayan de Oro were also included in 1995. In 1996, the cities of Baguio and Zamboanga were monitored. In 1997, Cagayan

de Oro was removed from the list, followed by Baguio in 1998. They were removed because they didn't have cases in their registry and in HSS results, and because of financial limitations. But despite their exclusion from USAID support, the DOH continued to give them technical support in terms of information dissemination and other material resources.

The HRGs included for HSS were the following:

- Registered Female Sex Workers (RFSWs)
- Freelance Sex Workers (FLSWs)
- Men Having Sex With Men (MSM)
- Male Clients of STI clinics (MSTD) and Male Commercial Sex Workers (MCSWs)
- Special HRGs: Injecting Drug Users (IDUs), Men At Risk (MAR), Deep Sea Fishermen (DSF) and military recruits

However, these HRGs were reduced to four – freelance sex workers (FLSWs), MSM, registered female sex workers (RFSWs), and IDUs – in 1998 and 1999 because of the group population in certain sites were small. The MSTD and MCSWs were included until 1996. For the BSS, RFSWs, FLSWs, MSM and IDUs were the first HRGs to be monitored.

Specifically:

- RFSWs are women, usually with health cards, employed in establishments where sexual favors are solicited in exchange for money (i.e. bars, massage parlors, night clubs and beer houses), and who reported having sex with clients during the past week prior to interview.
- FLSWs are non-establishment-based women who exchange sexual favors for money and can often be found in movie theaters, discotheques, resorts and hotel lobbies. They have reported having sex with clients during the past week prior to interview.
- MSM are men who have sex (anal/oral) with other men, either for economic reasons or for pleasure within the past month.
- IDUs are men and women who inject prohibited/regulated drugs for recreation, either intravenously, subcutaneously and/or intramuscularly within the past 6 months.
- MSWs are men who exchange sex for money and work in an establishment for this purpose.
- MSTDs are males who consult private or government STD clinics for STD treatment.

Sentinel groups for the extended NHSSS included the following: RFSWs, FLSWs, MSM, IDUs, and recruits of the AFP. Also, the deep sea fishermen group was included in General Santos. AFP recruits, however, were excluded from BSS.

#### 4.5 Financial Resources

The US Agency for International Development (USAID) grant for the surveillance component of ASEP amounted to \$2,095,020. The grant covered the period starting from September 10, 1993 to September 30, 1997.

Within the duration of the project (1993–2003), the USAID grant amounted to US\$3.8M and GOP contribution to 25% of project costs. For the extension phase (October 1997 to September 2000), the USAID provided US\$900,000. For the no-cost extension phase until September 2002, \$900,000 was allotted. Meanwhile, \$0.26M was allotted for the no-cost extension phase until September 2003. The total amount spent was US\$3.756M. Total GOP contribution was US\$1M from 1993–2002.

### 5.0 ACCOMPLISHMENTS

This section discusses the NHSSS' accomplishments at the national and local levels. The discussion on the national level focuses on the following aspects: (i) information dissemination and education; (ii) capacity-building; (iii) publications/materials developed; (iv) researches; (v) partnership-building; (vi) institutionalization; and (vii) management and supervision. Discussion on the local level focused on the following: (i) results of HSS and BSS; (ii) information dissemination and education; (iii) capacity-building; (iv) researches (v) partnership-building; (vi) institutionalization; and (vii) management and supervision.

#### 5.1 National Level

##### 5.1.1 Information dissemination and education

The NHSSS disseminated information and conducted education activities among partner-local governments, policymakers, NGOs, research institutions, the media, and the general public. Among its major activities include the National Dissemination Forum (NDF), orientation/lectures, radio blitz and distribution of IEC materials.

### ➤ *National Dissemination Forum*

A number of National Dissemination Fora were conducted from 1998–2003. The NDF was the venue for the yearly presentation of the HSS' and BSS' aggregated national results, results of special surveys and studies, new policies and standards relative to the implementation of HIV/AIDS prevention and control. Through NDF, concerted efforts were focused so as to prevent duplication and maximized limited resources to other interventions. It seeks as well to build broad-based public support for activities aimed at preventing the rapid transmission of HIV in the Philippines. Representatives of sentinel sites, organizations undertaking HIV/AIDS intervention programs, policymakers, local government, researchers, media personnel, and international donors were invited to attend this forum. The forum elicited their reactions and suggestions concerning policy, implementation, institutionalization, and mobilization of support.

### ➤ *Orientation/Lecture Activities*

Other activities complementing the NDF were the orientation/lecture activities given by NHSSS staff and partners. These include:

- A lecture entitled *Moving Concepts on "Dealing with the Media."* Its aim was to help sentinel sites hold their own local dissemination fora.
- HIV orientation for the Central Luzon Media Association, which aimed to familiarize the members of the press with the HIV situation in the two major cities of Region III – Angeles and Olongapo. Media people pledged to support the HIV/AIDS program.
- A series of orientation lectures on HSS to WHO fellows on rotation at the Department of Health. Different groups from China, Mongolia, Laos, Vietnam, Malaysia, and Cambodia were oriented.
- Orientation on HIV/AIDS for the San Lazaro Hospital Post-Graduate course, for the RITM in-country training for HIV/AIDS, and for the DOH/SACCL Physician's Training Course.

## 5.1.2 Capacity-building

### ➤ *Management and Technical Review*

The NHSSS conducted Management and Technical Reviews (MTRs) from 1993–2003. These were done every six months after each HSS and BSS round. The objectives of the MTR were to present the results of the HSS and BSS per sentinel site and to identify and solve technical and management issues related to implementation. Participants included officials and staff of the DOH, WHO, USAID, local government units, and some non-governmental organization partners.

### ➤ *Training Courses, Seminars and Workshops*

Basic training courses, seminars and workshops were conducted or attended to by NHSSS staff and partners, such as LGUs, NGOs and RIs in the sentinel sites, to equip them with the necessary knowledge and skills for the effective implementation of HSS and BSS.

The following training/seminar/workshop activities were conducted/attended from 1993–2003:

#### At the local level

- Training of surveillance team to prepare them for the implementation of HSS and BSS, particularly specimen and data collection.
- Training of surveillance team leaders to upgrade the capability and enhance the skills of HIV surveillance team leaders in epidemiology and data management.
- Team preparation workshop to re-orient the surveillance teams with basic knowledge and skills for planning and implementing HSS.
- Orientation Seminar for the National Implementation of HIV Behavioral Sentinel Surveillance, which discussed the following: operational definition of terms and subpopulations at risk, sampling size methodology, uniform interpretation of the questionnaire, analysis of data, reporting and dissemination of data.
- Proficiency training for Medical Technologists which included Laboratory Capability Assessment on all sentinel laboratories.

- Orientation workshop in BSS implementation for teams from sentinel sites.
- Attendance in Training on AIDS Counseling by sentinel nurse to equip NHSSS with counseling skills. This was conducted by Reachout Philippines, an NGO specializing in HIV/AIDS counseling.
- A Regional Epidemiology and Surveillance Unit (RESU) orientation was held by FETP and NHSSS to provide sentinel sites with substantial epidemiological/statistical support.
- Participation at WHO-sponsored workshop on HIV/AIDS and STI surveillance.

#### At the international level

- *HIV risk behavioral surveillance: Country examples, lessons and recommendations for the future, Bangkok, Thailand (August 11-14, 1997).* This workshop was sponsored by Family Health International to come up with recommendations on behavioral surveillance through lessons learned from countries which had already implemented BSS. This was attended by Dr. Maria Consorcia Lim-Quizon, NHSSS Resident Advisor, and Maria Concepcion R. Roces, FETP Program Manager.
- *Workshop on HIV/AIDS and STD Epidemiology in the Western Pacific Region held in Manila.* The workshop aimed to understand the HIV/AIDS/STDs status and surveillance activities developed in the Western Pacific region. Participants were updated on methods for surveillance as well as methods for estimation and projection of HIV/AIDS cases, and estimation and projection of STD cases. The prevention indicators (PIs) were presented and the group discussed the proper interpretation of the PIs.
- *A Seminar Workshop on HIV Surveillance in Berlin, Germany (September 22-24, 1997).* Sponsored by UNAIDS, WHO, Robert Koch Institute, and the German Ministry of Health. This workshop aimed to come up with recommendations on the different reporting systems used to track down the HIV epidemic in different countries particularly HIV serosurveillance, behavioral surveillance, and STD surveillance. This was attended by Dr. Maria Consorcia Lim-Quizon, NHSSS Resident Advisor.
- *Fellowship to Basic STI Research Course* at the University of Washington, USA (July 18-31, 1999). The course enhanced

the surveillance capabilities of participants which helped in expansion efforts. This was participated in by Dr. Ricardo Mateo, Dr. Teresita Esguerra and Dr. Maria Consorcia Lim-Quizon.

- *Participation of NHSSS/FETP at the Monitoring the AIDS Pandemic (MAP) Workshop and the 5<sup>th</sup> International Congress on AIDS in Asia and the Pacific* in Kuala Lumpur, Malaysia (October 23–28, 1999). The status and trends of HIV/AIDS/STI epidemics in Asia and the Pacific were presented by Dr. Maria Consorcia Lim-Quizon, NHSSS Resident Advisor.
- *13<sup>th</sup> International AIDS Conference in Durban, South Africa (July 2000)*. Intervention activities for women in the Philippines were discussed by Dr. Maria Consorcia Lim-Quizon, NHSSS Resident Advisor.
- *ASEAN Expert Group Meeting Cum Study Tour on HIV/AIDS Epidemiology Surveillance International Seminar Workshop* Hanoi, Vietnam, (Nov. 7–11, 2000). This was attended by Dr. Maria Consorcia Lim-Quizon.
- *Attendance in the 6<sup>th</sup> International Congress on AIDS in Asia and the Pacific in Melbourne, Australia (October 6–10, 2001)*. The following made paper presentations on the status and trends of HIV/AIDS/STI epidemics in the Philippines: Dr. Ricardo Mateo Jr. (NHSSS), Ms. Hazel Carillo (NHSSS), Dr. Teresita Esguerra (Angeles CHO), Dr. Ilya Tac-An (Cebu CHO), Ms. Marian Gumayan (Kabalaka), Dr. Carol Carabana (Zamboanga CHO), MS. Carla Ochotorena (ICOM Foundation), Dr. Domingo Non (SHED Foundation), and Dr. Rosita Cueto (Davao CHO).
- *Attendance to the Monitoring the AIDS Pandemic Network Symposium (July 2–4, 2002) and the 14<sup>th</sup> International AIDS Conference (July 7–12, 2002) in Barcelona, Spain*. Dr. Maria Consorcia Lim-Quizon; Dr. Ricardo Mateo Jr., NHSSS Resident Advisor; Ms. Anna Liza Carillo, Sentinel Nurse; and Mr. Noel Palaypayon, Sentinel Nurse, attended and made paper presentations.

