

PHILIPPINES FINAL REPORT

October 1997–June 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



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Final Report
for the
Implementing AIDS Prevention
and Care (IMPACT) Project in
the Philippines



October 1997 to June 2007

The Philippines Final Report

*Submitted to USAID
By Family Health International*

June 2007

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GLOSSARY OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
ASEP	AIDS Surveillance and Education Project
BBSW	Brothel-based sex workers
CEMSHAD	Center for Multidisciplinary Studies on Health and Development
CHD	Center for Health Development
CHO	City health office
DOH	Department of Health
FSW	Female sex worker
FLSW	Freelance female sex worker
FETPAFI	Field Epidemiology Training Program Alumni Foundation, Inc.
FHI	Family Health International
FHI/APD	FHI's Asia and Pacific Department
HIV	Human immunodeficiency virus
IDU	Injecting drug user
IMPACT	Implementing AIDS Prevention and Care
JFMH	Jose Fabella Memorial Hospital
LEAD	Local Enhancement and Development for Health Project
LGU	Local government unit
MARP	Most-at-risk population
MCSW	Male clients of sex worker
MSTI	Male clients of STI clinic
MOP	Manual of procedures
MSH	Management Sciences for Health
MSM	Men who have sex with men
NASPCP	National AIDS/STI Prevention and Control Program
NEC	National Epidemiology Center
NGO	Nongovernmental organization
NHSSS	National HIV Sentinel Surveillance System
PATH	Program for Appropriate Technology in Health
PCR	Polymerase chain reaction
PDEA	Philippine Drug Enforcement Agency
PNAC	Philippine National AIDS Council
PT	Presumptive treatment
RAS	Rapid assessment studies
RESU	Regional Epidemiology and Surveillance Unit
RFSW	Registered female sex worker
ROFI	ReachOut Foundation International
RPR	Rapid plasma reagin
RHU	Rural health unit
SACCL	STD/AIDS Central Cooperative Laboratory
SSESS	Sentinel STI Etiologic Surveillance System
SHC	Social hygiene clinic
UNAIDS	Joint United Nations Program on AIDS
UP-CPH	University of the Philippines-College of Public Health
UPMDF	University of the Philippines-Manila Development Foundation
USAID	US Agency for International Development
USPF	University of Southern Philippines Foundation
VCT	Voluntary counseling and testing
WAVES	Wo/Men's Access to Vital Education and Services International, Inc.

ACKNOWLEDGMENTS

Family Health International would like to thank the US Agency for International Development (USAID), a strong supporter of the Philippine Government's HIV/AIDS efforts, especially in surveillance and prevention education. USAID's provision of financial support and guidance to local government and nongovernmental partners during the Implementing AIDS Prevention and Care (IMPACT) project contributed to a successful prevention program for the country's most at risk groups.

We would also like to express our gratitude to the agencies involved in the AIDS Surveillance and Education Project and the Local Enhancement and Development for Health Project, bilateral USAID projects implemented concurrently during the life of the IMPACT project: Program for Appropriate Technology in Health; Management Sciences for Health; Philippine Department of Health agencies (National Epidemiology Center, National AIDS/STI Prevention and Control Program, Jose Fabella Memorial Hospital, and the STD/AIDS Central Cooperative Laboratory); Philippine National AIDS Council; De La Salle University; University of the Philippines–College of Public Health; Davao Memorial Medical Center; city health offices and their social hygiene clinics; and various nongovernmental organizations. We appreciate working with all of you, and we value our close and effective collaboration over the course of these projects. By working in close partnership, we were able to collectively contribute to HIV/STI programming in the Philippines.

EXECUTIVE SUMMARY

For almost a decade, the USAID-funded IMPACT Project implemented activities in the Philippines synergistically with the AIDS Surveillance and Education Project (ASEP) and eventually with the Local Enhancement and Development for Health Project (LEAD), both funded by USAID.

IMPACT/Philippines' goals were to improve the management of STIs and HIV/AIDS by increasing the availability, quality, and demand for STI services and to strengthen surveillance to generate quality data to reliably monitor HIV/STI prevalence and trends, program outcome, and impact. With a budget of about US\$2.1 million, the following activities to strengthen STI management and improve second-generation HIV surveillance were completed by IMPACT/Philippines:

- a study to validate and update the National STI Case Management Guidelines
- pilot syphilis screening and treatment among most-at-risk populations (MARPs) in Angeles City
- enhanced STI control in Angeles City and Cebu City
- establishment of a national STI surveillance system, including
 - strengthening of existing STI reporting mechanism from social health clinics (SHCs)
 - establishment of syndromic sentinel site reporting
 - development of a system of periodic surveys to complement STI universal reporting and syndromic site reporting
- population-based survey of male sexual behavior
- national preassessment of the injecting drug user (IDU) situation and response;
- sexually transmitted and blood-borne infection prevalence assessment among men who have sex with men (MSM)
- qualitative and bio-behavioral surveys
- improvement of the national HIV biological and behavioral surveillance, including identification of specific groups of men at high risk for HIV as one of the sentinel surveillance groups, and technical assistance for the implementation and analysis of the 2005 Integrated HIV Behavioral and Serologic Surveillance System (IHBSS).

Among the various donor-assisted projects, IMPACT/Philippines was by far the staunchest partner of the National AIDS/STI Prevention and Control Program—Department of Health (NASPCP-DOH) in the area of STI programming. The evaluations, operations research, training, and other related activities that the project implemented resulted to revisions in national STI guidelines; generation of reliable data for decision-making; crafting of evidence-based interventions; reduction in the prevalence of the more common STIs among MARPs and, eventually, the general population; and improvement in the health delivery system.

IMPACT/Philippines' collaboration with the Department of Health's National Epidemiology Center in HIV second-generation surveillance resulted in the current paradigm for STI surveillance, consisting of universal STI reporting, the Sentinel STI Etiologic Surveillance System (SSESS), and periodic population-based surveys. Triangulation of results from these data sources provided stakeholders with a clearer description of the burden of STI in the country.

The assessment by IMPACT/Philippines of the decade-old HIV biologic and behavioral surveillance system provided the impetus for major innovations to the system—foremost of which was the change in sampling methodology. While previous HIV surveillance results are nongeneralizable to the MARPs under study because of the inherent limitation of convenience sampling, current probability sampling techniques—in use and recommended by the assessment—allowed such generalizations. More importantly, the new system allowed the DOH and local government units (LGUs) to track HIV

prevalence and HIV risk behaviors over time. Likewise, the strengthened system enabled program planners to measure the impact of interventions.

IMPACT/Philippines supported the identification of occupational cohorts of men who were frequent clients of sex workers through rapid assessment studies and advocated that they be included in the active surveillance. This undertaking enabled the DOH to identify potential niches for HIV. Likewise, the project provided inputs for crafting behavior change interventions directed to the men.

Other endeavors supported by IMPACT/Philippines included its attempt to characterize the IDU situation in the Philippines and describe prevailing male sexual behavior and how this may influence the HIV dynamics. The project also supported a hallmark MSM study that debunked the previously held notion that Filipino MSM found in cruising sites were not really into the practice of anal sex. The latter study revealed high prevalence of rectal STI among MSM in cruising sites.

Despite the achievements posted by IMPACT/Philippines, there many gaps remain in STI/HIV programming that should be addressed so that HIV prevalence does not breach the 1 percent mark among the MARPs. The experience from IMPACT showed that sustained STI/HIV/AIDS evidence-based interventions, an enabling environment in which behavior change interventions and effective STI services can be implemented, and a congenial partnership between donors, government, and nongovernmental organizations are paramount to stopping HIV and other STIs dead in their tracks.

PROGRAM STRATEGIES, IMPLEMENTATION, AND RESULTS

In 1993, the USAID funded the AIDS Surveillance and Education Project (ASEP), which aimed to monitor HIV prevalence and HIV risk behaviors through active biologic and behavioral surveillance as well as prevent HIV/AIDS increase through prevention education. From April 1997 to September 2003, the Implementing AIDS Prevention and Care (IMPACT) Project supported ASEP in reducing the prevalence of common STIs, improving surveillance efforts, and refining prevention responses to augment past efforts.

Table 1: Country Program Financial Summary by Year, Philippines.

Fiscal Year	IMPACT Obligation (US\$)
1998	800,000
1999	500,000
2001	100,000
2002	725,000
TOTAL	2,125,000

IMPACT conducted its activities in close collaboration with ASEP implementers and complemented the ASEP program strategy with a budget of more than US\$2 million (Table 1). ASEP ended in September 2003. Although the project was able to meet its salient objectives, gaps were identified in HIV surveillance, education, policy, and advocacy.

With the USAID-funded Local Enhancement and Development for Health Project (LEAD) that began in 2004, IMPACT was again tasked with filling gaps for

HIV/AIDS programming in support of USAID's Strategic Objective 4 for the Philippines: to increase the use of improved effective and sustainable responses to reduce HIV transmission and mitigate the impact of the HIV/AIDS pandemic through enhanced quality, availability, and demand for STI management and prevention services, and improved availability of, and capacity to generate and apply, data to monitor and evaluate HIV/AIDS/STI prevalence, trends, and program.

Country Context

Geographic and Social Landscape

The Philippines is composed of more than 7,000 islands with a population of 87 million people (July 2005). The United Nations Population Fund situational analysis identified the country's annual growth rate as one of the highest in the region at 2.4 percent. Reproductive health services are weak, as evidenced by its high maternal mortality rate of 172 deaths per 100,000 live births and that one out of six pregnancies is unintended and terminated.

HIV/AIDS in the Philippines

The first known HIV/AIDS fatality in the Philippines was a foreign national who died of AIDS-related pneumonia in 1984. Between 1984 and 2006, passive surveillance by DOH's National Epidemiology Center (NEC) recorded 2,719 HIV cases, with sexual transmission as the major route of infection. The estimated number of HIV cases in the Philippines in 2005 was 11,200.

The Joint United Nations Program on AIDS (UNAIDS) categorizes the Philippines as a low HIV-prevalence country. HIV rates in all groups under surveillance—registered female sex workers (RFSWs), freelance female sex workers (FLSWs), men who have sex with men (MSM), male sex workers, injecting drug users (IDUs), and male clients of STI clinics (MSTIs)—have not breached the 1 percent prevalence. The low level of HIV may be due in part to the low number of clients per sex worker, the relatively low number of full-time sex workers, the low proportion of injectors among drug users, the presence of social hygiene clinics (SHCs) for sex workers, and the potential protective contribution of male circumcision.

However, the low HIV prevalence is not a permanent scenario if the Philippines lets its guard down and becomes complacent. Current surveillance information revealed 1 percent HIV prevalence and 81 percent hepatitis C prevalence among IDUs in Cebu City. Coupled with high levels of needle sharing and unprotected sexual partnerships, this is a potential route for further HIV transmission.

HIV transmission knowledge, which is less than 55 percent in all monitored risk groups, falls well below set DOH targets. Consistent condom use remains low in almost all populations and cities surveyed (less than 57 percent in many cities), and risk perception for HIV transmission revolves around drug injection and multiple sex partners, not unprotected sex. The high prevalence of STIs, a known cofactor for HIV transmission, amplifies the risk for the spread of HIV. Direct outreach information and services are sporadic for many cities and populations. Although some outreach interventions are available, no city offers a full package of HIV prevention outreach services. Access to voluntary counseling and testing (VCT) services remains low.