### 5.1.3 Publications/materials developed

Based on the available materials, from 1997–2003 the NHSSS was able to produce published and unpublished materials documenting and highlighting the results and experiences on HSS and BSS implementation.

Among its major outputs are the Technical Report of the NHSSS, Annual Newsletters, and the Manual of Procedures (MOP) for HSS, BSS and HIV surveillance system. The development of these MOPs was started in 1996 and completed in 2003. These were undertaken by NHSSS in partnership with individuals from research and academic institutions to provide local health officials with a guide on how to set-up HIV Surveillance System, HSS and BSS. (See Table for Details on the Publications/Materials Developed)

The outputs in this component are as follows:

Outputs	Title	Date
Published	HIV/AIDS Surveillance Report (Newsletters)	1997, 1998 and 2002
	Technical Report of the National HIV/AIDS Sentinel Surveillance System, Status and Trends of HIV/AIDS in the Philippines	1997, 1998, 1999, 2000, 2001 & 2002
	Setting-up an HIV Surveillance System, Manual of Procedures	2003
	HIV Behavioral Surveillance, Manual of Procedures	2003
	HIV Serologic Surveillance, Manual of Procedures	2003
unpublished	Proceedings, Management and Technical Review	1993-2003
	Proceedings, National Dissemination Forum	1998-2003
	HIV/AIDS Surveillance Institutionalization Strategic Planning Workshop	1999
	HIV Behavioral Sentinel Surveillance Systems, Review and Consultation Workshop	2001

#### 5.1.4 Researches

The NHSSS conducted studies and special surveys in partnership with national and local research institutions at the sentinel sites. Most of the researches were conducted in 1999 using both quantitative and qualitative methods. Funds for the conduct of the research project, utilization and dissemination of findings are provided for based on the approved budget allocation. (See Table 1 for details of the researches undertaken)

A total of 12 studies were conducted, namely:

Researches	Title	Date	Research Institution	
		Special Serologic and Behavioral Survey Among Truck Drivers (Phase 2)	1996	TriDev
		Behavioral Surveillance on HIV-AIDS (Phase 3)	1999	ICOM Health Foundation - Western Mindanao State University, Zamboanga City
		Third Behavioral Surveillance in Iloilo City: A Reward Surveillance Report to WHO - Western Pacific Regional Office	1999	KABALAKA Reproductive Health Center
		Study on Reproductive Health Knowledge, Attitudes and Behavior Among Youths in Quezon City	1999	University of San Carlos, Sociology - Anthropology Department
		Prevalence of STIs among Female Commercial Sex Workers and their Clients and Men who have Sex with Men in Angeles City	1999	FETPAFI, Family Health International and IMPACT
		HIV/AIDS Behavioral Surveillance (3 <sup>rd</sup> Round): A Study of Registered and Freelance Female Sex Workers, Men Having Sex with Men and IDUs in Cebu City	1999	
		Behavioral Patterns of High-Risk Groups with HIV in Davao City	1999	Davao Medical School Foundation, Center for Education, Research and Development in Health
		The Vulnerabilities of Filipino Seafarers to HIV/STIs	2002	FETPAFI
		HIV Prevalence Study Among Male Truckers in Central Luzon	2003	FETPAFI
		HIV prevalence survey among male prison inmates in the National Capital Region	2003	FETPAFI
		HIV Prevalence and High-Risk Behavior Among TB Patients in the National Capital Region	2003	FETPAFI
	HIV Behavioral Survey Among IDUs in General Santos	2003	SHED Foundation	
	Contact Tracing Among HIV Positive Cases in the Philippines	2003	FETPAFI	

### 5.1.5 Partnership-building

To strengthen relations with local, national and international partners, the NHSSS undertook partnership building initiatives.

➤ *Efforts at the national level include:*

- Consistent attendance at the regular ASEP partner's meeting.

- Participation in nationwide activities such as the 1998 World AIDS Day.
- Provision of assistance in the area of post-graduate courses and in-country and physicians' trainings on HIV/AIDS to health institutions such as the San Lazaro Hospital, RITM and the DOH/SACCL Physician's Training Course.
- Provision of assistance to private agencies (e.g. Tim Brown and Associates) regarding modeling technique/s for the reduction of HIV transmission.
- Coordination with organizations and institutions such as the Philippine National Red Cross, Bureau of Quarantine and International Health Surveillance, Bureau of Customs, Bureau of Immigration and Deportation, Department of Transportation and Communication and the Field Epidemiology Training Program Alumni Foundation regarding strategies to operationalize studies.
- Coordination with the Kabalikat ng Pamilyang Pilipino Foundation, Inc. regarding current and future interventions.
- Dialogues with USAID, DILG, and the Philippine National AIDS Council to discuss ASEP implementation experiences and intentions to replicate ASEP activities in other cities.
- Presentation of NHSSS program of activities and series of seminar-workshops on the Sentinel STI Etiologic Surveillance System Evaluation (SSESS), which was attended by epidemiologists, government and private STI coordinators, nurses and physicians from Baguio, Angeles, Pasay, Quezon, Legaspi, Batangas, Iloilo, Cebu, Cagayan de Oro, Davao, General Santos and Zamboanga.
- Presentation of the implementation of HSS in the Annual FETP Conference.
- Attended in the 6<sup>th</sup> ICAAP feedback session.
- Presentation of global and national HIV/AIDS status at Manila Doctors' Hospital.
- Conducted advocacy meetings with local chief executives and health officials in some sentinel surveillance sites to share results of HIV surveillance activities, and advocate for the institutionalization of HIV surveillance system in the existing sentinel sites
- Partnership with research institutions in the sentinel sites in the conduct of research projects, utilization and dissemination of findings. Among its partner-RIs include:

- Cebu City

University of San Carlos

- Quezon City	PLOMS
- Pasay City	TriDev
- Angeles City	SALU Foundation
- Zamboanga City	ICOM Foundation
- Davao City	Davao Medical School Foundation
- General Santos City	Mindanao State University
- Iloilo City	Kabalaka Foundation

➤ Efforts at the international level include:

- Conduct of series of orientation lectures on HIV Surveillance and on the Philippine HIV/AIDS situation and initiatives being done to World Health Organization fellows from China, Mongolia and Laos and to other international consultants and officials.
- Participation in the USAID team during the visit of USAID-Washington representative.
- Consultations with the USAID regarding HIV-related activities.
- Attendance in international and landmark activities such as the 14th International AIDS Conference.

#### 5.1.6 Institutionalization

The NHSSS' ultimate thrust was to institutionalize and maintain HSS and BSS activities at the national and local levels beyond 2003. Institutionalization became a recurring and pressing theme in various NDF, MTR, advocacy meetings and other fora, especially with the difficulty of some sentinel teams in convincing LGUs to institutionalize the system. The project aimed to achieve institutionalization through the enactment of policies or local laws that provide support to HIV/AIDS programs, especially adoption and continuance of HSS and BSS, LGU advocacy of and commitment to surveillance activities, budget allocation for HIV/AIDS-related activities, and participation of communities and NGOs in institutionalization.

Efforts by NHSSS concerning the institutionalization of HSS and BSS were the following:

- An "HIV/AIDS Surveillance Institutionalization Strategic Planning Workshop" in 1999. This was organized to explore issues related to institutionalizing surveillance activities. The issues that were discussed include (i) potentials for institutionalization; (ii) activities promoting institutionalization; (iii) necessary factors required for institutionalization; (iv) reasons LGUs should

institutionalize surveillance activities; and (v) the role of ASEP, local governments, DOH and the Phil. National AIDS Council in supporting the institutionalization of surveillance activities.

- Five policy directions, projected in 1999, concerning institutionalization of the project in the different sites, such as:
  - Mandatory education of all entertainers regarding HIV and STD prevention.
  - 100% condom use policy by all entertainment establishments.
  - Regular screening of entertainers for STD.
  - Access to quality health care.
  - Non-hiring of minors.
- The NHSSS' starting a special group of recruits from AFP as surrogates to general male population in 1995. This is another attempt at institutionalization of the HSS in the AFP.
- A national cities sharing workshop in 1996 to advocate for the institutionalization of HIV surveillance and HIV prevention and control program in collaboration with the League of Cities.
- Formulation of a plan to develop an advocacy kit. This kit would include (i) arguments on why it is important to continuously monitor HIV patterns and trends; (ii) economic and social impact of a serious HIV/AIDS epidemic; (iii) cost of institutionalizing surveillance activities; and (iv) case studies on Baguio and Cagayan de Oro.
- Development of Manual of Procedures, namely: (i) Setting-up and HIV Surveillance System, which defined and described public health surveillance in general and disease surveillance in particular and set the stage for and rationale of establishing an HIV/AIDS sentinel surveillance system when the locality's vulnerability to this disease has been adequately assessed; and (ii) HIV Serologic Surveillance and HIV Behavioral Surveillance, which provided the procedures on how to establish HSS and BSS.

These projected policy directions was implemented in some local sentinel sites. It is worth noting that in the 16<sup>th</sup> MTR in 2001, the 8 remaining sentinel sites still being funded by the ASEP committed to institutionalize HSS in their respective health offices and to fully fund HSS implementation from 2002 onwards.

It is also important to note that Baguio City and CDO may be considered as models in the operationalization of HSS and BSS. The LGUs owned the project, institutionalized the system, and maintained the operation of the surveillance activities on a self-reliant basis - meaning, the LGUs had taken full responsibility for operating the system since 1998.

#### 5.1.7 Supervision, monitoring and evaluation

Supervisory visits to sentinel sites were conducted three times per round. The objectives were to assess the sentinel site's preparedness to implement the surveillance round and to discuss the resources needed for the implementation of the 40-day data and blood collection. The visit was to ensure the quality of laboratory activities. Meanwhile, a second visit was undertaken to supervise and monitor the NHSSS teams and the implementation of the surveillance round based on standards set by the central office. A third visit was optional and done to provide assistance in data management.

Other tasks handled by the supervisory team included the following:

- Assistance to sentinel sites in evaluating research institutions for the implementation of BSS.
- Familiarization with the activities of the SHCs.
- Inventory of equipment.

The team was usually made up of NHSSS project members, Field Epidemiology Training Program representatives, laboratory specialists, reference laboratory personnel and representatives from WHO and JICA. Members of the supervisory team even observed actual interviews and data gathering and supervised data collation such as data encoding.

Besides the dealing with the technical aspects of HSS and BSS, the supervisory visits were occasions to monitor the institutionalization processes, collect serological or behavioral data, and distribute procured supplies and equipment.

A team of external evaluators evaluated the surveillance component during ASEP's mid-term evaluation from February 6-28, 1995. The Assessment Team recommended the extension of ASEP's assistance for three additional years, with a new completion date set on September 30, 2000, and

the provision of additional funding to finance surveillance and education activities.