National and Local Policy Response to STI/HIV/AIDS

The Philippine Government responded aggressively to the HIV/AIDS threat and adopted a dual strategy of surveillance and prevention education. The DOH classified HIV/AIDS as a notifiable disease in 1986 and established the National HIV/AIDS Sentinel Surveillance System (NHSSS) in 1993.

The Philippine National AIDS Council (PNAC) created in 1992, is a coordinating body composed of 26 public and private organizations. One of its most significant accomplishments was the enactment of *The Philippine AIDS Prevention and Control Act of 1998* (Republic Act 8504). The law integrated HIV/AIDS education and services into a variety of government departments—Education, Culture and Sports, Health, Interior and Local Government, Labor and Employment, Tourism, Social Welfare and Development, Foreign Affairs, National Economic Development, and Justice.

Program Strategies and Activities

In keeping with the USAID HIV/AIDS strategic plan of keeping HIV infections low, preventing infections among the most-at-risk populations (MARPs), and integrating sustainable HIV/AIDS interventions into local government units (LGUs) and nongovernmental organization (NGOs) programs, IMPACT/Philippines set the following goals:

- Improve the management of STIs and HIV/AIDS by increasing the availability, quality, and demand for STI services.
- Strengthen surveillance to generate quality data to reliably monitor HIV/STI prevalence and trends, program outcome, and impact.

To strengthen STI syndromic management in the Philippines, IMPACT conducted a study to validate and update the National STI Case Management Guidelines. It also supported STI services for MARPs, including pilot syphilis screening and treatment in Angeles City and enhanced STI control in Angeles City and Cebu City.

The following were among major activities undertaken to improve the second-generation HIV surveillance system:

- the establishment of a national STI surveillance system that included
 - the strengthening of existing STI reporting mechanism from SHCs
 - establishment of syndromic sentinel site reporting
 - development of a system of periodic surveys to complement STI universal reporting and syndromic site reporting

- a population-based survey of male sexual behavior
- a national preassessment of the IDU situation and response
- an assessment of sexually transmitted and blood-borne infection prevalence among MSM
- qualitative and biobehavioral surveys
- improvement of the national HIV biological and behavioral surveillance, including identification of specific groups of men at high risk for HIV as one of the sentinel surveillance groups, and technical assistance for the implementation and analysis of the 2005 Integrated HIV Behavioral and Serologic Surveillance (IHBS).

IMPACT produced publications and materials that were circulated to partners and became useful reference sources (Table 2).

Table 2: IMPACT Publications, Philippines.

Title	Quantity
<i>Male Sexual Risk Behavior and HIV/AIDS: A Survey in Three Philippine Cities</i>	500
<i>Enhanced STI Control in Angeles City, Philippines</i>	200
<i>Manual of Procedures for Social Hygiene Clinics</i>	200
<i>SSESS Manual of Operations</i>	150
<i>Sexually Transmitted and Blood-Borne Infection Prevalence Assessment in a High Risk Population: MSM the Philippines</i>	150

Strengthening STI Syndromic Management

Validation and Revision of STI Case Management Guidelines

Poor accessibility, acceptability, and availability of services, as well as the rampant use of ineffective drugs, defined STI management in the Philippines. To address this, the DOH included STI services in the health delivery system and promoted STI syndromic case management. To ensure integration of STI services and adoption of correct guidelines for STI management, IMPACT/Philippines, with technical assistance from the Program for Appropriate Technology in Health (PATH)-Philippines, assisted the DOH in evaluating the existing STI syndromic case management guidelines and the risk assessment tools.

IMPACT/Philippines conducted a study in 1998 to

- determine the validity of the flowchart for vaginal discharge
- determine the etiologic agents causing vaginal discharge in women and urethral discharge in men
- assess the validity of the current STI diagnosis and management practices in the study clinics in relation to gold-standard etiologic diagnosis
- improve diagnostic validity of vaginal and urethral discharges and revise national STI case management based on the study results

IMPACT/Philippines collaborated with the DOH, the University of the Philippines-Manila Development Foundation (UPMDF), the University of the Philippines-College of Public Health (UP-CPH), Jose Fabella Memorial Hospital, Davao Memorial Medical Center, PATH, STD/AIDS Central Cooperative Laboratory (SACCL), and the LGUs in the study sites. The two-phase cross-sectional study compared syndromic diagnosis with gold-standard etiologic diagnosis and was completed in 2002. A total of 2,000 women with vaginal discharge and 200 men with urethral discharge participated in the study. In the first phase, the researchers identified various behavioral, clinical, and laboratory factors associated with

chlamydia and gonococcal infections. These factors were used to modify the flowchart for cervical and vaginal infections diagnosis.

The second phase validated the diagnostic performance of the modified flowchart for the diagnosis of cervical and vaginal infections. The flowchart that was developed had moderate sensitivity (79 percent) and low specificity (30 percent). Investigators thus constructed alternative flowcharts and tested them by computer simulation to analyze sensitivity, specificity, and positive predictive values. The cost analyses of the various flowcharts were also determined.

The diagnostic validity and cost analysis of these flowcharts were presented to a technical advisory group. A flowchart with a reasonable sensitivity, specificity, positive predictive value, cost effectiveness balance, and feasibility to implement in the Filipino setting was selected as the recommended national STI case management guideline for vaginal and cervical discharge. A dissemination forum was held during which IMPACT/Philippines presented the findings of the study.

FHI assisted the NASPCP in drafting an administrative order to revise the current national STI case management guidelines. In January 2003, the DOH secretary of health signed administrative order No.5-As 2003 entitled, *Revised National Sexually Transmitted Infections (STI) Case Management Guidelines*. Attachment 1 is the full text of the administrative order, without the flowcharts. IMPACT likewise assisted PNAC to develop the national guidelines on STI diagnosis and management for female sex workers (FSWs), MSM, and transgendered individuals. The guidelines have been used for STI management all over the country. IMPACT organized workshops for health workers to disseminate the new guidelines.

STI Services for MARPs

HIV surveillance revealed low HIV but high syphilis rates among certain MARPs in some sites like Angeles City. This was mainly due to the inability to treat cases because of poor FSW coverage in SHCs, the absence or irregular supply of STI drugs, lack of emphasis on partner notification and treatment, and low condom use. Likewise, the MARPs refused to avail of STI services because of stigmatization, perceived poor quality of SHC services, and fear of being identified. To improve the access to and quality of STI services, IMPACT/Philippines implemented the pilot syphilis screening and treatment among MARPs in Angeles City and the enhanced STI control in Angeles City and Cebu City.

Pilot Syphilis Screening and Treatment Among MARPs in Angeles City

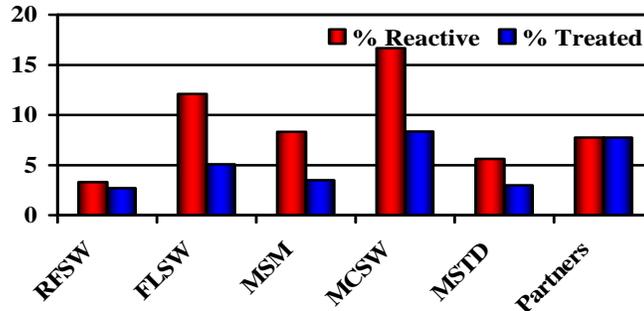
Given the high syphilis prevalence among certain MARPs, its tendency to be asymptomatic and the availability of a cost-effective screening test, IMPACT/Philippines worked with ReachOut Foundation International (ROFI) and the Angeles City Government to

- develop a clinic-based and outreach model for effective screening, diagnosis, and treatment of syphilis
- improve the screening, treatment, and counseling skills of healthcare providers
- increase the number of MARPs screened and treated for syphilis
- increase the number of clients and partners properly counseled in preventing reinfection
- increase the number of partners notified and treated through intensive counseling
- develop a mechanism for government and NGO collaboration
- examine the effectiveness and impact of the intervention and the feasibility of replication
- promote the allocation of resources to sustain the activity after the initial intensive phase of syphilis screening and treatment

An enhanced syphilis screening and treatment study was conducted in Angeles City to address the issue of high syphilis rates among MARPs. This included on-site and clinic-based syphilis screening and treatment.

A total of 2,445 MARPs were screened; 5 percent were reactive and treated for syphilis (Figure 1). Pockets of active syphilis were found among FLSWs who did not have access to STI services or HIV/STI prevention activities.

Figure 1: Percent Reactive and Treated for Syphilis Among MARPs, Angeles City, 1999.



Not all reactive cases were treated with at least one dose of 2.5M unit of benzathine penicillin. Only 60 percent of male clients of sex workers (MCSWs) were treated for syphilis. This was done either on-site or during a follow up visit in the clinic. Of those treated, 8 percent received treatment on the same day and 53 percent during follow-up visits. The 40 percent of cases who were not treated were mostly cases whose blood samples were taken in the field and tested in the clinic. The majority of these cases failed to show up for their test results. Other failure to treat was due to clients being unable to wait for the test results.

The syphilis screening and treatment, in conjunction with outreach education activities and in collaboration with NGOs and the government, was an effective way to reach people most vulnerable to HIV with asymptomatic syphilis.

Enhanced STI Control in Angeles City and Cebu City

After both the pilot syphilis screening and treatment and the prevalence study among MARPs in Angeles City, IMPACT/Philippines proposed an operations research for expanded and enhanced STI treatment to attain a rapid decrease of gonorrhea and chlamydia infection in the cities of Angeles and Cebu using the “STI Control Nexus” model as framework. The general objective of this operations research was to build a model for enhanced STI control through combined government- and NGO-delivered STI interventions to provide an effective STI management package for FSWs. Specifically, the activity aimed to:

- reduce levels of common curable STIs by providing a round of presumptive treatment (PT) to women at high risk
- maintain low prevalence of common curable STIs by strengthening preventive and curative services
- determine the prevalence of gonorrhea and chlamydia among FSWs and MCSWs prior to PT, one month, and six-to-twelve months later
- monitor STI rates in local health facilities during this period through records review

The government SHCs took charge of diagnosis and treatment, while health education, counseling, behavior change communication, and condom promotion and distribution were carried out by partner NGOs. The operations research also included the provision of a single round of PT for FSWs to reduce gonorrhea and chlamydia infection rates. In greater detail, the activities included the following:

- Reinforcement of routine screening of RFSWs using standardized clinical guidelines for STI screening and management. Training on the use of clinical guidelines was provided to healthcare providers at the SHC. The SACCL provided training to strengthen the laboratory capacity of the clinic.
- Collaboration with PATH's existing outreach and peer education efforts to improve access of FLSWs to preventive and curative services.
- Promotion of 100 percent condom use in commercial sex encounters.
- Improvement of access to effective STI treatment for symptomatic men through strengthening services of private-sector doctors and pharmacies. Private practitioners and pharmacists received training conducted by PATH and FHI on STI case management.
- Provision of a single round of PT to FSWs and their clients to rapidly reduce gonorrhea and chlamydia rates. FSWs were randomly selected and given a single, one-time, 1 gram dose of azythromycin as PT for several common, curable STIs; the DOH provided azythromycin for the project. Investigators coupled the provision of the PT with reinforced prevention education and intensified condom promotion through outreach and peer educators. Following PT, health workers encouraged the FSWs to attend ongoing preventive screening services provided by the SHC and outreach clinics.