Among their technical findings and recommendations were:

- 6–8 cities were inadequate to monitor HIV prevalence trends in the Philippines.
- Only three risk groups (MSMs, FLSWSs and IDUs) were needed in Cebu City and Quezon City. In all the other sites, only FCSWs should be included in the HSS in the BSS.
- HSS rounds could be carried out annually in all sites except Angeles and Cebu where bi-annual rounds should be maintained.
- The HSS sample size should remain at 200–300 per group. The allotted time period of blood collection could be extended to 3–4 months as needed.

Also, to determine the impact of the surveillance activities, a team of external evaluators conducted an impact/final evaluation of ASEP/NHSSS from April–May 200.

The major findings were:

- The HSS provided 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 had sufficient experience with the HSS to continue it, and several local governments were funding annual seroprevalence surveillance.
- Behavioral surveillance data from ASEP cities showed considerable variation regarding condom use and reported very high use needs to be verified through appropriate methods.
- Condom use data by sex workers should be further disaggregated by partner category (regular/non-regular, paying/non-paying) to make them more useful.
- It was 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 infection would 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 other infectious disease surveillance within the NEC as soon as possible and make associated staffing reductions and administrative changes when integration occurs.

## 5.2 Local Level

This sub-section looks at the latest results of HSS and BSS implementation in the 10 local sentinel sites/cities, namely: Angeles, Baguio, Cagayan de Oro, Cebu, Davao, General Santos, Iloilo, Pasay, Quezon and Zamboanga. A discussion of their accomplishments in the following aspects is also included: (i) information dissemination and education; (ii) capacity-building; (iii) research; (iv) partnership-building; (v) institutionalization; and (vi) publications/materials developed. However, information for each site varies due to lack of substantial data.

Results of HSS and BSS rounds conducted in the 10 sentinel sites were classified into several variables and indicators. Under HSS, syphilis and HIV seroprevalence rates were monitored using the modified Lot Qualified Assurance Sampling (LQAS) method. A 95% confidence interval and seroprevalence of >1% was calculated. For example, a positive result in a sample of 300 is indicative of an HIV seroprevalence of >1% for the particular HRG. If none were found to be positive, then HIV seroprevalence is <1% and not 0%.

Under BSS, indicators were divided into three: demographic profile of core sentinel sites, risk behavioral indicators, and reported health-seeking behavior and sources of information. For the first group, the *age, educational attainment and civil status* of study participants were known. Meanwhile, the risk behavioral indicators dealt with the *knowledge of the three correct ways of HIV prevention* (being faithful to one faithful partner, consistent and correct condom use, and non-sharing of injecting equipment); *number of sex partners* in the past week (for FSWs) or month (for MSM); *consistent condom use* (during last sex with a non-regular, regular-paying and regular non-paying partner); and *injecting drug use*. For the last group, the health-seeking behavior (whom do HRGs consult when experiencing signs and symptoms of STIs?); proportion of reported signs and symptoms of STIs; and credible sources of HIV/AIDS information were monitored.

The HSS and BSS results per site are briefly discussed according to the aforementioned variables and indicators. (See Table 1 for a background on the HSS and BSS sites and study participants; Table 2 for the number of HIV positive subjects per site from 1993–2003; and Tables 3, 4a and 4b for a summary of the HSS and BSS results per site.)

### 5.2.1 Angeles City

HSS and BSS were established in 1994 and 1997, respectively. A total of 17 rounds were conducted among RFSW, FLSW, MSM and MAR. The study participants were between the ages of 14–49. Majority of the RFSW and FLSW were high school graduates while most of the MSM have reached or finished college and are single.

#### ➤ *Results for HSS*

##### Syphilis (SY) seroprevalence

Since 1994, HSS revealed that SY rates for the RFSWs had been low at <5%. A sudden increase, however, from 3% to 13% was observed among FLSWs from 1999–2000 and continued to rise to 16% in 2001. The 2002 SY rate was pegged at 11% and in 2003 at 16%.

##### HIV seroprevalence

HIV positive subjects had been consistently detected among RFSWs and in one round, among the MSM and FLSWs. Based on LQAS, HIV seroprevalence among the HRG groups is >1%. There was a total of 10 HIV+ for RFSWs and 2 for FLSWs.

#### ➤ *Results for BSS*

##### Knowledge on HIV prevention

There was no significant change in knowledge on the three correct ways of preventing HIV transmission among the FSWs and MSM. The 50% level for this variable among the MSM was the lowest recorded for this group in the six years (1997–2002) of BSS implementation in Angeles.

### Credible sources of information

The FSWs cited the government health workers as the most credible sources of information while MSM mentioned television.

### Number of sex partners

RFSWs had an average of two partners per week. For FLSWs, sex partners per week had increased from 2 in 1997 to 18 in 2003. The MSM had 3 partners per month.

### Condom use

About one in every five FLSW consistently used condom during sex. There was a decline in condom use during last sex with a non-regular partner among the RFSWs and most especially among the MSM from 1997 to 2002. In 2003, 53% of RFSWs and 4% of FLSWs reported to have consistently used condom during sex.

### Injecting drug use

Drug users were detected in all HRGs but it was only in the FLSW and MSM groups were 2% of the drug users admitted to using injectable drugs for recreation. For 2003, however, no injecting drug user was reported.

### Signs and symptoms of STI

The proportion of HRGs who reported signs and symptoms of STIs decreased for RFSWs. The MSM had the lowest number of reports ranging from 5-12 during the 1997-2002 period. Meanwhile, the number of reports from FSWs ranged from a low of 8 in 2001 to a high of 38 in 1999.

### Health-seeking behavior

When confronted with signs and symptoms of STIs, the FSWs usually consulted at the SHC while majority of MSM consulted friends.

### ➤ *Information Dissemination and Education*

Local Dissemination Fora (LDF) was conducted to disseminate the results of HSS and BSS rounds at the local level. These became a venue for the CHO, LAC, NGOs, health centers and local media to learn about the current situation of HIV prevalence in the area as well as gain information on high-risk groups' profile, knowledge, attitudes and practices. As the BSS and HSS continue to be implemented every year, the local team that organizes the LDF also made the effort to reach out to other concerned groups that would really benefit from the fora. Hence by 2003, other groups such as bar owners and managers and local truck owners also became part of the LDF.

Outcomes of the LDF were not confined to raising level of awareness. Through the 1998 LDF, the local team was able to solicit support for surveillance activities from local officials, while through the 2003 LDF, the CHD committed to conduct an epidemiology and surveillance training course for local staff.

#### ➤ *Partnership-Building*

The local team partnered with Tri-Dev Specialist Foundation, Inc. in the conduct of its local researches.

#### ➤ *Institutionalization*

Institutionalization efforts at the local level started in 1998 when the Angeles City AIDS Council was established in collaboration with the LGU and local NGOs. The council became the model for other sentinel sites to establish AIDS councils. In 1999, local policies for compulsory STD/AIDS education among owners and entertainers, 100% condom use, penalty for establishments with STD incidence, regular medical examination and non-hiring of minors were proposed. One major accomplishment in this arena was the passing of the City Ordinance No. 106s-2000 in 2000.

The city ordinance now promulgates policies and measures for the prevention and control of HIV/AIDS and STD. It also strengthened the Angeles City AIDS Council by providing its powers and functions. Currently, the local team is pushing for the establishment of the City Epidemiological Surveillance Unit (CESU).

Mechanisms for Institutionalization	Year	Roles of Different Parties	Outcomes
AIDS Council established	1998	In collaboration w/ LGU & NGOs	Given working budget Being considered as a model to be used to encourage all sentinel sites to establish AIDS councils
Proposed local policies (Compulsory STD/AIDS educ. among owners & entertainers; 100% condom use; fine for establishment w/STD incidence; reg. med. exam non-hiring of minors)	1999		
City Ordinance No. 106 s-2000	2000		Promulgates policies & measures for the prevention & control of HIV/AIDS & STD Strengthens the Angeles City AIDS Council by providing its powers & functions
Establishment of the City Epidemiological Surveillance Unit (CESU)			

➤ *Capacity-Building*

Assessments, team preparation and team-building workshops were conducted from 1997 to 2001 at the local level to provide the local team with a venue for the discussion of issues and concerns encountered every HSS and BSS round. These activities serve as preparatory activities for the surveillance rounds, involving the review of questionnaires, manual of procedures and the updating of the team members regarding current developments.

➤ *Supervision and Management*

Supervisory visits were conducted every HSS and BSS round to monitor each implementation process and to assess the basic knowledge and skills of local team members.

## 5.2.2 Baguio City

In 1996, Baguio was selected as one of the four HSS sentinel sites in Luzon. The following year, BSS was also established. However, in 1999, it was dropped from the USAID-ASEP sites due to financial limitations. Despite of its exclusion from the ASEP pilot activities, Baguio City continued the NHSSS component of ASEP through LGU initiatives and with minimal support from the DOH-NHSSS. A total of 14 rounds were conducted among RFSW, FLSW, MSM and MAR. Participants were between the ages of 14-58 and most of them were single. Most of the RFSW and FLSW were able to complete the secondary level of education and most of the MSM were college graduates.

### ➤ *Results for HSS*

#### Syphilis (SY) seroprevalence

HSS since 1996 revealed that SY rates for RFSWs and MSM had been low. The highest SY rate was registered in 1996 among the FLSWs. For 2002, SY rates for the FSWs and MSM were <1%. In 2003, 6 FSWs and 4 MSM were reported to have SY.

#### HIV seroprevalence

HIV positive RFSWs were detected in 2000 and 2002. Based on LQAS, HIV seroprevalence among RFSWs is >1%.

### ➤ *Results for BSS*

#### Knowledge on HIV prevention

In the 1997 BSS, levels for knowledge on three correct ways of preventing HIV was greater than 50% for all HRGs. Except for the waiters, there was an observable decline in the level of knowledge from 1997 to 1998. From 1999 onwards, constant increases in the proportion of HRGs who knew of HIV prevention were noted and in 2002, the levels exceeded 60% except for the FLSWs.

### Credible sources of information

Most RFSWs said that health workers were the most credible source of HIV/AIDS information while the remaining HRGs credited multimedia, particularly television.

### Number of sex partners

The MSM had a median of two sex partners per month. The usual number of sex partners was one per week for the FSWs and one per month for the waiters. As of 2003, MSM had a median of one sex partner per month while FSWs had one sex partner per week.

### Condom use

Consistent condom use rates for all HRGs were very low since 1997, ranging only from 2% to 12%. Although from 2001 to 2002, there was an increase in condom use during last sex with a non-regular partner among RFSWs and MSM. In 2003, consistent condom use for RFSWs was 65% while FLSWs only had 8%. For MSM, 20% reported consistent condom use.

### Injecting drug use

Drug use among all HRGs was >20%. No one admitted using injected drugs for recreation. In 2003, 8 RFSWs and MSM admitted to have used injectable drugs.

### Signs and symptoms of STI

Number of reported signs and symptoms of STIs for FSWs had an average of 12 per year (1997–2002). The MSM had no reported case in 1998 and had the lowest number of reports in all HRGs with a high of only 10 reports in 2001.

### Health-seeking behavior

RFSWs frequently cited SHC as their consultation site when experiencing signs and symptoms of STIs. For FLSWs, they seek help from government clinics and for MSM, from their friends.

↘ *Information Dissemination and Education*

Through the Local Dissemination Fora conducted in 2003, the local team was able to reach out to the members of the Baguio Correspondents Broadcasters' Club and the AIDS Watch Council. Together with staff from the Baguio Health Department, NHSSS, SHC, CHO and the local surveillance team, they participated in the planning for future activities.

↘ *Partnership-Building*

The local team partners with the LGU in the undertaking of its local researches.

↘ *Institutionalization*

Institutionalization efforts in Baguio City started as early as 1997, when the CHO and NHSSS conducted a round table discussion on institutionalization with the city councilors and local health board. In the same year, budget allocation in the CHO for the fiscal year was given for the creation of SHC. The AIDS Council was established in 1998. From 1998 to 1999, the city government and the FETP provided funding and technical support, respectively, for local initiatives. This experience in implementing the HIV serologic and behavioral surveillance with financial support from the LGU was presented as a good practice for institutionalization of surveillance activities in the Philippines.

Mechanisms for Institutionalization	Year	Outcomes
Budget allocation in the CHO for the fiscal year 1997 for the creation of SHC	1997	
CHO & NHSSS conducted round table discussion on institutionalization w/ city councilors & local health board	1997	
AIDS Council established	1998	
Funding from city government & FETP	1998	80% of supplies, reagents & gasoline funded by gov't and 20% by FETP
Funding from city government & FETP	1999	90% of supplies, reagents & gasoline funded by gov't and 10% by FETP
Activities supported by LGU & FETP	1999	

(technical support)

### ↳ *Capacity-Building*

Operationalization trainings, workshops on implementation, team preparation and team-building workshops were conducted at the local level to provide the local team with a venue for the discussion of issues and concerns encountered every surveillance round. These activities serve as preparatory activities for the surveillance rounds, involving the review of questionnaires, manual of procedures and the updating of the team members regarding current developments.

Activity	Year	Topic/s	Participants	Outcomes
Training on the Operationalization of HSS	1996			
HIV Surveillance Orientation & Workshop	1996		LGU officials GOI & NGO members	
Workshop on Implementation	1997	Implementation of BSS	SHC staff CHO members	Site prepared for BSS implementation in the area
Laboratory Capability Assessment	1997			
Team Preparation & Team-Building Workshop	2001	HSS round Manual of Procedures questionnaire	Members of sentinel surveillance team	Prepared teams for HIV serosurveillance round Manual of Operational procedures & questionnaires reviewed Teams updated

### 5.2.3 Cagayan de Oro City

Cagayan de Oro established HSS in 1995 and BSS in 1997. A total of 14 rounds were conducted among RFSW and FLSW. Most of the participants were high school graduates, single and between the ages of 14–57.

However, in 1999, it was dropped from the USAID–ASEP sites due to financial limitations. Despite of its exclusion from the ASEP

pilot activities, CDO continued the NHSSS component of ASEP through LGU initiatives and with minimal support from the DOH-NHSSS.

➤ *Results for HSS*

Syphilis (SY) seroprevalence

HSS revealed that SY rates for RFSWs had been low at <1% from 1997–2002. The FLSWs SY rates showed a decreasing trend from 6% in 2000 to 1% in 2002. However, in 2003, SY rates increased to 1.3%.

HIV seroprevalence

An HIV positive RFSW was detected in 1999. Based on LQAS, HIV seroprevalence among RFSWs is > 1%.

➤ *Results for BSS*

Knowledge on HIV prevention

BSS results from 1997–2002 showed that more RFSWs knew of three correct ways of preventing HIV as compared to FLSWs.

Credible sources of information

Majority of RFSWs and FLSWs mentioned government health workers as credible sources of information.

Number of sex partners

The FLSWs had a median of four sex partners per week compared to one per week for the RFSWs. In 2003, the median number of sex partners for RFSWs and FLSWs were 1 and 2 per week, respectively.

Condom use

From 1997 to 2002, consistent condom use rates were below 27% for both RFSWs and FLSWs. The steady increase in condom use during last sex with a non-regular partner among the RFSWs from 1997 to 1999 was halted in 2000. However, the 2001 level of 58% and the 2002 level of 82% showed a statistically significant increase.

Meanwhile, levels decreased to 13% and 8% for RFSWs and FLSWs, respectively, in 2003.

#### Injecting drug use

As of 2003, many FSWs admitted to have used prohibited drugs but no one admitted to using injectable drugs.

#### Signs and symptoms of STI

The proportion of reported signs and symptoms of STIs in the site from 1997–2002 ranged from 16–42. Years 1999 and 2000 had the highest number of reported cases for RFSWs and FLSWs, respectively.

#### Health-seeking behavior

The Social Hygiene Clinic was the frequently cited consultation site of FSWs when experiencing signs and symptoms of STIs.

#### ➤ *Information Dissemination and Education*

The LDF conducted in 2003 was attended by representatives from LGU, CHD, LAC, CHWs and NGO partners.

#### ➤ *Partnership-Building*

Partnership-building at the local level was strengthened in 2002 when the local team partnered with the NEC and CHD-Northern Mindanao and organizations such as Talikala and Iwag to spearhead campaigns and intervention activities addressing the information and health needs of different high-risk groups. Significant outcomes of these collaborative activities include being able to access MSMs, which is a difficult group to access, and being able to provide high-risk groups with medicines for STI treatment.

Partners	Joint Activities Undertaken	Outcomes	Year
NEC	Planning for implementation of 2003 HIV/STI prevention and control comprehensive plan		2002
Taljkala	Addressing needs of FLSWs (e.g. need for information on HIV/STI) provides assistance (e.g. referrals & steps for prevention, treatment & control) to FLSWs w/ signs & symptoms of STIs		2002
Iwag	Intervention activities	Able to access MSMs for HIV/STI education	2002
Social Hygiene Clinic	Day-time operations of SHC	SHC and surveillance teams assist each other in the operations	2002
CHD-Northern Mindanao LGU	<ul style="list-style-type: none"> <li>HIV/STI Surveillance &amp; BSS</li> <li>Intervention activities</li> <li>researches</li> </ul>	Target groups provided w/ medicines for STI	2002

### ➤ Institutionalization

The NHSSS project was institutionalized in Cagayan de Oro in 1999. Although this area was first considered as a weak prospect for institutionalization, it has proven that it can implement surveillance activities even without the budget allocation that was being given to the other sites. The CDO was included as a sentinel site in 1995 but it was dropped in 1997 because there were no cases in their HIV/AIDS Registry and HSS. Yet even when dropped and without budget, City Health Officers, the NEC of DOH and a local chief executive then decided to push through with the HSS and BSS independently, and they have carried this through until this time. Hence, while not getting any budgetary support, the CDO is still being invited during MTRs, trainings, fora and other activities of the NHSSS.

At present, the local team in Cagayan de Oro is spearheading good practices in its efforts to further strengthen the institutionalization of the project in the area. HSS and BSS rounds are already assured in the 2003 CDOCHO workplan and the funding for this was already approved by the LGU. Also, the 2003 budget for the CDO SHC, which is now fully equipped, is as well guaranteed.

At the policy level, an Executive Order carried out in 2003 now supports the implementation of an HIV/AIDS and STI program

including the organization of a Local AIDS Council. Currently, the local team is lobbying for a local ordinance so that the CDO LAC will be guaranteed of budget support and will continue despite changes in local leadership. This is because the existing LAC created through the Executive Order is still not assured of funding support for implementation of activities. The proposed ordinance is now in its 2<sup>nd</sup> reading at the Committee on Health and Communication on Women.

Mechanisms for Institutionalization	Year	Roles of Different Parties	Issues and Concerns	Outcomes
Lobbying for Local Ordinance	2002		Pushing for passing of local ordinance so that the CDO LAC will be guaranteed of budget support & will continue on despite changes in local leadership because existing LAC created through EO not assured of funding support for implementation of activities	Ordinance now in 2 <sup>nd</sup> reading at the Committee on Health and Communication on Women
Executive Order	2003			Supports the implementation of an HIV/AIDS and STI program including the organization of a Local AIDS Council (LAC)
CDOCHO WorkPlan	2003	CDO LGU approved funding		Funding for HSS and BSS assured in 2003 CDOCHO workplan
CDOCHO WorkPlan	2003			Budget for CDO SHC assured in CDO CHO WorkPlan
SHC				Fully equipped w/ necessary instruments in the laboratory

➤ *Capacity-Building*

Workshops in implementation, assessments, team preparation and team-building workshops were conducted at the local level to provide the local team, the SHC staff and members of the CHO with a venue for the discussion of issues and concerns regarding the implementation of every HSS and BSS round. These activities served as preparatory activities for the surveillance rounds, involving the review

of questionnaires, manual of procedures and the updating of the team members regarding current developments.

Activity	Year	Topic/s	Participants	Outcomes
Workshop on Implementation	1997	BSS implementation	Social Hygiene Clinic staff Members of CHO	Site prepared for the implementation of BSS in the area
Laboratory Capability Assessment	1997			Prepared teams for HIV serosurveillance round
Team Preparation & Team-Building Workshop	2001	HSS round Manual of Procedures questionnaire	Members of sentinel surveillance team	Manual of Operational procedures & questionnaires reviewed Teams updated

#### ➤ *Supervision and Management*

NHSSS representatives visited CDO in 2002 to specifically assist the CHO in planning for the implementation of the 2003 HIV/STI prevention and control comprehensive plan. In the same year, the NHSSS team joined the CDO team during their data gathering for RFSWs and FLSWs. The supervision teams provided checklists for BSS and these are attached to reports.

#### 5.2.4 Cebu City

HSS and BSS were established in Cebu on 1993 and 1997, respectively. A total of 19 rounds were conducted. Groups monitored include RFSW, FLSW, MSM and IDU. The age range of participants was 11–53 and most of them were single. Also, majority of the RFSW and FLSW were high school graduates and most of the MSM completed their college education.

## ➤ *Results for HSS*

### Syphilis (SY) seroprevalence

SY rates for RFSWs had been low at 2% or less except for a 5% level in 1995. On the other hand, SY rates among FLSWs had been consistently high and were pegged at 18% for 2002 and 15% in 2003. SY rates among IDUs declined from 12% in 2001 to 6% in 2002.