Table 3: *Neisseria gonorrhoeae* and *Chlamydia trachomatis* Prevalence Among FSWs, Angeles City, Enhanced STI Control in Angeles City Study, 2001.

Timing of Test	<i>Neisseria gonorrhoeae</i> and <i>Chlamydia trachomatis</i> prevalence (%)			
	BBSW	FLSW	RFSW	Guest relations officers
Baseline	52	41	36	20
1 month post PT	27	25	26	6
7 months post PT	23	28	34	25

In Angeles City, the prevalence of *Neisseria gonorrhoeae* and/or *Chlamydia trachomatis* at baseline, one month after PT and seven months after PT for bothel-based sex workers (BBSWs), FLSWs, RFSWs, and guest relations officers are in Table 3.

Declines in *Neisseria gonorrhoeae* and *Chlamydia trachomatis* were significant for all groups one month after PT. Six months later, prevalence remained low for BBSWs ($P<0.001$) and FLSWs ($P=0.05$) but had returned to preintervention levels for the

RFSWs and guest relation officers. Decreases at one month were proportional to the percent of women who had received PT one month earlier. Six months later, ongoing screening methods were more important. The prevalence of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* among clients of FSWs declined from 28 percent early in the intervention to 15 percent ($P=0.03$) six months later.

Table 4: *Neisseria gonorrhoeae* and *Chlamydia trachomatis* Prevalence Among FSWs, Cebu City, Enhanced STI Control in Cebu City Study, 2003.

Timing of Test	<i>Neisseria gonorrhoeae</i> and <i>Chlamydia trachomatis</i> prevalence (%)	
	RFSW	FLSW
Baseline	27	53
1 month post PT	5	24
7 months post PT	19	44

In Cebu City, the prevalence of *Neisseria gonorrhoeae*/*Chlamydia trachomatis* at baseline, one month after PT and seven months after PT for RFSWs and FLSWs are in Table 4. The one-time PT with azithromycin given to FSWs reduced the prevalence of gonorrhea and chlamydia infection. Results of the first assessment one month after PT showed a 71 percent reduction in STI prevalence.

However, STI prevalence increased by 160 percent from its reduced levels after six months. Looking into the succeeding assessment surveys, a continuous reduction in PT coverage was also observed (90 percent first follow-up; 64 percent second follow-up). Among the reasons cited for the low PT coverage were (1) mobility of the women; (2) new women coming into the system; and (3) returning women who had stopped working during the PT campaign. This implies that a large number of women tested at the six months interval had not received PT during the one month PT campaign. If higher PT coverage had been achieved, reductions in STI prevalence would have been greater. In fact, when gonorrhea and chlamydia infection rates at baseline and follow-up surveys were compared, greater reductions were indeed noted among PT recipients. The same outcome was found in the Angeles City study.

The operations research showed that the enhanced STI control package and the single round of PT significantly reduced STI prevalence among FSWs. Through the PT, the STI prevalence was reduced very quickly among FSWs, although the impact was negatively influenced by the relatively low coverage of FSWs. Low STI prevalence was then maintained through strengthened preventive and curative STI services for FSWs and their clients.

The laboratory tests are an essential component of STI control. However, the availability of quality laboratory services is severely limited in most settings owing to cost, expertise, supply, and quality-control constraints. In addition, laboratory tests for specific STI pathogens vary widely in sensitivity and specificity to detect specific etiologic agents and each test has specific requirements for handling and processing. Based on this study, routine laboratory screening done locally showed a 32 percent sensitivity and a specificity of 72 percent. Using the modified screening algorithm, which combines symptoms with clinical and laboratory findings, the sensitivity was increased to 52 percent. The modified screening algorithm was therefore able to detect 20 percent of additional infections compared to routine laboratory screening performed locally.

In conclusion, approximately 3,500 FSWs received a single round of PT with azithromycin for gonococcal and chlamydia infection in Angeles City and Cebu City. Combining government and NGO STI services improved the women's access to STI services. PT dramatically reduced the high baseline prevalence of gonorrhea and chlamydia infections among sex workers. However, PT is a short-term intervention to reduce high STI rates in key populations and is not an STI control measure in itself. To maintain reductions, a broad range of curative and preventive services for all categories of entertainment workers, and for their clients, needs to be strengthened. The research showed a need to improve the quality of STI preventive and curative services and the role of the SHCs in providing STI services.

Development of Manual of Procedures for SHCs

In collaboration with the National AIDS/STI Prevention and Control Program (NASPCP), IMPACT/Philippines developed a manual of procedures (MOP) that described the minimum standards required for satisfactory management of STIs. The National STI Technical Committee approved the development of these standards during a consultation with its members, select SHC physicians, and regional STI coordinators.

The MOP aimed to improve the quality of services and interventions to HIV/STI-vulnerable populations. It prescribed standard guidelines for the daily operations of the SHC, the provision of quality and expanded range of services, including increased coverage for a wider range of clients. It also redefined the role of the SHC not only as a regulatory body issuing health certificates to FSWs but also as a clinic providing quality sexual and reproductive health services.

With funding support from the Management Sciences for Health (MSH)/LEAD, 30 SHC staff received training on the MOP in January 2006. Six months after the training, IMPACT followed up on the use of the MOP in 10 cities and their compliance to standards set by the DOH as contained in the MOP.

Activities included interviews with key staff of the SHC; review of records; observation of client handling and management; inspection of the health facility including physical set-up, equipment, laboratory supplies/reagents and medicines. A checklist was developed to correspond to sections outlined in the MOP. The findings, including identified technical assistance needs, were formally presented through an exit briefing to the concerned LGU officials operating the SHCs. Furthermore, researchers consolidated these findings and presented this to NASPCP-DOH, USAID, and other stakeholders. The Report on the Assessment of Use of MOP for SHCs was presented to various stakeholders and the final report was submitted to NASPCP-DOH in October 2006.

Improving the Second-Generation Surveillance System

Establishing the National STI Surveillance System

STI surveillance findings provide evidence on the magnitude and trends of the STI. These are important for crafting interventions and leveraging support from program planners, policymakers, and decisionmakers. It defines and monitors effective diagnostic and therapeutic guidelines by measuring frequency, distribution, and antimicrobial sensitivity of STI pathogens. The existing monitoring of STIs through syphilis screening in the national HIV surveillance system and through caseload reports from SHCs was inadequate to describe the prevalence and trends of the more common STIs in the Philippines. In a country with a low HIV prevalence such as the Philippines it was imperative that extra effort be made to monitor the trends of STIs and reduce them to the lowest levels possible.

IMPACT/Philippines supported the establishment of an STI surveillance framework to monitor STIs and STI syndromes in conjunction with HIV biologic and behavioral surveillance. To rationalize data collection, IMPACT/Philippines supported the NASPCP to develop the National STD Surveillance Strategy. This provided the Philippines with a reliable monitoring system for measuring prevalence and trends of the more common STIs and to provide data for program planning, management, and evaluation. To complement this initiative, IMPACT/Philippines coordinated with SACCL who provided training to medical technologists of private clinics and SHCs on specimen collection, processing, and laboratory diagnosis.

Upon approval of the STI surveillance strategy (Attachment 2), IMPACT/Philippines worked with the UPMDf to finalize the STI universal reporting protocol. The activities included the following:

- IMPACT/Philippines worked with the Field Epidemiology Training Program Alumni Foundation, Inc. (FETPAFI) to develop the protocol/guidelines for STI sentinel site reporting based on the national health objectives and USAID indicators.
- Investigators conducted the pretesting of the sentinel site reporting in Baguio City, one of the ASEP project sites.
- After three months of pilot testing, during which all primary healthcare units, private practitioners, and NGO clinics in Baguio City were included as reporting sites, IMPACT/Philippines worked with the UPMDf to: (a) finalize the STI universal reporting protocol; (b) conduct a consultation workshop to present the final STI universal reporting protocols incorporating results of the pilot testing for comments, recommendations, and approval; and (c) provide training on integrating STI universal reporting system for SHCs, city health offices (CHOs), rural health units (RHUs) with laboratory capacity in Region 11, and private practitioners.

With support from USAID and NASPCP, IMPACT/Philippines replicated and integrated the system for STI reporting into the NEC to ensure continuous and regular data collection, analysis, and feedback to

provide information to the national and local STI programs. The STI reporting and feedback mechanism is described in Attachments 3 and 4.

Twelve sites fully implemented the new STI universal reporting system in representative areas in the country. While these sites adopted the new reporting system, the rest of the cities and municipalities in the region were still using the old reporting system. To ensure that the STI reporting system would truly be universal, all those involved in the loop were oriented and trained on the schema. IMPACT/Philippines emphasized the flow of reporting and roles and responsibilities of health staff at the different levels of the health system.

IMPACT/Philippines likewise assisted NASPCP in establishing a Sentinel STI Etiological Surveillance System (SSESS). A MOP was developed and 12 sentinel sites were established. To ensure smooth SSESS operations, staff from the 12 government sentinel sites (including their partner private practitioners) were trained on the SSESS and its software for data entry, processing, and analysis. NEC was tasked to implement SSESS.

To ensure consistent flow of information and feedback, IMPACT/Philippines worked with FETPAFI to establish the system for STI reporting from the SHC to the NEC to

- ensure consistent flow of information from SHC through city offices and regional epidemiology and surveillance units (RESUs) to the central STI surveillance unit
- ensure consistent availability of necessary guidelines and reporting forms at the SHC
- ensure capability of staff to report consistently and timely feedback of all surveillance findings after data analysis
- establish evaluation and monitoring of reporting objectives

The effort included the development of a training manual for STI reporting, based on the guidelines and reporting forms for use as a reference, as well as the development of a software application to facilitate data entry, analysis and standardized reporting. It also included orientation training for 30 city and RESU point-persons from all over the country and staff from 12 SHCs and 12 private clinics. Since 2004, 12 SHCs and 12 private STI clinics have consistently submitted timely and satisfactory STI reports based on the reporting guidelines. STI point-persons at the Center for Health Development (CHD) collated data from the clinics and submitted quarterly reports to the NASPCP and NEC.

Lastly, IMPACT/Philippines and FETP developed the protocol for etiologic surveys of STI prevalence among MARPs for the periodic clinical surveys. The MARPs included were FSWs, MSM, and MCSWs. The protocol described the overall and specific objectives, implementation, and activities of the component. It also included the following: (1) a sampling plan (incorporating a sampling frame, study population, criteria for inclusion and exclusion of samples, criteria for site selection, sample size computations, and procedures for sampling that are easily replicated in future surveys); (2) data collection (including procedures and guidelines in sample collection and testing, collection and handling of laboratory specimens, laboratory procedures, operational manual for field and laboratory personnel, and terms of reference of study personnel); (3) data management (specifying the manner of data entry and analysis); and (4) study instruments and forms.

After the protocol development, IMPACT/Philippines worked with FETPAFI to test the protocol by conducting an STI prevalence survey among 300 RFSWs, 100 FLSWs, 100 MSM, and 100 MCSWs in Angeles City to

- determine the prevalence of gonorrhea, chlamydia, syphilis, trichomoniasis, and bacterial vaginoses among FSWs in Angeles City

- to determine the prevalence of gonorrhea, chlamydia, and syphilis among MSM and clients of FSWs in Angeles City
- to develop standard protocols for the periodic surveys of MARPs to support the national STI surveillance system

The final protocol and the manual have been used by NASPCP for periodic surveys of MARPs to support the national STI surveillance system.