### HIV seroprevalence

HIV positive subjects had been detected among RFSWs, MSM, IDUs and MSTDs. Seven HIV positive subjects had been recorded from 1993–2003. Based on LQAS, HIV seroprevalence among these groups is >1%.

## ➤ *Results for BSS*

### Knowledge on HIV prevention

There is a marked increase in the knowledge of three correct ways of preventing HIV among the RFSWs from 2001 to 2002 in contrast to the other three HRGs where levels declined in the same period. No clear trend could be discerned from the six-year proportions recorded for this variable in all HRGs.

### Credible sources of information

For the RFSWs, FLSWs, MSM and IDUs, the cited credible sources of information for HIV were health workers, peer educators, friends and television, respectively.

### Number of sex partners

Among the four groups, the FLSWs had the most number of sex partners at seven per week. In 2003, median number of sex partners for FLSWs lowered to 4 per week while RFSWs had 3 per week. For MSM, they had a median number of 1 sex partner per month.

### Condom use

One in every five FLSWs consistently used condoms during sex. Consistent condom rates among the male study participants had been consistently low from 1997–2002 – the highest in 1997 with only 27% among MSM. Although in 2003, percentages have increased with 55% of RFSWs admitting to have consistently used condoms during sex.

### Injecting drug use

Approximately one in every two FLSWs used prohibited drugs in 2002. Drug use for the same period was lower at 9% and 30% for the RFSWs and MSM, respectively. In 2003, however, 55 of the total study participants admitted to have used injectable drugs.

### Signs and symptoms of STI

Reported signs and symptoms of STIs for IDUs and FLSWs significantly declined. For RFSWs, reports have significantly increased from 8 increased from 8 in 1997 to 30 in 2002.

### Health-seeking behavior

When confronted with signs and symptoms of STIs, most of the study participants consulted the Cebu City STD/AIDS Detection Center. Private clinics were favored by IDUs.

### ✦ *Information Dissemination and Education*

Since 1998, LDF and other information and education activities were conducted at the local level. The 2001 “Establishment-Based Health Education Campaign” on condom use advocacy contributed to the intensification of condom use advocacy in the area. Local Dissemination Fora became the venue for the discussion and distribution of HSS and BSS results to the City Multi-Sectoral STD/AIDS Council representatives, League of Barangay Captains, the DOH-CHD (C. Mindanao), the CHO, SHC, district health officers, NGOs, RESU staff and NHSSS representatives.

It was through one of the LDF in the area that recommendations to monitor activities of the LAC, course regular funds for the program establishment of AIDS council at the barangay

level, conduct in-depth studies to understand condom use and develop strategies to encourage condom use were brought up and discussed. It was also through an LDF that a more proactive Local AIDS Council was established.

Title	Theme/s	Participants	Outcomes	Year
LDF				1998
Establishment-Based Health Education Campaign	Condom use advocacy		Intensified condom use advocacy	2001
Local Dissemination Forum	2002 HSS & BSS results	City Multi-Sectoral STD/AIDS Council reps League of Barangay Captains DOH-CHD (C. Mindanao) CHO NHSSS SHC District Health Officers NGOs RESU staff	the recommendation was to monitor activities of the LAC; course regular funds for the program establishment of AIDS council at the barangay level; in-depth study to understand condom use & develop strategies to encourage use	2003
Local Dissemination Forum	2003 HSS & BSS results	Representatives from GOs, NGOs, CHO, SHC, DHO & RESU	Established a more proactive local AIDS council	2003

➤ *Partnership-Building*

The local surveillance team partnered with the City Health Office in its BSS implementation. It also collaborated with NGOs in its activities such as the implementation of harm reduction strategies, distribution of bleach and water (for instruments), needle exchange program, condom distribution and health education campaign. One major accomplishment from these partnerships is being able to access IDUs, another group which is difficult to access. The team also partnered with the University of San Carlos Social Science Research Center in the conduct of its researches.

➤ *Capacity-Building*

Trainings were conducted as early as 1993, at the start of the NHSSS project implementation. Trainings at this time focused on orientations regarding the local surveillance system. In 1997, a laboratory capability assessment was conducted to educate local

surveillance teams regarding necessary equipments to be used during surveillance. In 2001, the trainings focused more on risk reduction and condom use advocacy. As a result, condom use advocacy intensified in the area during this time. A team preparation and team-building workshop was as well conducted to review surveillance instruments and procedures.

Activity	Year	Topic/s	Participants	Outcomes
Training	1993 (last qtr)- 1994 (1 <sup>st</sup> qtr)	Local surveillance system	Local surveillance staff	
Laboratory Capability Assessment	1997			
Orientation of New Registrants	2001	Condom use advocacy	New registrants	Condom use advocacy intensified
Risk reduction counseling for STD cases	2001	Condom use advocacy		Condom use advocacy intensified
Team Preparation & Team-Building Workshop	2001	HSS round Manual of Procedures questionnaire	Members of sentinel surveillance team	Prepared teams for HIV serosurveillance round Manual of Operational procedures & questionnaires reviewed Teams updated

### 5.2.5 Davao City

In 1994, Davao was chosen as one of the four HSS sentinel sites in Mindanao. It was in 1997 that BSS was established in the site. With these, a total of 14 rounds were conducted among RFSW, FLSW, Clients of FSW and MSM. Those who participated were between the ages of 11-60 and most of them were high school graduates and single.

#### ➤ *Results for HSS*

##### Syphilis (SY) seroprevalence

SY rates for RFSWs had always been <1% and in 2000 and 2001, no RFSW tested positively for SY. There was a big drop in SY rates for FLSWs from a 12% level in 1994 to 2% in 2003.

### HIV seroprevalence

HIV positive RFSWs had been detected in 1995 and 1998. In 2002, one FLSW tested positively for HIV. Based on LQAS HIV seroprevalence among the HRGs in Davao is >1%.

#### ➤ *Results for BSS*

### Knowledge on HIV prevention

The 2002 BSS showed a decline in the proportion of study participants who knew of three correct ways of preventing HIV transmission compared to the 2001 levels.

### Credible sources of information

Mass media, particularly television, was cited by all HRGs as credible sources of HIV/AIDS information.

### Number of sex partners

In 2003, the FLSW had more sex partners at three per week compared to the two per week for the RFSWs. Both the MSM and CFSWs had a median of three sex partners per month.

### Condom use

From 1997 to 2001, an increasing trend for consistency in condom use was noticeable for all HRGs, especially among the FLSWs. However, 2002 levels showed a drop for this variable in the RFSW, MSM and CFSW groups. Except for the CFSWs, condom use during last sex with a non-regular partner among all HRGs was on the rise with proportions as high as 96% for the FLSWs in 2002. Rates, however, dropped to 11% for RFSWs and 14% for FLSWs in 2003.

### Injecting drug use

Approximately one in every five study participants admitted to using prohibited drugs. And of those who admitted using prohibited drugs, 8% used injectable drugs for recreation. In 2003, however, no one was reported to have used injectable drugs.

### Signs and symptoms of STI

Proportion of reported signs and symptoms of STI for RFSWs have increased while reports for both FLSWs and MSM declined from 1997–2002.

### Health-seeking behavior

When confronted with signs and symptoms of STIs, most of the female participants consulted at the SHC. Most MSM consulted friends while most CFSWs consulted private doctors.

#### ➤ *Information Dissemination and Education*

In an LDF conducted in 2002, plans of action for more intensive educational activities in priority barangays were formulated. The plan also included the creation of the Barangay AIDS Plan for expansion of services for STI/HIV/AIDS not only in SHC but also safe motherhood, Family Planning services, services for adolescents and the inclusion of the business sector in the partnership visit. These were discussed with the LGU officials, NHSSS staff, CHWs and members of LAC, GOs, NGOs and DOH–CHD–Southern Mindanao.

#### ➤ *Partnership-Building*

The local team collaborated with the Center for Education, Research and Development in the conduct of its local researches.

#### ➤ *Capacity-Building*

Assessments, team preparation and team-building workshops were conducted at the local level to provide the local team with a venue for the discussion of issues and concerns encountered every HSS and BSS round. These activities served as preparatory activities for the surveillance rounds, involving the review of questionnaires, manual of procedures and the updating of the team members regarding current developments.

#### ➤ *Supervision and Management*

In 2002, as part of supervision efforts conducted in the area, the team conducted a consultative meeting with SHC physicians to

discuss plans for enhancing service at the Social Hygiene Clinic and the training of SHC personnel in relation to HSS activities.

#### 5.2.6 General Santos City

It was in the years 1995 and 1997 that HSS and BSS, respectively, were established in General Santos City. A total of 15 rounds were conducted among RFSW, FLSW, MSM and DSF. The participants' age ranged from 13–71 and most of the RFSW and MSM were high school graduates and single. As to the FLSW, most of them were able to finish their elementary education and are living in.

##### ➤ *Results for HSS*

#### Syphilis (SY) seroprevalence

SY rates for RFSWs had always been <1% since 1998. From a high of 14% SY rate in 1995 for the FLSWs, it declined to 5% in 2003. As for the MSM, SY rate of 2% was detected in 2003.

#### HIV seroprevalence

HIV positive RFSWs had been consistently detected from 1997 to 1999. Based on LQAS, HIV seroprevalence among RFSWs is >1%.

##### ➤ *Results for BSS*

#### Knowledge on HIV prevention

The 2002 BSS showed a general decline in the level of knowledge on three correct ways of HIV/AIDS prevention as compared to the 2001 levels. From 1997–2002, though, knowledge levels of FLSWs and DSF increased. For RFSWs and MSM, levels have decreased from 88–98% in 1997 to 86–76% in 2002.

#### Credible sources of information

The most credible sources of information for HIV/AIDS were the health workers, peer educators, friends and radio for the RFSWs, FLSWs, MSM and DSF, respectively.

### Number of sex partners

In 2003, results revealed an increase in the number of sex partners among the FSWs at four per week. In contrast, the MSM posted a drop in the number of sex partners from five per month in 2001 to two per month in 2003. The DSF had an average of two partners per month.

### Condom use

Although the consistent condom use rate among the RFSWs was maintained at 42% from 1997–2002, this dropped to 25% in 2003. For the FLSWs, consistent condom use was 9% while only 4% for MSM. Marked decreases from the 2001 to the 2002 levels were also apparent in all HRGs for condom use during last sex with a non-regular partner.

### Injecting drug use

As of 2002, four of every five MSM and approximately one of every two FSW and DSF study participants admitted to using prohibited drugs. There were participants who admitted to using injectable drugs for recreation in all HRGs. This is still apparent in 2003 wherein 3 FLSWs admitted using injectable drugs.

### Signs and Symptoms of STI

The proportions of reported signs and symptoms for all HRGs have increased from 1997 to 2002. FLSWs had the highest proportion with 31%.

### Health-seeking behavior

The SHC is the favored consultation site by FSWs and MSM when confronted with signs and symptoms of STIs. The DSF usually consulted their co-workers.

### **➤ *Information Dissemination and Education***

The LDF conducted in 2001, which was participated in by representatives from the CHO, NHSSS, GO, NGO and the media became a venue for reorientation on roles and functions of each member and resulted in the conduct of team-building activities. In the

2003 LDF, participants included academicians, members of the SHED and the Philippine National Red Cross.

#### ➤ *Partnership-Building*

Efforts at partnership building started in 1997 when the local team partnered with the DOH and SHED Foundation, Inc. in its HIV Behavioral Surveillance among commercial deep sea fishermen. Through this partnership, they were able to monitor knowledge on correct ways to prevent HIV infections and on sources of information; identified behaviors that predispose acquiring HIV and determined STI prevalence and health-seeking behavior of the study participants.

The local team continues to collaborate with LGAs, NGOs, City AIDS Councils, the mass media and the local police in joint activities addressing HIV/AIDS and STDs. In 2001, the local team worked with the Mahintana Foundation, Inc. (MFI) in a Forum for Media practitioners and local government officials on STD/AIDS prevention and control. The NHSSS was able to present the global and national situation with regards to HIV/AIDS advocacy and information dissemination.

#### ➤ *Institutionalization*

Institutionalization efforts at the local level started in 1999 when the local team and other partners proposed the following policies in relation to the local entertainment industry:

- Compulsory HIV/AIDS education
- 100% condom use
- regular periodic medical examination
- access to quality RH care
- non-hiring of minors
- drafting of policy implementing guidelines
- lobbying for passage of city ordinances

The following table lists the current practices and efforts at institutionalization:

Mechanisms for Institutionalization	Year
Conducting "monthly calls" on bar owners & managers	1999
Membership of good standing in the Gen. San. City Entertainment Operators Assoc. (GSCEOA) shall be a pre-requisite prior issuance of business permit	1999
Attendance in seminars on AIDS/STD shall be a pre-requisite for registered owners/managers & entertainers in the issuance/renewal of buss. permit & health cert.	1999
Local government shall be responsible for sourcing funds for seminars w/c are to be conducted by accredited NGOs	1999
All entertainment establishments shall display posters & other materials promoting condom use	1999
Bar owners/managers shall promote condom use & be responsible for monitoring this	1999
Bar owners/managers shall shoulder cost of medication of entertainers in excess of 30% weekly incidence of STD cases	1999
Owners of entertainment establishments shall develop & maintain a written RH plan for all workers	1999
In absence of authentic birth cert./legal document, the CH Officer shall determine by way of med. exam & certify as to the age of applicant	1999
A committee shall be created by the GSCEOA to monitor compliance & render decisions re: penalties	1999
Fines shall be imposed for violations & shall be collected from establishment owners by the GSCEOA w/c shall be used to provide med. & social assistance to entertainment/workers	

Part of the institutionalization concerns at the local level at present is the recommendation for LGUs to have freedom in identifying special groups that they perceived to be at risk.

#### ✦ *Capacity-Building*

Hands-on computer training for HS implementers, assessments and team preparation and team-building workshops were conducted at the local level to provide the local team with a venue for the discussion of issues and concerns encountered every HSS and BSS round. These activities served as preparatory activities for the surveillance rounds, involving the review of questionnaires, manual of procedures and the updating of the team members regarding current developments.

#### ✦ *Supervision and Management*

In 1999, visits to establishments were conducted. The said visit also monitored radio and TV broadcasts and newspapers. Annual

analysis of STD/HIV screening and syphilis testing results were also conducted.

### 5.2.7 Iloilo City

HSS was established in Iloilo on 1994 and BSS in 1997. A total of 17 rounds were conducted among HRGs which include RFSW, FLSW, and MSM. The study participants were between the ages of 15–58 and most of them were single and able to complete their high school education.

#### ➤ Results for HSS

##### Syphilis (SY) seroprevalence

HSS since 1997 revealed that SY rates for RFSWs had been at <2%. The SY rates, however, increased from a 2000–2001 level of 7% to 11% in 2002. In 2003, SY rate was 6% for FLSWs and 1% for RFSWs.

##### HIV seroprevalence

HIV positive subjects had been detected among RFSWs in 1995 and 1998 and among FLSWs in 1999 and 2002. Based on LQAS, HIV seroprevalence among these groups is >1%.

#### ➤ Results for BSS

##### Knowledge on HIV prevention

Data from 2001 to 2002 revealed a decreasing trend in the knowledge of three correct ways of preventing HIV in all HRGs. However, comparison of the 1997 and 2002 knowledge levels showed an increase of 18% for RFSWs while FLSW maintained the 45% knowledge level.

##### Credible sources of information

Health workers, peer educators, and television were the most often cited credible sources of HIV/AIDS information among the RFSWs, FLSWs and MSM, respectively.

##### Number of sex partners

Compared to the RFSWs who usually had one sex partner per week, the FLSWs had more sex partners at two per week in 2003. Meanwhile, the MSM had a median of two partners per month.

#### Condom use

From 1996 to 2001, consistent condom use rates for all HRGs decreased. For 2002, there was not much change in the condom use rates except for the FLSW group where there was an increase from 11% in 2001 to 26% in 2002. However, in 2003, this dropped to 13%. As for the RFSWs, consistent condom use rate was 9%.

#### Injecting drug use

All the HRGs had study participants who admitted to using prohibited drugs. Among the MSM, 51% used prohibited drugs, of which, 2% admitted to using injectable drugs for recreation. For 2003, no one admitted using injectable drugs.

#### Signs and symptoms of STI

For the FLSWs and MSM, proportion of reported signs and symptoms of STI has increased. Reports for all HRGs ranged from 3-21 in the years 1997-2002.

#### Health-seeking behavior

When confronted with signs and symptoms of STIs, the RFSWs usually consulted at the SHC. In contrast, FLSWs consulted at an NGO clinic while the MSM consulted with their friends.

#### ➤ *Information Dissemination and Education*

The local team had been conducting information and education activities as early as 1996. These information dissemination drives were triggered by the difficulty in accessing MSMs during that time. Low condom use was also prevalent hence the distribution of IEC materials on the subject by the local team. As a result of these efforts, there was an increased number of MSM participating in surveillance activities and there was an increase also in the number of condom users. The team continues to coordinate with LGUs, CHs, LACs, CHWs and NGOs.

### ➤ *Partnership-Building*

The local team started partnership initiatives as early as 1996. During this time, the team had strong links with NGOs since they were able to work with them in every surveillance activity. In 2001, the local team tapped the CHD-Western Visayas and the City Health Office in the analysis and write-up of the 2001 HSS. In the conduct of local researches, the team collaborates with the KABALAKA Reproductive Health Center.

### ➤ *Institutionalization*

A local ordinance was passed in 2001 Creating the La Paz Maternity and RH Clinic (LPMRHC). The LGU is responsible for its passage. Through this ordinance, the LPMRHC was able to house the Iloilo City SHC and laboratory.

### ➤ *Capacity-Building*

Capacity-Building efforts started as early as 1996. The problem faced by the local team during this time was the increase in syphilis incidences among FCSWs, FLSWs and IDUs. As response, the team undertook a series of lectures on STD and HIV/AIDS. As a result, there was a lowering in the syphilis incidences. Assessments, team preparation and team-building workshops were also conducted from 1997 to 2001 at the local level to provide the local team with a venue for the discussion of issues and concerns encountered every HSS and BSS round. These activities served as preparatory activities for the surveillance rounds, involving the review of questionnaires, manual of procedures and the updating of the team members regarding current developments.

### ➤ *Supervision and Management*

The HSS team was reconstituted in 2000 to 8 members from Iloilo CHO and two from Western Visayas Regional Medical Center. It was also during this time when the CHD-Western Visayas limited its involvement on HSS implementation to technical support and provision of vehicle during rounds.

### 5.2.8 Pasay City

In 1994 and 1997, HSS and BSS were established in Pasay. A total of 17 rounds were conducted among RFSW, FLSW, MSM, and MSTD. The study participants were mostly single and between the ages of 12–55. Most of the RFSW and FLSW were only high school graduates as opposed to majority of the MSM who were college graduates.

#### ➤ *Results for HSS*

##### Syphilis (SY) seroprevalence

HSS since 1994 revealed low SY rates among FSWs. SY rates for FLSWs in 2002 is at 0.4% from 4% in 1994 and for RFSWs at 0.3%. In 2003, rates were 0.7% for RFSWs and 1% for FLSWs.

##### HIV seroprevalence

HIV positive subjects had been consistently detected among RFSWs up to 1996. In 2000, an FLSW tested positive for HIV. Based on LQAS, HIV seroprevalence among these groups is >1%.

#### ➤ *Results for BSS*

##### Knowledge on HIV prevention

The 2001–2002 proportions among FSWs for knowledge of three correct ways of preventing HIV showed a decreasing trend while for the same period, an increasing trend was apparent for the MSM.

##### Credible sources of information

The health workers were cited as the most credible sources of HIV information by most FSWs and MSM.

##### Number of sex partners

In 2003, the FSWs had a median number of three sex partners per week. The MSM had a median of two sex partners per month.

### Condom use

A decrease in consistent condom use rate among the FSWs, especially among the FLSWs was apparent from 2001–2002. The MSM groups, on the contrary, posted a slight increase for the same period. In 2003, 71% of RFSWs and 57% of FLSWs reported to have consistently used condoms during sex.

### Injecting drug use

All HRGs had study participants who used prohibited drugs as of 2002 but no one admitted to using injectable drugs for recreation. In 2003, however, 2 RFSWs admitted to have used injectable drugs.

### Signs and symptoms of STI

RFSWs and MSM who reported signs and symptoms of STI have decreased from 1997–2002. Reports for all HRGs ranged from 3–32 per year.

### Health-seeking behavior

When confronted with signs and symptoms of STIs, the HRGs usually consulted at the SHC and/or private clinics.

### ➤ *Information Dissemination and Education*

In the 2002 and 2003 LDF, the results of the 2002 HSS and BSS results were presented to representatives from NHSSS, LGU, CHD, LAC, CHO, GO, NGO and the media. The main recommendation by the participants was to strengthen advocacy especially among local government officials and partners.

### ➤ *Partnership-Building*

The local team undertook researches in partnership with Tri-Dev Specialists Foundation, Inc.

### ➤ *Capacity-Building*

Assessments, team preparation and team-building workshops were conducted from 1997 to 2001 at the local level to provide the local team with a venue for the discussion of issues and concerns

encountered every HSS and BSS round. These activities served as preparatory activities for the surveillance rounds, involving the review of questionnaires, manual of procedures and the updating of the team members regarding current developments.