IMPACT/Philippines disseminated the results of the study at a national dissemination forum attended by major stakeholders in STI prevention and care programs both at national and local levels. The results were also shared at the National Forum on HIV Serologic and Behavior Sentinel Surveillance. A local dissemination was done in Angeles City during the tripartite meeting of NGOs supported by ASEP. The findings from the study urged the NASPCP to renew its commitment toward STI control.

Population-based Survey of Male Sexual Behavior

IMPACT/Philippines supported the Behavioral Sciences Department of De La Salle University to conduct a population-based survey in the cities of Quezon, Cebu, and Davao to assess the level of HIV/AIDS risk behaviors among males ages 15–44 years in the general population. The objectives of the study included

- identification of risky sexual practices of low-income young and adult males
- identification of the health-seeking behaviors related to HIV/AIDS/STIs among young and adult males
- determination of the factors that influence their sexual and health-seeking behaviors
- formulation of recommendations to aid the crafting of intervention programs

The Male Sexual Behavior Survey, with a sample of more than 6,000 men in the three cities, found that the large majority of Filipino urban men were less likely to acquire and transmit HIV. The men with safer-sex practices were greater in number than those with unsafe sex practices. Unsafe sex was measured by three indicators: (a) having used a condom during sex with sex workers or strangers, (b) having had sex with sex workers or strangers without using condoms, and (c) having had multiple partners. Injecting drugs was also used as an indicator of risky behavior for HIV.

The majority of the men interviewed had sexual experience. Older, married, and working men reported having more sexual activity. The respondents' sexual experience was mainly heterosexual. However, 14 percent of men in the general population had experienced sex with another man, which is high compared to data derived from other Southeast Asian countries. Six percent had experienced injecting illegal drugs. Those who had ever used drugs tended to be more sexually experienced.

During the past 12 months, only 13 percent of the sexually active men reported having had multiple partners. Less than one-tenth had exchanged money for sex. The large majority of men (81 percent) had not used a condom in the past 12 months. Those who were 15–24 years old demonstrated the highest risk behavior. Proportionally more men in this age group had multiple partners and had paid for sex. The same group also reported the highest percentage of bisexual experiences.

The men in this study had moderate to high levels of knowledge about HIV-transmission routes. The majority of men had learned about HIV/AIDS through television, radio, newspapers, magazines, and books.

National Preassessment of IDU Situation and Response

Available data on the number of IDUs in the Philippines are very limited and often conflicting. The DOH estimated that there were 10,000 IDUs, but other sources indicated that the figure may be as high as

400,000. A study conducted in Cebu City in 1993 estimated 2,000 IDUs, while another study in Manila found only one IDU among 960 drug users. Behavioral surveillance in General Santos City reported deep-sea fishermen and FSWs who were IDUs.

The existing responses to reduce the health and social impact of injecting drug use in the country were very limited. Government responses focused an aggressive campaign on supply-and-demand reduction. With the approval of Republic Act 9165 (the Comprehensive Dangerous Drugs Act of 2002) drug users, dealers, and drug syndicates shall be meted with much greater penalties. Due to the illegal nature of drug use, it was very difficult for any organization with HIV-prevention programs to access and serve IDU communities. This is why IDUs were excluded from the sentinel groups of both the HIV serologic and behavioral surveillance in 1994. Very few NGOs implemented HIV-prevention interventions among IDUs. In Cebu, the University of Southern Philippines Foundation (USPF) has been implementing a small-scale program since 1996 through community health outreach workers. The same program was implemented briefly by Kabalikat ng Pamilyang Pilipino in Metro Manila in 1996.

Since available data were very limited to a few cities, understanding the magnitude and patterns of HIV transmission among IDUs became very difficult. Thus, a nationwide IDU situation assessment was both necessary and timely. Results of such an assessment could provide important inputs in developing appropriate programs for IDU communities.

Prior to a national IDU assessment, an assessment in three ASEP sites, representing Luzon, the Visayas, and Mindanao, was highly recommended in order to determine the viability of a national study and develop appropriate data collection instruments and protocols. In June 2003, IMPACT/Philippines funded the Wo/Men's Access to Vital Education & Services (WAVES) International, Inc., to conduct a national preassessment among IDUs in Metro Manila, Cebu City, and Davao City. The objectives were to

- develop data collection instruments and protocols
- produce realistic estimates on the number of IDUs in three ASEP sites
- identify and describe geographic areas or communities with IDUs
- explore the sociodemographic profile of IDUs
- explore drug-taking practices that increase the IDU's vulnerability to HIV and other blood-borne infections
- identify and describe the current interventions targeting IDUs

At the time of the assessment, the Philippine Drug Enforcement Agency (PDEA) was very active in implementing the newly approved Republic Act 9165, which made it difficult to access and recruit IDU respondents. Nevertheless, 104 IDUs and key informants were accessed through focus-group discussions and face-to-face interviews.

The study revealed that the sharing of injecting equipment was the norm in all sites, even for those who knew about its risks. Almost 90 percent of IDU respondents reported to have been sharing equipment with their friends. Practices of reusing or recycling old or used needles and syringes were also common, especially in Cebu. Very few IDUs, however, used the correct cleaning agents, such as bleach and water. Most respondents also reported sexual intercourse in the past six months and that they had not used a condom during the last sexual intercourse. While many respondents were aware that certain diseases could be transmitted through blood via needle sharing, the level of awareness for other diseases, such as hepatitis and malaria, was higher than that for HIV/AIDS. Drugs commonly injected include Sosegon, Dormicum, and Nubain.

The results of these assessments clearly indicated the need for a more intensive IDU assessment linked with an HIV/STI prevalence study at the national level. The assessments also showed that follow-up studies needed to identify good entry points for accessing and building rapport with IDUs.

Qualitative, Behavioral, and Biological Studies of Sexually Transmitted Blood-borne Infection Prevalence among MSM

HIV/STI prevention efforts for hidden populations, especially MSM, remain a difficult and challenging task faced by the NASPCP. In the past years, prevention efforts have been limited by the lack of information and understanding of behaviors of the subgroups in this population, as well as the dynamics of HIV/STI infection. To help address this need, IMPACT/Philippines and the Center for Multidisciplinary Studies on Health and Development, Inc. (CEMSHAD) conducted a formative and qualitative assessment on HIV of MSM that focused on identities, sexualities, and social mobility; and an HIV behavioral and biological assessment of MSM in Metro Manila and Baguio.

The assessment of sexual behavior and practices of MSM and the STI/HIV prevalence study among MSM in selected sites in the Philippines led to a better understanding of their sexual health needs. In addition, the assessment and study helped design appropriate HIV/AIDS interventions for MSM. The first part of study was titled, *Phase 1: A Formative and Qualitative Assessment of HIV/AIDS of MSM in Baguio City, Municipality of Pagsanjan, Municipality of Puerto Galera, and Selected Sites in Metro Manila (Manila, Pasay, and Quezon City): Identities, Sexualities, and Social Motilities*.

Researchers conducted phase 1 of the study from July to October 2004). They used literature review, in-depth interviews, and focus-group discussions to provide insight into the venues where MSM meet and their sexual practices, including number of partners, condom use, sexual risk perception, and health-seeking behaviors. The key findings are summarized below.

- MSM in the Philippines subsume a multiplicity of identities, from highly masculine men whose primary sexual partners are women to “gay” and bisexual men and transgendered individuals. (“Gay” has a slightly different meaning in the Philippines than in Western countries. In Filipino terms, “gay” is usually restricted to effeminate men. Although some organizations and individuals use the word to refer to a broad range of MSM and to imply a sociopolitical viewpoint, the vast majority of MSM in the Philippines do not identify as gay.)
- The diversity of identities is complemented by the diversity of sexual transactions.
- Commercial sex plays a central role in the lives of many MSM, and there are opportunities to buy sex in many different locations, including commercial establishments (such as bars and massage parlors) and public “cruising” areas (such as parks and beaches). Sex may be bought from a wide variety of males, from highly masculine men to men who are very effeminate, and from teenagers to men in their thirties.
- Partners for noncommercial sex are equally diverse, and can also be found in many places. Opportunities for noncommercial sex appear to be increasing, particularly through growing use of the internet and the opening of sex clubs. Travel is also associated with sex, as many men visit other cities and municipalities to seek sexual partners on either a paying or nonpaying basis.
- Anal sex is common, but condom use is low for several reasons, including the stigma associated with condoms and the perception that they reduce pleasure.

Phase 2 of the study, *HIV/AIDS Behavioral and Biological Assessment of MSM in Selected Sites of Metro Manila (Manila, Pasay, and Quezon City) and Baguio City*, was an integrated HIV behavioral and biological assessment conducted between October and December 2004. The study focused on the sexual

behavior of 522 MSM in these locations and the prevalence of gonorrhea, HIV, syphilis, and chlamydia through urine, blood, and rectal swab examinations and their exposure to STI/HIV.

SACCL was commissioned to

- perform urine polymerase chain reaction (PCR) test for the detection of *Neisseria gonorrhoeae/Chlamydia trachomatis* in 522 subjects
- extract blood from 522 subjects and test for syphilis and HIV antibody using rapid plasma reagin (RPR) and enzyme immunoassay (EIA), respectively
- perform confirmatory test for syphilis using FTA-Abs and HIV-reactive blood samples using Western blot

The key findings showed the following:

- Nearly one in three MSM studied had contracted at least one STI; infections were more likely to be rectal than urethral.
- None of the participants in the behavioral and biological assessment tested positive for HIV, but nearly 50 percent of those asked to participate refused. This high rate may indicate that the disease is already present in the various MSM communities.
- Awareness of MSM interventions is low. Although MSM have been the target of a number of HIV/AIDS prevention programs, many of those interviewed claimed never to have heard of the disease. Those who were aware of HIV had poor knowledge of how the virus was transmitted and how transmission could be prevented.
- Health-seeking behavior was further handicapped by the tendency of those who reported STI symptoms to self-medicate, often using ineffective and potentially dangerous methods such as drinking coconut juice or soap suds.

The study results were disseminated in May 2005 among key stakeholders from government, NGOs, community-based organizations, UN agencies, and the private sector in Manila and Baguio. The findings and recommendations were used in the development of the HIV behavioral surveillance questionnaire for MSM, intervention framework, and behavior change communication strategy.

This study may not have detected the presence of HIV, but it has shown that STI rates—rectal STIs especially—are high among MSM in cruising sites. This finding is very significant, since no other local study had ever attempted to check the prevalence of rectal STIs among MSM. Given these results, plus a presence of a vibrant sex industry, the clandestine or covert and diverse sexual networking among MSM, prevalence of risky sexual behaviors, anal sex with multiple partners, low condom use, and increasing prevalence of STIs, the MSM community in the Philippines has all the ingredients for a serious HIV epidemic. The results of these assessments call for a stronger commitment from the Government of the Philippines to strengthen their response in HIV/STI prevention among MSM.

Improving National Biological and Behavioral Surveillance and Technical Assistance to IHBSS 2005

In 2004, the DOH deemed it is necessary to strengthen the second-generation HIV surveillance system to better understand the magnitude of HIV infection and the dynamics of HIV spread. The DOH requested IMPACT/Philippines to assist in the improvement of the behavioral surveillance component of the second-generation surveillance system.

IMPACT/Philippines conducted a review of the system in May 2004. The review identified several ways in which behavioral surveillance in the Philippines might be strengthened as the country moved to

institutionalize its surveillance systems. Potential improvements were identified in three areas: structural, operational, and technical. Based on the assessment, the following recommendations were made to the DOH:

- Revise the national guidelines and protocols for surveillance in relation to the population groups to be included, mapping and sampling methodologies used, sample sizes to be obtained, protocols for anonymity or confidentiality used, and behavioral questionnaires used.
- Develop clear funding mechanisms for national HIV surveillance that will set aside resources for training, quality assurance, data analysis, data use, and for conducting biologic and behavioral surveillance in a minimum number of “core” national sites
- Develop systematic estimates for the sizes of populations at risk.
- Provide training on the analysis and use of biologic and behavioral data for program planning and evaluation purposes.
- Involve staff of NEC, PNAC, DOH, and their regional and local government counterparts in the revision of the guidelines and other modifications.

Following the review, a series of consultations regarding the surveillance system were organized. One of the consultations was a workshop convened by NEC, during which the activities in each of the surveillance sites in the post-ASEP period were reviewed; plans to address the technical issues in the presurveillance process were discussed; and a new set of behavioral surveillance survey questionnaires for four MARPs—FSWs, MSM, occupational cohorts of men, and IDUs—was drafted. The revised methodology and questionnaires were later presented to partners, program managers, and stakeholders at a validation and consensus workshop.

Responding to a recommendation from the behavioral surveillance survey review, IMPACT/Philippines looked at the feasibility of including new subpopulations and occupational groups of men who frequent sex workers in the surveillance system to improve data availability and understanding of HIV dynamics in the Philippines. IMPACT/Philippines carried out rapid assessment studies (RAS) among high-risk men in 10 sentinel sites between November 2004 and February 2005. The RAS looked at the size and gathering places of subpopulations and possible sources through which specimens for unlinked, anonymous testing could be obtained. Researchers used different qualitative research techniques, such as observation, informal and key informant interviews, and focus-group discussions.

The assessments showed that the inclusion of MSM in all but one site would be feasible and useful. Different occupational groups to be included in the surveillance in the different sites were identified, such as construction workers in Cebu City and men in uniform, businessmen, drivers, and laborers in Zamboanga City, government and nongovernment employees in Iloilo City, and tricycle drivers in Angeles City. The assessments also indicated that in places where annual mass HIV testing among FSWs with good coverage was already done by city governments, the surveillance system should use those data instead of duplicating efforts. All of the above led to the design of the 2005 IHBSS that included several innovations (Table 5).

Table 5: Innovations Incorporated in the 2005 IHBSS

- Behavioral and biological components were conducted in tandem.
- Questionnaires were revised to include more questions to measure behavioral risks.
- Interviewer selection criteria were revised and program implementers were not allowed to conduct interviews (to minimize the potential interviewer bias).
- Centralized HIV testing and enzyme-linked immunosorbent assay (ELISA) testing were introduced, and HIV tests became unlinked and anonymous.
- A new group—occupational cohorts of men— was introduced as a proxy for measuring the behaviors of clients of sex workers.
- Probability-based sampling methodology was adopted (instead of convenience sampling).

With support from USAID and LEAD, FHI technical staff provided technical assistance to the DOH in the implementation and analysis of the 2005 IHBSS conducted in 10 sites. FHI and NEC developed a detailed training manual and trained the surveillance team and partners in Cebu City. The team leaders from other sites were also present at the training, and they provided the same training in their respective sites. Technical assistance was also provided to the surveillance teams from 10 sites; assistance ranged from sample-size calculation and sampling methodology to the implementation of data gathering using the sampling frames.

From March to May 2005, 6,371 sex workers, 1,673 MSM, 888 STI patients, 729 IDUs, and 3,328 men in occupational cohort groups were interviewed. The DOH and IMPACT/Philippines supervised and monitored the data collection teams. With IMPACT funds, FHI provided technical assistance to the NEC, RESUs, and HIV-surveillance teams at the city level in data entry, cleaning, and analysis, as well as in report writing and dissemination of the findings in January 2006.

Implementation and Management

The IMPACT/Philippines office, located within the premises of the DOH in Manila, was responsible for the management and day-to-day implementation of the IMPACT activities in the country, including the provision and coordination of technical assistance, monitoring of project activities, and reporting and liaising with key players within ASEP and LEAD. The country office team comprised one country director, one senior technical officer, two technical officers, one finance officer, one administrative assistant, and one secretary. The office staff received management, programmatic, and technical assistance from FHI's Asia and Pacific Department (FHI/APD) in Bangkok, Thailand.

Besides expertise from FHI/APD, IMPACT/Philippines brought in local and international experts to provide technical assistance to the DOH, partner agencies, and implementing agencies. IMPACT/Philippines provided technical oversight of all IMPACT studies undertaken in collaboration with ASEP and the LEAD, including study design, review of study instruments, sampling design, monitoring of study progress, judicious fund use, and review of research findings.

IMPACT/Philippines financially supported and provided technical assistance to the various implementing agencies through 11 subagreements and one small grant (Rapid Response Fund). (Details of subprojects are contained in the section highlighting implementing partner activity.)

In addition, IMPACT/Philippines directly implemented the following activities with technical assistance from FHI and consultants:

- replication of enhanced STI control in Cebu City
- review of the behavioral surveillance system and documented structural, technical, and operational issues to be addressed
- conducted RAS among men in high-risk-behavior groups in 10 sentinel sites to identify specific groups of men at high risk for HIV as additional sentinel surveillance groups
- developed a manual of operations for enhanced STI control for SHCs
- provided technical assistance in the implementation and analysis of IHBSS 2005

Table 6 shows the breakdown of the level of efforts for each subproject.

Table 6: Level of Effort by Subproject, IMPACT/Philippines.

Program Element	IMPACT (US\$)	% Allocation
Validation of STI syndromic case management	279,439	13.15
Improving STI services for MARPs	240,338	11.31
Establishing the national STI surveillance system	157,160	7.40
Population-based survey of male sexual behavior	158,433	7.45
National preassessment of the IDU situation and response	5,889	0.28
STI and blood-borne infection prevalence assessment among MSM	121,932	5.74
Improving national biological and behavioral surveillance	84,167	3.96
Program management, implementation, and operation cost	1,077,642	50.71
Total	2,125,000	100.00

Monitoring and Evaluation

Local FHI staff conducted monitoring and evaluation of the IMPACT/Philippines program with support from FHI/APD. The country director was responsible for monitoring the project implementation through regular meetings, reporting of activity progress by implementing agencies and partners, and periodic on-site visits. Evaluation of activities was done with technical assistance from FHI/APD and external consultants.

Primarily, IMPACT activities provided technical assistance; thus, reporting on progress and achievements of output indicators was done regularly and this constituted the primary type of data reported. IMPACT/Philippines worked closely with LEAD in developing the output indicators and in collecting data that were used as indicators for the project's HIV/AIDS component. IMPACT/Philippines measured the outcome indicators in partnership with the NEC and MSH through IHBSS to track the course of the epidemic and measure behavior indicators related to USAID-supported activities.

Implementation Constraints

Nearly one-third of the men selected for the male sexual health survey did not participate. Part of the refusal rate was due to the absence of selected respondents present at their home during visits. Other reasons were that some men mistook the interviewers as tax collectors, law enforcers, or lawless elements. It was also found that men residing in more well-off neighborhoods refused more often to participate than men in low-income communities. The high refusal rate may have influenced the outcome of the survey, especially with a bias toward lower-income men.

The campaign against illegal drugs by PDEA strongly influenced the injecting drug use assessments. The campaign followed the approval of Republic Act 9165, which imposes capital punishment on those convicted for selling, trading, trafficking, importing, and cultivating dangerous drugs and their controlled precursors. Therefore, recruitment of IDU respondents was very difficult and the criteria for inclusion in the assessment had to be widened to allow those who had not injected in the past six months to also be included in order to interview a sufficient number of former IDUs.

The IDU assessment and rapid assessments among men who engage in high-risk behaviors in 10 sentinel sites aimed to estimate population size in the different sites. Doing so required obtaining statistical data from reliable sources. Although the teams made considerable effort to find such data, they were not able to do so because of weak record keeping and a lack of useful data. The teams had to rely on estimates made by people from the target groups or key informants but were not able to triangulate these figures with data from other sources.

The rapid assessments among men in high-risk-behavior groups identified male cohort groups that should be included in surveillance but that realistically are difficult to include. Businessmen, for instance, were found to be among the most common sex partners of FSWs in several sites; the more affluent men were reluctant to participate in surveillance and many of them do not reside in the cities where they had commercial sex encounters. An important group may have been missed in the surveillance system owing to the difficulty of sampling the identified groups.

Some failure to treat occurred during the syphilis screening study in Angeles City. Although 8 percent of those treated received treatment on the same day, 53 percent received treatment during follow-up visits. Failure to treat was due to the client not being able to wait for the test results or the client's failure to come to the clinic for the result. This often happened in cases when blood was collected in the field and needed to be tested in the clinic.

The PT component of the enhanced STI control study was influenced by the relatively low coverage of FSWs who received PT during the one-month campaign. Although the study results showed that PT can rapidly reduce STI prevalence levels, the study results were negatively influenced by the low coverage due to the high mobility of FSWs. The same study showed very low consistent condom use levels (18–24 percent) and a large population of infected FSWs. Even though PT dramatically reduced the high baseline prevalence of gonorrhea and chlamydia infection, in order to maintain low levels of STI, consistent condom use levels need to be increased.

Until 2004, donors provided funding for the surveillance system. When this support stopped, surveillance needed to be institutionalized within the government system. This meant a severe reduction in resources for the system that influenced the protocols, procedures, and staffing, and made the provision of technical assistance to improve the system more challenging.

Country Activity Timeline

Major Program Deliverables	Fiscal Year									
	97	98	99	00	01	02	03	04	05	
Strengthening STI syndromic management										
Validate STI syndromic case management			X	X	X	X				
Revise the National STI Case Management Guidelines and training manual						X				
Endorsement of the revised National STI Case Management Guidelines by DOH for use nationwide							X			
Improving STI services for MARPs										
Pilot syphilis screening and treatment among MARPs		X	X							
Improve STI services for MARPs through enhanced STI Control in Angeles City				X	X					
Enhance STI control in Cebu City						X	X			
Improving the second-generation surveillance system and technical assistance to IHBSS 2005										
Population-based survey of male sexual behavior		X	X	X	X					
Conduct STI prevalence survey among MARPs to field-test the protocol for the STI surveillance component			X	X						
Establish SSESS as part of the second-generation surveillance system				X	X					
Finalize and expand STI universal reporting				X	X					
Develop a MOP for enhanced STI control for SHCs						X	X			
Conduct a national preassessment of IDU situation and response							X			
Sexually transmitted and blood-borne infection prevalence assessment among MSM: Qualitative, behavioral, and biological studies								X	X	
Review the behavioral surveillance system as part of the second-generation surveillance system								X		
Conduct rapid assessments among men in high-risk-behavior groups in 10 sentinel sites to identify groups of men at high risk for HIV as additional sentinel surveillance groups										X
Provide technical assistance for the implementation and analysis of IHBSS 2005										X

Program Results

Between FY 1997 and FY 2005, IMPACT/Philippines accomplished a number of program results. Key program and service outputs achieved through 11 subagreements, one small grant (Rapid Response Fund), and directly implemented activities under IMPACT are included in the following tables.