#### 5.2.9 Quezon City

HSS was established in 1993 and BSS in 1997. A total of 19 rounds were conducted among RFSW, FLSW, MSM and MSTD. Most of the study participants were between the ages of 13–55, high school graduates, and single.

##### ➤ *Results for HSS*

#### Syphilis (SY) seroprevalence

The HSS revealed that SY rates among the RFSWs were low at <1% from 1997–2002. For the FLSWs, an increase from 0.5% to 4% was noted from 2001 to 2002 and back to 0.5% in 2003. For the RFSWs and MSM, SY rates in 2003 were 0.3% and 2%, respectively.

#### HIV seroprevalence

HIV positive RFSWs were almost always detected. Likewise, MSM, MCSW and MSTD subjects had already been tested positively for HIV in one or two HSS rounds. Based on LQAS, HIV seroprevalence among these groups is >1%.

##### ➤ *Results for BSS*

#### Knowledge on HIV prevention

Significant increase in knowledge on correct ways of preventing HIV was noted among the FLSWs and MSM from 1997–2002. In contrast, a decline from the 2001–2002 proportions was noted for the RFSWs.

#### Credible Sources of Information

The health workers, peer educators and televisions were the most often cited credible sources of HIV information among the RFSWs, FLSWs, and MSM, respectively.

Number of sex partners

As of 2003, FSWs had an average of four sex partners per week while the MSM had three sex partners per month.

Condom use

Only about two in every five FSWs consistently used condoms during sex and a downward trend was evident since 2000. The proportion is even lower among the MSM at 13%. In 2003, consistent condom use rates for RFSWs and FLSWs were 43% and 29% respectively. Compared to the MSM, rates were lower at 12%.

Injecting drug use

From 1997, all HRGs had study participants admitting to the use of prohibited drugs. Three percent of MSM drug users admitted to using injectable drugs in the past six months as of 2002. In 2003, 15 FLSWs and MSM admitted to have used injectable drugs.

Signs and symptoms of STI

Proportion of all HRGs who reported signs and symptoms of STI in the years 1997–2002 ranged from 3–34 per year. The lowest report was observed among MSM and the highest among FLSWs.

Health-seeking behavior

Most study participants mentioned SHCs as consultation sites whenever they are confronted with the signs and symptoms of STIs.

➤ *Information Dissemination and Education*

In the three LDF conducted from 2002 to 2003, the HSS and BSS results for 2001–2003 were highlighted and used in the formulation of the plan of action for sustainability of ASEP activities. Discussions focused on the need for HIV surveillance education and the prevention and control of HIV/AIDS and STI. The LDF were attended by representatives from the Quezon City Health Department and the Division of City Schools, middle managers and representatives from PAH, PNAC, DOH and NGOs.

➤ *Partnership-Building*

The local team partners with the LGU in the conduct of local activities (e.g. World AIDS Day activities within Quezon City). In the conduct of its researches, the team partners with PLOMS Consultancies, Inc.

➤ *Institutionalization*

In Quezon City, the 2001 HIV Surveillance was significant in providing an enabling environment for prevention in Quezon City. The surveillance results were instrumental in the formation of the Quezon City AIDS Council, which is mandated to plan, integrate, coordinate, monitor and evaluate all programs and services concerning AIDS/STD prevention. A local ordinance requiring health certificate applicants to undergo HIV awareness seminar was also enacted. Presently, the City Health Department is advocating for the enactment of 100% condom use by sex workers and allocation of funds to institutionalize the HIV surveillance activities.

In 2002, in response to HIV prevalence and high risk sexual practices in Quezon City, the Quezon City Task Force on AIDS was created and was able to make several accomplishments which included undertaking IEC campaigns especially on condom promotion, supporting the approval of additional funds for STI drugs and assisting in the monitoring of compliance level of establishment-based sex workers for a regular SHC check-up. In response to the BSS findings, the Quezon City government created the Quezon City Anti-AIDS Council, which lobbied for the enactment of ordinances on 100% condom use policy in sex establishments and on mandatory attendance of prospective workers to an HIV seminar. The local team continues to discuss with LGU officials and staff representatives the local ordinance for STI/HIV prevention and control.

Mechanisms for Institutionalization	Year	Roles of Different parties	Outcomes
AIDS Council formed	2001	HSS & BSS team instrumental in providing for an enabling environment	
Local Ordinance enacted	2001		Local ordinance requires health certificate applicants to undergo HIV awareness seminar
Advocacy for enactment of 100% condom use	2001	City Health Department	
Discussion of local ordinance for STI/HIV prevention & control	2002	LGU officials & staff representative form NHSSS	
Quezon City Task Force on AIDS created	2002	HSS & BSS team instrumental in providing for an enabling environment	accomplishments included IEC campaigns on condom promotion, passing of additional funds for STI drugs, monitoring compliance of establishment-based sex workers for a regular SHC check-up
Quezon City Anti-AIDS Council created	2002		lobbied for enactment of ordinances on 100% condom use policy in sex establishments & on mandatory attendance of prospective workers to an HIV seminars

➤ *Capacity-Building*

Initiatives toward building capacities in HIV/AIDS prevention and control started in the last quarter of 1993. Since surveillance activities were just starting at the local level, capacity-building activities focused on training of implementers on the local surveillance process and on the equipping of the team in preparation for surveillance activities. Activities included laboratory capability assessment and team preparation, team-building and team planning workshops. These served as preparatory activities for surveillance implementation since they were venues for the review and discussion of surveillance plan, instrument and procedures.

Activity	Year	Topic/s	Participants	Outcomes
Training	1993 (last qtr)- 1994 (1 <sup>st</sup> qtr)	Local surveillance system	Local surveillance staff	
Training of Implementers	1993			
Equipping of Office	1993			
Laboratory Capability Assessment	1997			
Team Preparation & Team-Building Workshop	2001	HSS round Manual of Procedures questionnaire	Members of sentinel surveillance team	Prepared teams for HIV serosurveillance round Manual of Operational procedures & questionnaires reviewed Teams updated
Planning Workshops & Team Bldg.	2002	For HS team DHO NHSSS (sponsor)	HS team District Health Officers	

### 5.2.10 Zamboanga City

In 1996, Zamboanga was selected as one of the HSS sentinel sites in Mindanao. The following year, BSS was established. A total of 14 rounds were conducted among HRGs which include RFSW, FLSW and MSM. Most of the RFSW and FLSW were able to complete high school and most of the MSM were college graduates. Study participants were between the ages of 14-63 and majority was single.

#### ➤ *Results for HSS*

##### Syphilis (SY) seroprevalence

HSS since 1996 revealed that SY rates for the FLSWs had been consistently higher compared to the SY rates for RFSWs, which was maintained at <1% from 1999-2002. In 2003, SY rates were high at 9% for MSM and 3% for FLSWs. As for the RFSWs, SY rate was 1% and still lower compared to the SY rate of FLSWs.

### HIV seroprevalence

No subject has yet tested positively for HIV from 1993–2003. Based on LQAS, HIV seroprevalence in Zamboanga is <1%.

#### ➤ *Results for BSS*

### Knowledge on HIV prevention

The 1997 to 2002 proportions for knowledge of three correct ways of preventing HIV showed increases in proportion for all FSWs. A decline, however, was observed among the MSM.

### Credible sources of information

Most study participants credited the health workers as credible sources of HIV information.

### Number of sex partners

Based on the 2003 results, it revealed that the RFSWs had more sex partners at two per week compared to the one per week of FLSWs. The MSM had an average of two sex partners per month.

### Condom use

For the FSWs, the 2002 proportions for consistent condom use were the highest registered in the six years of BSS implementation. The steady increase in condom use during last sex with a non-regular partner among the RFSWs was negated by a slight decrease in 2001. About half of the MSM reported that they have used condoms during last sex with their non-regular partner from 1999–2002. In 2003, 34% of RFSWs, 11% of FLSWs and 16% of MSM reported to have consistently used condoms during sex.

### Injecting drug use

As of 2003, drug use among the HRGs was highest among the MSM at 22%. It was only among the RFSWs where injecting drug use was documented. In 2003, however, there was no reported case of injecting drug use.

### Signs and symptoms of STI

The proportion of reported signs and symptoms of STI among all HRGs in the year 1997–2002 ranged from 3–27. The lowest proportion was observed among MSM in 2001 and the highest among RFSWs in 2002.

### Health-seeking behavior

Most study participants mentioned SHCs as consultation sites whenever they are confronted with the signs and symptoms of STIs.

#### ➤ *Information Dissemination and Education*

In 1999, as part of information dissemination strategies, members of the local surveillance team proposed the following:

- Require all RFSWs to undergo an STD/AIDS prevention and control seminar—the mechanisms for which will be developed by multi-sectoral groups.
- Train more freelancers to become peer educators.
- Incorporate STD/AIDS prevention and control information in all routine health departments' information drive such as in food handlers and mothers' class, pre-clinic lectures, pre-marriage counseling sessions and others.
- In coordination with city schools office, provide the students with appropriate information.
- Schedule regular screening and treatment of FLSW symptomatics on site.
- Maintain adequate supply of condoms and STD drugs.

In terms of LDF, the forum conducted in 1998 became the venue for solicitation for support to be used on surveillance activities. New elected local officials were able to give their support. The two LDF conducted in 2003 was participated in by establishment owners and managers, a select group of EFSW and representatives from NHSSS, WHO, City AIDS Council, LGU, DILG and CHO. This list of participants manifests that the local team is opening its fora to other groups that would most learn and benefit from it (e.g. establishment owners and managers).

➤ *Partnership-Building*

The local team partnered with the City Health Office in 1999 in an activity on STD/AIDS prevention and control. In the conduct of local researches, the team coordinates with ICOM Health Foundation.

➤ *Institutionalization*

The local team members had been advocating for LCE's full support of surveillance plans since 1999. In 2001, these efforts were rewarded when Ordinance No. 234 was passed, creating the Zamboanga City Multi-Sectoral AIDS Council. The said ordinance also provided for the appropriation of P2M from funds of the City Treasury to fund projects and purchase medicines for treatment.

➤ *Capacity-Building*

Initiatives in this aspect started in 1996. Since surveillance activities were just starting in the area, capacity-building activities focused on the training on the operationalization of the HSS. Among the activities undertaken were: laboratory capability assessment and team preparation, team-building and team planning workshops. These served as preparatory activities for surveillance implementation since they provide a venue for the review and discussion of surveillance plan, instrument and procedures.