Program and Service Outputs via Subagreements and the Rapid Response Fund

Subproject	Program/service outputs
Strengthening STI syndromic management	
Validation of STI syndromic case management	<ul style="list-style-type: none"> ▪ One study protocol developed for study sites ▪ One MOP for field study and health-care workers developed ▪ 12 healthcare workers from four study sites trained on study procedures ▪ 40 health-care providers from study sites trained on syndromic case management ▪ 2,000 women with vaginal discharge and 200 men with urethral discharge were recruited ▪ One consensus workshop held

Subproject	Program/service outputs
	<ul style="list-style-type: none"> ▪ One set of revised national STI case management guidelines with revised flowcharts developed and disseminated ▪ 170 distributed to LGUs and partners
Improving STI services for most-at-risk populations	
Pilot-enhanced syphilis screening and testing in Angeles City	<ul style="list-style-type: none"> ▪ One baseline assessment conducted on the quality of existing services and physical infrastructure of selected SHC and NGO clinics ▪ One set of standard operating guidelines for syphilis screening and treatment developed ▪ 13 health workers trained on STI management and orientated on the guidelines ▪ Two laboratory clinics' capacity upgraded to conduct on-site serologic testing for syphilis ▪ Two medical technologists based in SHC trained at SACCL on syphilis testing ▪ Campaign plan and materials to increase awareness on enhanced screening and treatment developed and used for outreach. ▪ SHC's outreach team reached 407 FLSWs, male sex workers, and MSM ▪ Over 2,445 clients were screened for syphilis, and 5 percent of these who reacted to the test received prepackaged syndromic treatment for genital ulcer ▪ 60 percent of clients were treated for syphilis infection
Enhanced STI control in Angeles City	<ul style="list-style-type: none"> ▪ One study protocol STI prevalence surveys developed and used by NASPCP ▪ 15 health workers trained on study protocol ▪ One baseline STI prevalence study conducted prior to a single round of PT ▪ 300 RFSWs and 200 FLSWs given PT ▪ 200 clients of FSWs recruited ▪ Two assessments conducted at 1 month and 7 months after a single round of PT ▪ One local and a national dissemination of the study results conducted
Enhanced STI control in Angeles City, laboratory testing for PCR GC and <i>Chlamydia trachomatis</i>	<ul style="list-style-type: none"> ▪ Five field-research assistants trained in specimen collection and handing of specimen ▪ Urine PCR for gonorrhea and chlamydia among 300 RFSWs and 200 FLSWs performed during baseline STI prevalence survey ▪ Urine PCR for gonorrhea and chlamydia among 300 RFSWss 200 FLSWs and 200 clients of FSWs performed one month after a single round of PT ▪ One report of PCR laboratory results submitted
Improving the second-generation surveillance system	
Establishing the national STI surveillance system 1. Establishing SSES 2. Developing systems for the national STI surveillance 3. Developing a system of periodic surveys.	<ul style="list-style-type: none"> ▪ 36 health workers trained on syndromic case management and reporting of cases ▪ One field testing of protocol conducted in Baguio City ▪ One workshop held to finalize the protocol ▪ One protocol for STI syndromic sentinel site reporting for STI surveillance developed ▪ One consultation workshop held to present the final protocol for approval ▪ One training manual on STI reporting developed ▪ One software application for STI reporting developed and distributed to 12 sentinel sites ▪ 51 health-care providers from 17 city health offices/SHCs and rural health clinics in Region 11 trained on STI reporting. ▪ 60 staff from 12 SHCs and 12 private STI clinics trained on STI reporting and use of software ▪ One protocol on etiologic surveys of STI prevalence among MARPs developed for the national STI surveillance component of periodic clinical surveys ▪ One operational manual and guideline developed for use by health-care workers ▪ An STI prevalence survey conducted among 100 registered FSWs, 100 freelance FSWs, 100 MSM and 100 clients of sex workers in Angeles City to test the protocol ▪ The results of the study disseminated at a national dissemination forum attended by major stakeholders in STI prevention and care programs both at national and local levels ▪ One final protocol adopted for the periodic surveys of MARPs to support the national STI surveillance system
Population-based survey of male sexual behavior	<ul style="list-style-type: none"> ▪ One set of criteria for geographic site selection developed ▪ One study protocol including study instruments developed ▪ Three supervisors and 25 interviewers trained

Subproject	Program/service outputs
	<ul style="list-style-type: none"> ▪ One study conducted among 3,615 male respondents ▪ Study results disseminated at the National Dissemination Forum of HIV and Behavioral Sentinel Surveillance, also disseminated locally in Cebu City and Davao City ▪ Final survey report submitted
National preassessment of IDU situation and response	<ul style="list-style-type: none"> ▪ One study protocol including study instruments developed ▪ One assessment conducted among 104 IDUs and key informants were interviewed ▪ One assessment report produced
Sexually transmitted blood-borne infection prevalence among MSM: Qualitative, behavioral, and biological studies	<ul style="list-style-type: none"> ▪ One formative and qualitative assessment conducted ▪ One behavioral and biological assessment conducted among 522 MSM ▪ Study results disseminated in Manila and Baguio in May 2005. ▪ One final report produced
Laboratory testing for sexually transmitted and blood-borne infection prevalence assessment among MSM in selected sites of Metro Manila cities and Baguio City	<ul style="list-style-type: none"> ▪ Five medical technologists trained on proper specimen collection, storage, packing, and transport of the collected specimen from study sites to the central laboratory ▪ Urine PCR test for the detection on <i>Chlamydia trachomatis</i> and <i>Neisseria gonorrhoeae</i> performed on 522 study participants ▪ Blood samples from 522 study participants tested for syphilis and HIV-antibody screening using RPR and EIA, respectively ▪ Confirmatory test on syphilis using FTA-Abs and HIV-reactive blood samples using Western blot performed ▪ One report of laboratory results submitted

Program and Service Outputs via Directly Implemented Activities

Activity	Output
Replication of enhanced STI control in Cebu City	<ul style="list-style-type: none"> ▪ One study protocol and instruments developed ▪ 24 health workers trained on study protocol ▪ One baseline STI prevalence study conducted prior to a single round of PT ▪ 1,193 RFSWs and 205 FLSWs given PT ▪ 200 clients of FSWs were recruited ▪ Two assessments conducted 1 month and 7 after a single round of PT ▪ One local and a national dissemination of the study results conducted
Development of the MOP for enhanced STI control for SHCs	<ul style="list-style-type: none"> ▪ MOP for enhanced STI control for SHCs ▪ 30 health workers trained on the manual ▪ 30 manuals distributed to SHCs
Review of the HIV behavioral surveillance system	<ul style="list-style-type: none"> ▪ One review of the HIV behavioral surveillance system conducted ▪ Structural, technical, and operational issues documented and addressed ▪ Improved design of the 2005 IHBSS adopted and implemented by DOH ▪ Rapid assessments among men who engage in high-risk behaviors conducted in 10 sentinel sites to identify groups of men at high risk for HIV as one of the sentinel surveillance groups
Technical assistance to IHBSS 2005	<ul style="list-style-type: none"> ▪ One training manual developed ▪ 10 surveillance teams and partners from 10 sites trained ▪ Technical assistance provided to surveillance teams from 10 sites in sample size, sample methodology, and implementation of the sampling frames ▪ Technical assistance provided to NEC, RESUs, and HIV-surveillance teams at the city level in data entry, cleaning, and analysis ▪ 27 staff trained on advanced in-depth analysis using Stata version 9 ▪ Technical assistance provided in report writing and dissemination of the findings

IMPACT provided technical assistance to NASPCP for the development of:

- the National STD strategy for 1999 to 2004
- the National STD Surveillance System (NSSS)
- the Sentinel STI Etiologic Surveillance System (SSESS)
- a standardized STI reporting system including software for recording and analysis
- syndromic sentinel site reporting
- National STI Case Management Guidelines and revision of the flowchart for the management of vaginal discharge

Program Outcomes and Impact

IMPACT/Philippines' role during ASEP and LEAD was to provide technical assistance and data for informed programming to complement the direct programming of the other agencies involved in the projects. By making the data available, programs become evidence based, better targeted, and, as a result, more strategic. IMPACT/Philippines has been able to redirect or target programs to those most at risk for HIV in order to reduce their STI and HIV vulnerability.

The STI research accomplished under IMPACT involved thousands of MARPs, as evidenced by the service output data. The provision of strengthened STI services among MARPs substantially reduced the HIV vulnerability of the groups: STI cases were identified and treated, thus maintaining low STI prevalence levels, and improved health-seeking behavior has further reduced HIV vulnerability.

Consistent condom use among FSWs has increased over time. A study undertaken in Angeles City in 2000 showed consistent condom use of 36 percent. In comparison, the 2005 IHBSS showed consistent condom use of 67 percent in the same city in the same population group. Although it is not possible to prove that this is a result of the interventions supported by ASEP and LEAD targeting of FSWs, it is likely that these interventions have contributed to the increase in condom use.

LESSONS LEARNED AND RECOMMENDATIONS

The experience from IMPACT has shown that it is possible to maintain a low and slow epidemic through sustained and effective STI/HIV/AIDS interventions. An enabling environment, in which behavior-change interventions, effective STI services, and condom promotion can be implemented for those most at risk for HIV, is paramount to achieving this goal. The lessons learned and recommendations are listed below.

A. Surveillance System

- Funding mechanisms for surveillance should be put in place to ensure its continuous implementation in all sentinel sites, at least until national funding is available. This funding should take into account resources for training, quality assurance, data analysis, and use and the implementation of HIV and behavioral surveillance in a minimum number of “core” national sites.
- The DOH might want to also consider identifying future funding for the preparation of a comprehensive report that gives a picture of the HIV epidemic and feeds into the crafting of evidence-based interventions. An enormous amount of information on HIV, STIs, and behavioral risk exists or is currently being collected in the country. While the findings from some of these surveys have been documented in numerous reports, a single comprehensive document explaining the past, current, and potential for future HIV, STI, and behavioral trends in the Philippines does not exist. It is difficult for implementing agencies, donors, and government agencies to access and assess all of the sources of information to develop policies, programs, and funding priorities, and it would be of real value to the country to provide this information, alongside recommendations, in one snapshot report that can be easily digested and widely used. IMPACT/Philippines has already begun this process by providing technical assistance to NEC in doing national-level data analysis of the first round of combined surveillance results. However, NEC was not able to draw all data sources into one document during the proposed timeline for analysis and reporting.
- HIV serologic and behavioral surveillance among IDUs should be expanded to other cities with sizable numbers of IDUs, such as General Santos City and Zamboanga City.
- Males in groups that engage in high-risk behaviors, such as MCSWs and MSTIs, should be routinely monitored through surveillance.
- To avoid biases, SHC staff involved in interventions should not be assigned as field interviewers for IHBSS. Interviewers should preferably be associated with the groups being monitored (such as peers).
- The IHBSS model should continue to be used, and the recommendations and lessons learned from the first round documented to fine-tune sampling methods and the surveillance process. It is also important to revisit surveillance populations and geographic areas to check whether any affected populations or regions were missed.
- Population-based surveys on male sexual behavior should be conducted every five years as part of the second-generation surveillance system. This would help the monitoring of male sexual behavior and provide input for proactive interventions to improve male sexual health and reduce the spread of HIV. These surveys should be conducted in a mix of large, medium-sized, and rapidly growing urban centers to obtain a broad picture of men’s sexual behavior.
- A more in-depth analysis of population demographics, behaviors, and access to interventions should be conducted on a site-by-site basis.

- Training on the use of surveillance data for program planning and evaluation purposes should be organized by NEC to assist IHBSS implementers on data analysis, technical writing, and presentation of 2005 HIV surveillance results.
- Size estimates for populations who are most at risk for HIV should be calculated.
- The influence of male circumcision on the continued low HIV prevalence should be explored.
- The surveillance data should become part of the national monitoring and evaluation system.
- The SSESS should be assessed to identify implementation needs, gaps, and constraints. Collaborating partners should be consulted during the assessment and involved in design or methodological revisions. Subsequently, the MOP for SSESS should be revised, in line with the changes that have been agreed upon by the implementing partners. The revised MOP will then have to be introduced to the sites and its use and implementation monitored, with technical assistance or onsite coaching whenever and wherever necessary.

B. STI management and SHCs

- To increase access to STI services for sex workers, the SHCs should expand their links with NGOs to reach different types of sex workers. Routine examination of all sex workers should be encouraged, either through establishing links between entertainment places and SHC or through encouraging nonregistered sex workers to go for regular examinations. Outreach clinics for FLSWs should be established to increase access to STI services.
- STI prevention should also be strengthened through promotion of 100-percent condom use among sex workers and their clients. Condoms should be made readily available in establishments.
- Training should be organized and conducted nationwide to ensure that the MOP for SHC becomes operational. Priority should be given to the SHCs participating in surveillance. Following the training, the use of the SHC MOP should be monitored and onsite coaching undertaken when and where necessary.
- PT for STI should be provided to MARPs to rapidly reduce STI infection rates. PT must be accompanied by a broad range of curative and preventive services in order to maintain the reduction achieved through PT.
- The modified algorithm, using a combination of symptoms and clinical and laboratory findings for screening, should be used. This modified screening algorithm increases the sensitivity; it is able to detect an additional 20 percent of infections, compared to laboratory testing alone.
- The laboratory capability of SHCs should be upgraded. Proper training of SHC staff in specimen collection and reading of smears should be organized. Networking with other laboratories, including regional and national reference laboratories, should be encouraged.
- The existing HIV counseling and testing activities should be assessed to help local governments develop or improve counseling and testing services in their localities. Such an assessment will also help the DOH develop a program to improve access to counseling and testing on a nationwide scale.

C. Male Sexual Health

- The kind of MSM formative assessments carried out in Metro Manila and Baguio City should be conducted in other cities. Surveillance activities and assessments have shown significant MSM populations in other cities, and behavioral change interventions are required for MSM in those cities to address their needs. Specific attention should be given to those younger than 34, because various studies showed that these individuals engage in riskier behaviors for HIV and STIs than do older men.
- Future interventions must move beyond the provision of knowledge and information among men. Attention must be given to building skills and personal motivation for safer behavior. Prevention interventions should take into account men's lifestyles, including alcohol and drug use, religious activities, aspirations, and other characteristics. Furthermore, interventions are likely to have better outcome and impact if they do not concentrate on STI/HIV prevention alone.
- Media and other sectors should continue to provide HIV/AIDS information to the general population to sustain interest and concern about the seriousness of the disease. Information must further reduce or remove stigma and discrimination of people living with HIV/AIDS.

D. Injecting Drug Users

- The IDU national preassessments showed that access to IDU communities is possible only in a confidential and nonthreatening environment. Hence, more innovative and discreet ways to improve access (besides peer education, use of telephone, text messaging, internet, and other communication means) should be developed. Efforts should also be made to include IDU-related questions in behavioral surveys, admission data of rehabilitation and treatment centers, and other possible places to ensure that better data regarding IDUs become available. A search for other possible sources that could provide useful data on IDUs should also be undertaken.
- The 2005 IHBSS reported a 1 percent HIV prevalence among IDUs in Cebu City, the highest HIV prevalence measured among any group in the Philippines so far. It is therefore imperative that HIV prevention interventions be designed and implemented to address risk behaviors among IDUs. It is recommended that formative assessments be conducted to assess the extent of the injecting drug use and sexual risks of IDUs in other cities. These assessments will inform the development of IDU interventions needed for one of the most-at-risk populations in the country.

IMPLEMENTING PARTNER ACTIVITY HIGHLIGHTS

Implementing and Collaborating Partner List

Implementing Agencies	Collaborating Partners
<ul style="list-style-type: none"> • Behavioral Sciences Department, De La Salle University • Center for Multidisciplinary Studies on Health and Development, University of the Philippines Development Foundation/University of the Philippines College of Public Health • Field Epidemiology Training Program Alumni Foundation, Inc. • ReachOut Foundation International • STD/AIDS Central Cooperative Laboratory • STD/AIDS Philippines Foundation, Inc. • Wo/Men’s Access to Vital Education and Services International, Inc. 	<ul style="list-style-type: none"> • Department of Health • National AIDS/STD Prevention and Control Program • National Epidemiology Center • STD/AIDS Cooperative Central Laboratory • Research Institute of Tropical Medicine • World Health Organization • Management Sciences on Health • Japan International Cooperative Agency • Program for Appropriate Technology on Health • Jose Fabella Memorial Hospital • Davao Medical Center • DKT International • Field Epidemiology Training Program Alumni Foundation Inc. • Human Development and Empowerment Services • Philippine HIV/AIDS NGO Support Project • Philippine Legislators, Committee on Population and Development Foundations, Inc. • PROCESS Foundation – Panay, Inc. • Social Health Environment and Development Foundation, Inc. • Tri-Dev Specialists Foundation, Inc. • University of Philippines Population Institute • University of Southern Philippines Foundation

Subproject Highlights

Subprojects/implementing partners	Organizational type	Objectives	Location	Target population	Budget (US\$)	Intervention	Project dates
Strengthening STI syndromic management							
Validation of STI syndromic case management Implementing Agency: University of the Philippines Manila/ Development Foundation	University/ NGO	See Strengthening STI Syndromic Management	Metro Manila, Davao, Cebu	Women with vaginal discharge Men with urethral discharge	259,903	Operation research Strategy/guidelines	July 15, 1999– Aug. 15, 2002
Improving STI services for most-at-risk populations							
Pilot-enhanced syphilis screening and testing in Angeles City Implementing Agency: ReachOut Foundation International	NGO	See Pilot Syphilis Screening and Treatment	Angeles City	FSWs, MSM, partners of MARPs, SHC staff in Angeles City	17,602	STI diagnosis and treatment	Jan. 11, 1998–June 30, 1999
Enhanced STI Control in Angeles City Implementing Agency: FETPAFI	Government	See Enhanced STI Control	Angeles City	FSWs and clients	43,330	STI diagnosis and treatment	Jan. 1, 2001– August 31, 2001
Enhanced STI Control in Angeles City, Laboratory testing for PCR GC, and CT Implementing Agency: SACCL/Action for STD/AIDS Philippines Foundation, Inc.	Government	See Enhanced STI Control	Angeles City	FSWs and clients	48,644	STI diagnosis and treatment	Jan. 1, 2001–June 30, 2001
Improving the second-generation surveillance system and technical assistance to IHBSS 2005							
National STI Surveillance: STI Prevalence Survey Among MARPs Implementing Agency: FETPAFI	Government	See Establishing the National STI Surveillance System	Angeles City	FSWs and clients, MSM	37,081	Biological surveillance (HIV/STI)	Aug. 1, 1999– Mar. 31, 2000
Finalization and Expansion of STI Universal Reporting Implementing Agency: UP-Manila Development Foundation	University/ NGO	See Establishing the National STI Surveillance System	Manila and 10 cities from Region 11	SHCs, city health office, rural health unit with laboratory capacity	15,612	Biological surveillance (HIV/STI)	Sept. 1–Nov. 30, 2000

Subprojects/implementing partners	Organizational type	Objectives	Location	Target population	Budget (US\$)	Intervention	Project dates
Developing systems for the National STI Surveillance Implementing Agency: FETPAFI	Government	See Establishing the National STI Surveillance System	12 sentinel SHCs across the country	12 private STI clinics, city epidemiology and surveillance units, RESUs, and CHDs	28,105	Biological surveillance (HIV/STI)	Dec.1, 2001– Aug.15, 2002
Population-based survey of male sexual behavior Implementing Agency: Behavioral Sciences Department, De La Salle University	University	See Population-based Survey of Male Sexual Behavior	Cebu, Davao, Quezon City	Males ages 15–24, 25–34, and 35 years and older	139,912	Behavioral surveillance	Aug. 1, 1999– May 31, 2001
National preassessment of IDU situation and response Implementing Agency: WAVES	NGO	See National Preassessment of IDU Situation and Response	Davao, Quezon and Cebu	IDUs	5,000	Situation analysis	Aug.2003– Nov. 2003
Sexually transmitted and blood-borne infection prevalence assessment among MSM: Qualitative, behavioral and biological studies Implementing Agency: CEMSHAD	NGO	See Sexually Transmitted Blood-borne Infection Prevalence	Metro Manila, Baguio City, Pagsanjan, Laguna, and Puerto Galera, Mindoro Oriental	MSM situated in tour sites	28,240	Biological surveillance (HIV/STI) Behavioral surveillance Situation analysis	July 1, 2004– Jan. 31, 2005
Laboratory Testing for Sexually Transmitted and Blood Borne Infection Prevalence Assessment in MSM in Selected Sites of Metro Manila Cities and Baguio City Implementing Agency: SACCL/Action for STD/AIDS Philippines Foundation, Inc.	Government		Metro Manila, Baguio City	MSMs situated in tour sites	34,233	Biological surveillance (HIV/STI) Behavioral surveillance Situation analysis	Oct.1, 2004– Dec. 31, 2004

ATTACHMENTS

Attachment 1: Administrative Order No.5-As 2003 entitled, *Revised National Sexually Transmitted Infections (STI) Case Management Guidelines.*



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10 January 2003

ADMINISTRATIVE ORDER NO. 5-As. 2003

SUBJECT: Revised National Sexually Transmitted Infections (STI) Case Management Guidelines

I. Background:

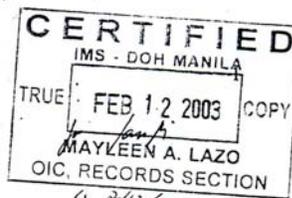
Recognizing the public importance of Sexually Transmitted Infections (STI), particularly in the era of AIDS various administrative orders were prepared to intensify STI care and prevention strategy. Administrative Order #2 s 1997 "The National Policy Guidelines for the Prevention and Management of Sexually Transmitted Diseases (STD)" was developed to provide strategic directions for future activities and complement the existing guidelines on the National AIDS/ STI Prevention and Control program. It forms the basis for the prevention and management of STI at all levels of health care system nationwide. One of the components of the guideline is the promotion of the syndromic approach to STI case management when reliable laboratory diagnostic support is not consistently available. A training manual on the Comprehensive STD Case Management has been developed and implemented.