Activity	Year	Topic/s	Participants	Outcomes
Training on the Operationalization of the HSS	1996			
Laboratory Capability Assessment	1997			
Team Preparation & Team-Building Workshop	2001	HSS round Manual of Procedures questionnaire	Members of sentinel surveillance team	Prepared teams for HIV serosurveillance round Manual of Operational procedures & questionnaires reviewed Teams updated

Table 1: Background of HSS and BSS Sites

Site	Date of Establishment		Number of Rounds		HRGs included for HSS and BSS	Demographic Profile of Study Participants		
	HSS	BSS	HSS	BSS		Age Range	Educational Attainment	Civil Status
Angeles City	1994	1997	11	6	RFSW FLSW MSM MAR	14-49	High school	Single
Baguio City	1996	1997	8	6	RFSW FLSW MSM MAR*	14-58	RFSW and FLSW - High school MSM - College	Single
Cagayan de Oro City	1995	1997	8	6	RFSW FLSW	14-57	High school	Single
Cebu City	1993	1997	13	6	RFSW FLSW MSM IDU	11-53	RFSW and FLSW - High school MSM - College	Single
Davao City	1994	1997	8	6	RFSW FLSW MSM Clients of FSW	11-60	High school	Single
General Santos City	1995	1997	9	6	RFSW FLSW MSM DSF	13-71	RFSW and MSM - High school FLSW - Elementary	RFSW and MSM - Single FLSW - Living in
Iloilo City	1994	1997	11	6	RFSW FLSW MSM	15-58	High school	Single
Pasay City	1994	1997	11	6	RFSW FLSW MSM MAR*	12-55	RFSW and FLSW - High school MSM - College	Single
Quezon City	1995	1997	13	6	RFSW FLSW MSM MSTD	13-55	High school	Single
Zamboanga City	1996	1997	8	6	RFSW FLSW MSM	14-63	RFSW and FLSW - High school MSM - College	Single

Note: All HRGs were monitored until 2002 unless otherwise indicated.

\* monitored up to 2001

Table 2: Sites with HIV Positive Subjects (n=57) 1993-2003.

Rounds	HIV Serologic Surveillance Site									
	QC	CC	DC	AC	PC	IC	CDO	GC	BC	ZC
1993	1 RFSW									
1994A	1 RFSW									
1994B	1 RFSW				1 RFSW					
1995A	1 MSM		1 RFSW	2 RFSW						
1995B				2 RFSW 1 MSM	2 RFSW	1 RFSW				
1996A	1 MSTD			2 RFSW						
1996B	1 RFSW	1 IDU		4 RFSW	1 RFSW					
1997	1 RFSW 1 MCSW	1 MSM 1 MSTD		1 RFSW				2 RFSW		
1998			1 RFSW	2 RFSW 1 FLSW		1 RFSW		1 RFSW		
1999						1 FLSW	1 RFSW	1 RFSW		
2000	1 RFSW	1 RFSW		1 RFSW	1 FLSW				1 RFSW	
2001	1 RFSW 1 MSM			2 RFSW						
2002		1 RFSW	1 FLSW	2 RFSW		1 FLSW			1 RFSW	
2003		1 RFSW 1 MSM								
TOTAL	11	7	3	20	5	4	1	4	2	

Note: QC=Quezon City; CC=Cebu City; DC= Davao City; AC=Angeles City; PC=Pasay City; IC=Iloilo City; CDO=Cagayan de Oro; GC=General Santos City; BC=Baguio City; ZC=Zamboanga City

Table 3. Summary of HSS Results

Sites	SY prevalence rates			HIV prevalence rates
	RFSW	FLSW	MSM	
Angeles	1	16		>1%
Baguio	0	1	1	>1%
Cagayan de Oro	0	13		>1%
Cebu	1	15	0	>1%
Davao	0	2		>1%
General Santos	0.3	5	2	>1%
Iloilo	1	6		>1%
Pasay	0.7	1		>1%
Quezon	0.3	0.5	2	>1%
Zamboanga	1	3	9	<1%

Table 4a. Summary of BSS Results (risk behavioral indicators)

Sites	Knowledge of HIV prevention %			Median number of sex partners %			Consistent condom use %			Injecting drug use (% of participants)
	RFSW	FLSW	MSM	RFSW	FLSW	MSM	RFSW	FLSW	MSM	
ASEP TARGETS	>79	>75	>88				>50	>40	>30	<40
AC	63	71	58	2	18	3	53	4		0
BC	73	46	64	1	1	1	65	8	20	8
GDO	83	55		1	2	3	73	8		0
CC	78	50	40	3	4	1	55	25	5	55
DC	66	51	65	2	3		11	14		0
GC	86	60	76	4	4	2	25	9	4	3
IC	56	45	32	1	2	2	9	13		0
PC	88	81	89	3	3	2	71	57		2
QC	84	78	79	4	4	3	43	29	12	15
ZC	64	73	74	2	1	2	34	11	16	0

Table 4b. Summary of BSS Results (health-seeking behavior and sources of info)

Sites	Reported signs & symptoms of STIs %			Health-seeking behavior	Sources of info
	RFSW	FLSW	MSM		
AC	10	28	7	SHC, friends	HW, TV
BC	23	1	3	SHC, GC, PC	HW, TV
CDO	37	25		SHC	HW
CC	30	14	7	SHC, PC	HW, PE, friends, TV
DC	37	17	3	PC, SHC, friends	TV
GC	24	13	16	SHC, co-workers	Radio, HW, PE, friends
IC	16	31	13	SHC, NGO clinics, friends	HW, PE, TV
PC	23	18	3	SHC, PC	HW
QC	13	25	3	SHC	HW, PE, TV
ZC	27	5	6	SHC	HW

Note: QC=Quezon City; CC=Cebu City; DC= Davao City; AC=Angeles City; PC=Pasay City; IC=Iloilo City; CDO=Cagayan de Oro; GC=General Santos City; BC=Baguio City; ZC=Zamboanga City; SHC=Social Hygiene Clinic; GC=Government Clinic; PC=Private Clinic; HW=Health Worker; TV=Television; PE=Peer Educator

## 6.0 SUMMARY OF MAJOR ACCOMPLISHMENTS

Based on the results of the impact evaluation and review of documents, these are the major accomplishments of the NHSSS project:

- The HSS provides a reliable basis for monitoring any changes in HIV/AIDS prevalence.
- HSS and BSS were implemented in 10 sentinel sites.
- HSS and BSS were institutionalized in the cities of Baguio and Cagayan de Oro in 1999 and the remaining sites in 2002.
- In terms of institutionalization, the NHSSS team was able to facilitate the enactment of City Ordinances, local ordinances and Executive Orders.
- Management and Technical Reviews (MTRs) were conducted every after conduct of HSS and BSS.
- Major trainings were undertaken at the national and local levels (e.g. team preparation and team-building workshops, proficiency trainings for medical technologies and training on AIDS counseling).
- National Dissemination Fora were conducted yearly.
- Local Dissemination Fora (LDF) were conducted by each site every year, at least once.

- Supervisory visits were conducted as targeted—three (3) times at every HSS and BSS round.
- Manual of Procedures for HSS and BSS, and on how to set-up an HIV Surveillance System were developed and published.
- Publication of six (6) NHSSS Technical Reports.
- Able to collaborate with LGUs, NGOs, research institutions and other organizations in the conduct of HIV/AIDS activities.
- Four highest-risk groups (RFSWs, FLSWs, MSMs and IDUs) were maintained as study participants for surveillance and able to include special survey groups (AFP, MSTDs, DSFs, truckers, prison inmates, TB patients, seafarers, IDUs and clients of FSWs) in surveillance activities.
- Owners and managers of entertainment establishments, HRGs and truckers (groups usually hard to convince to attend such activities) were reached through capability-building and information and education activities.
- Able to make available and distribute throughout the country statistically reliable time series data on HIV seroprevalence to track changes in HIV seropositivity, monitor progression of the AIDS epidemic in the Philippines and target preventive intervention in the most cost-effective manner.

## 7.0 LESSONS LEARNED

- Sustained and innovative advocacy strategies generate positive and effective responses from LGUs (e.g. institutionalization, ownership and mobilization of resources).
- Ensuring confidentiality of information is necessary in gaining the trust of study participants, as well as in creating a conducive atmosphere for participation where they become more open in their responses.
- Systematic documentation of best practices and failures will greatly help in future formulation of strategies and policies for implementation. It could be noted that there were no case studies conducted on sites which were able to institutionalize or those unable to push through the institutionalization processes.
- The MTR was an effective internal evaluation mechanism of the BSS and HSS activities because it responded to issues and problems confronting the implementors, and discussed good practices of other sites where other sites can benefit.

- A national law is effectively implemented when it is adopted as a local law or policy and guided by implementing rules and regulations which are suited and responsive to local priorities and needs.
- Exchange of experiences and accomplishments among ASEP project areas both in meetings and visits on site served as effective learning tools for LGUs in the process of setting up a more dynamic and effective HIV/AIDS and STI prevention and control program, and for other related actions and innovations. This kind of sharing also strengthens commitment and political will.

## 8.0 RECOMMENDATIONS

### 8.1 On surveillance implementation

- The HSS Teams should support, maintain and exert all efforts to attain the desired sample size of 300 per risk group so that the HSS would be sensitive to detect the presence of HIV at the 1% level. To assist the HIV surveillance teams, the LGU should consider hiring the better performing peer educators and community health outreach workers as contractual or volunteer workers in the CHO.
- Review and improve measures on how to ensure confidentiality of information in order to create a “safe atmosphere” for the study participants.
- The Department of Health and partner agencies should continuously provide technical support to the ten (10) ASEP sites through follow ups, logistics support, field visits, fora and other initiatives to maintain linkages. The attainment of the 100% CUP is the next level to reach and provision of anti-retroviral drugs for the HIV patients at the community level is another tall order to achieve in support of the 3x5 initiatives.

### 8.2 On surveillance findings

- Develop strategies on how to address the wide gap between knowledge and adoption of positive behaviors.

### 8.3 On future undertakings:

- The DOH should consider: (1) maintaining the overseas Filipino seafarers as one of the groups for surveillance with assistance from the different manning agencies and conducting special studies among land-based OFWs; (2)

Advocating for expansion of HIV surveillance in other cities, specifically those that are contiguous to the present sentinel sites; (3) Identifying data sources that will provide denominators for the HIV/AIDS Registry for it to be more informative and useful; and (4) Identifying other core or bridge-groups that have risk potentials for HIV spread and conducting special surveys to assess level of risk.

- Conduct case studies of successful and weak HSS and BSS sites in order to learn from good and failed practices in HIV/AIDS surveillance.
- 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.
- Integrate HIV/AIDS surveillance with the other infectious disease surveillance within the NEC and make associated staffing and administrative actions.
- In compliance to Republic Act 8504 (The Philippine AIDS Prevention and Control Act of 1998), the LGUs, aside from the 10 ASEP sites, should intensify HIV/AIDS education and information campaigns that focused on sub-populations of highest risk to acquiring HIV and other STIs. Likewise, they should have ample supply of condoms and drugs for treating identified persons with STIs.
- Intensify and strengthen advocacy network to influence other LGUs in sustaining and adopting the HSS and BSS in their locality as a priority concern.

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