To provide directions on the STI case management at the different levels of health care system from tertiary hospitals down to the barangay health stations, Administrative Order # 5 s 1998 "Implementing Guidelines in STI Case Management at the different levels of the Health Care System" was developed. This guideline provided standards for the implementation of syndromic STI case management at all levels of health care, defined roles, functions and requirements in the provision of STI services at all levels of health care, establish the referral system of STI case management and extent of care and technical boundaries that can be provided at the different levels of care.

A validation study on syndromic approach to the National STI Case Management was conducted to improve the quality of STI care provided by increasing the diagnostic validity of the national STI case management guidelines. The study aimed to determine the validity of the Philippine flowchart for vaginal discharge and urethral discharge and determine the etiological agents causing vaginal discharge in women and urethral discharge in men.

Based on the results of the study and after consensus with STI technical committee, a new National STI Case Management Guidelines is being recommended for the management of vaginal discharge in women. The flowcharts being recommended have a good balance of sensitivity, specificity and positive predictive value, thus reducing over treatment and under treatment. It is more cost effective and has a better diagnostic validity compared to the current National STI Case Management

Signed AO
Received in the Records
Section on 2-10-03



Guidelines. It is also feasible to be implemented in the primary level of care and has a good compromise between the technical accuracy and realities in the field.

II. Purpose:

1. To provide health care workers in all levels of the health system guidance and a standard approach in managing STI;
2. To enable all health care workers at all levels of the health system to provide effective, acceptable and affordable STI case management; and,
3. To make recommendations on the best drugs to use.

III. Scope:

These guidelines replace the flowcharts recommended in the training manual on "Comprehensive STI Case Management" specifically on the module on Syndromic Approach to STI. In order to provide a more universal effective STI management these guidelines will be utilized in all health facilities with limited capabilities for etiologic diagnosis of STI among patients with reproductive tract infections and sexually transmitted infections. These guidelines will provide the basis for the management of vaginal discharge and lower abdominal pain in women, urethral discharge and scrotal swelling in men and genital ulcers in men and women.

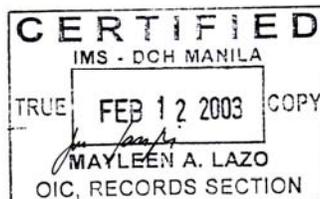
IV. Guidelines and Procedures:

To ensure a more cost effective approach in the management of STI in the Philippines the following guidelines and flowcharts are being recommended:

A. Management of Women with Vaginal Discharge:

1. In the absence of laboratory support and facilities for genital examination, vaginal discharge should be managed as a case of vaginitis. If symptoms persist after treatment this must be referred to a higher level of care where facilities for genital examination and laboratory testing are possible.
2. In the absence of laboratory support (microscope, simple reagents and trained health personnel to perform the test) but with facilities for genital examination such as:
 - Presence of sterile speculum and examining gloves
 - A private area with good lighting with an examining table for genital examination and with a trained health care worker and the patient agrees.

The flowchart below is recommended.



IV. IMPLEMENTING MECHANISM

Administrative Order #5, s, 1998 will stay in effect to provide guidance in the implementation of the revised STI Case Management.

The following will be the role and nature of assistance at the Department of Health and the local government units in implementing the revised guidelines.

A. Role of Department of Health and Nature of Assistance

1. Provide technically sound recommendations as the need arise to improve STI case management at all levels of health care.
2. Provide training of trainers on STI case management.
3. Develop standardized training modules and materials.
4. Monitor and conduct evaluation of the quality of STI case management and training.
5. Advocate to policy makers, local government units the importance of providing adequate STI services to generate resources, sustain the implementation of activities and develop local policies that are consistent with national policies.
6. Coordinate the implementation of activities at the different levels of health care system to ensure proper utilization of limited resources, prevent duplications of functions and render adequate referral mechanism.
7. Develop methodologies and procedures for referral

B. Role of Local Government Unit and Nature of Assistance

1. Implement these guidelines for the management of STI.
2. Provide adequate resources and environment for the provision of STI services.
3. Ensure that effective, acceptable STI services are available at the local health unit.
4. Legislative support to include the review, amendment and enactment of ordinances that will improve STI case management in accordance with the Department of Health guidelines

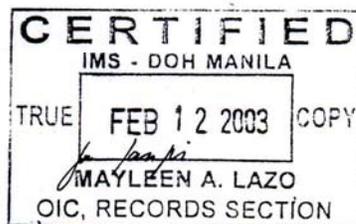
VI. FUNDING

Provision of funding shall be the main responsibility of the local government unit; however assistance may come from the National government or other donor agencies.

VII. EFFECTIVITY CLAUSE

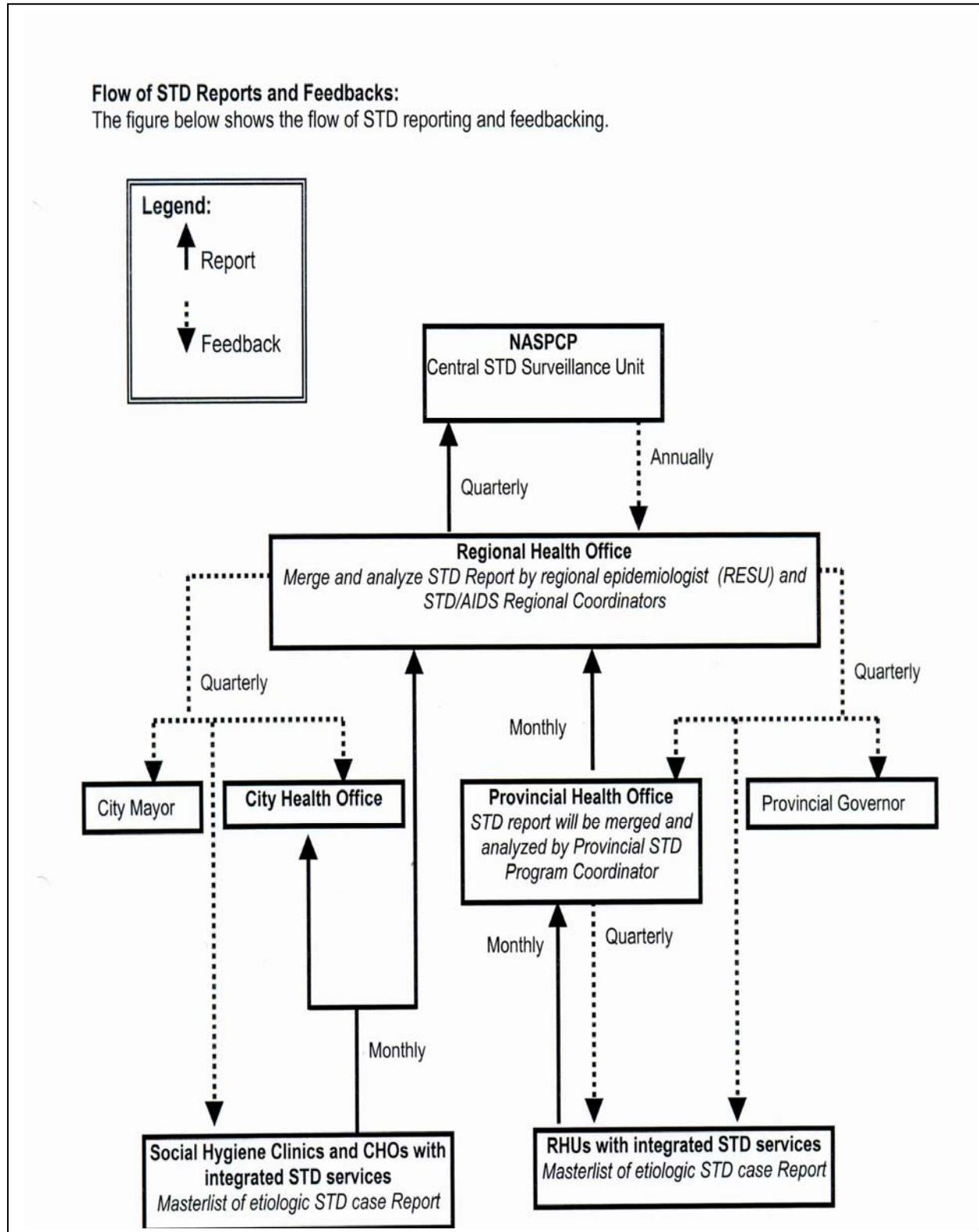
This order shall take effect immediately.


MANUEL M. DAYRIT MD, MSg.
Secretary of Health



ca 2/13/03

Attachment 3: STI Reporting and Feedback Flow



Attachment 4: STI Reporting and Feedback Mechanism Summary

The table below summarizes the reporting and feedback mechanism of STI data.

STI Reporting and Feedback Mechanism

Schedule	Activities	Person Responsible
End of every day	- Consolidates/totals daily smears done from the daily STI service record. Enters total smears and STI cases in the facility-based STI logbook. If computer is available, STI data must be entered in the computer.	STI nurse
First week of every month	- Consolidates monthly data (smears and STI cases) in the monthly STI master list and monthly summary form (MSF). If STI data is being entered in a computer, a diskette copy of the master list may be made. - Submit monthly STI master list and MSF report to the STI physician for analysis and notation - Noncategorical STI clinics submit monthly STI master list/diskette copy and MSF report to the provincial STD program manager. SHCs send monthly reports to the regional STD program manager. - Retains a copy of the monthly STI master list and MSF report to the health facility.	STI nurse
	- Analyzes, reviews, and approves monthly STI master list report	STI physician
Second week of every month	- Receives and enters/processes STI data in a computer - Reviews and analyzes STI data	STD provincial program manager
Third week of every month	- Consolidates all monthly consolidated STI report. - Enters and merges monthly STI master list in a computer. - Submit diskette copy of the monthly STI master list and a monthly provincial consolidated STI report to the STD regional program manager.	STD provincial program manager
Second week of every quarter	- Reviews and analyzes monthly STI reports into a quarterly report - Provide STI quarterly feedback to CHO and city mayor	RHU and SHC physician
	- Reviews and analyzes monthly STI reports into a quarterly report - Provide STI quarterly feedback to PHO and governor	STD provincial program coordinator/FHSIS
	- Consolidates monthly provincial consolidated STI reports - Merges and analyzes monthly provincial STI reports into regional quarterly report - Provide STI quarterly feedback to CHOs, city mayors, PHOs, and governors/congressmen - Submits diskette of regional quarterly STI master list and a regional consolidated STD report to the National Surveillance Unit of NASPCP-DOH	STD regional program manger/RESU
Third week of every quarter	- Consolidates, reviews, and analyzes quarterly regional STI reports. - Area monitoring progress of regional and provincial/city (SHCs) STI surveillance system	National STD surveillance point-person
First month of the incoming year	- Provide STI annual feedback to the secretary of health, under secretary for office of public health services, director of NASPCP, and the national STD program manager. - Disseminates national STD annual report to all DIRFOS and regional program managers, DILG (national and regional), and CHOs/SHCs	National STD surveillance point-person



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This publication was funded by USAID's Implementing AIDS Prevention and Care (IMPACT) Project, which is managed by FHI under Cooperative Agreement HRN-A-00-97-00017-00.

Produced June 2007