

PN-ACW-583

*The AIDS Surveillance and Education Project Experience in the Philippines*

# **Best Practices in HIV and AIDS Prevention Education**

August 2003

**path**  
Program for Appropriate Technology in Health



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Special recognition also goes to former staff of the Field Epidemiology Training Program of the Department of Health who helped PATH design the Education Strategy for ASEP, particularly Dr. Manual Dayrit, present Secretary of Health.

Forty-nine different private-sector groups have contributed to the development and implementation of AIDS prevention education and other HIV interventions under ASEP. Foremost amongst these are 13 local NGOs who have been steadfast partners and major contributors to ASEP's success. They include:

- Bidlisiw Foundation Inc., Cebu City
- Kabalaka Reproductive Health Center, Central Philippines University, Iloilo City
- DKT Philippines Inc., Quezon City
- FreeLAVA Inc., Cebu City
- Human Development and Empowerment Services (HDES) Inc., Zamboanga City
- Kabalikat ng Pamilyang Pilipino Inc., Quezon City
- Mahintana Foundation Inc., General Santos City
- Pearl S. Buck International Inc., Angeles City
- PROCESS Foundation Inc., Iloilo City
- ReachOut AIDS Education Foundation Inc., Pasay City
- SHED Foundation, Inc., General Santos City
- University of the Southern Philippines Foundation (USPF) Inc., Cebu City
- Wo/Men's Access to Vital Education and Services Inc. (WAVES) Davao City

# acknowledgements

**T**his report synthesizes the experiences of the United States Agency International Development (USAID)-supported AIDS Surveillance and Education Project (ASEP) in the Philippines. It draws on numerous project reports and documents written by key ASEP personnel, namely: Carmina Aquino, the ASEP Program Manager, Leona D'Agnes, the Technical Director, Joan Regina Castro, the sexually transmitted disease (STD) Medical Specialist, and Ma. Elena Borromeo, the IEC Specialist. External authors that assisted with the synthesis and preparation of this report include Program for Appropriate Technology in Health (PATH) Consultant Karen Schmidt and PATH Program Officer Kirrin Gill.

This report also cites findings from several external evaluation reports and draws on the work, ideas, and contributions of local nongovernmental organizations (NGOs) and pharmacy partners, local government officials, and health workers, as well as staff and consultants of PATH, particularly Lyn Rhona Montebon, the ASEP Program Monitoring Specialist, Enrique Hernandez, the Policy Advisor, and Cristina Mutuc, ASEP Program Associate.

Among the first researchers to investigate the spread of Human Immunodeficiency Virus (HIV) in the Philippines was Dr. Cora Manaloto, the USAID Technical Officer who has nurtured ASEP's development over the past decade and provided inspiration and guidance to PATH and partners.

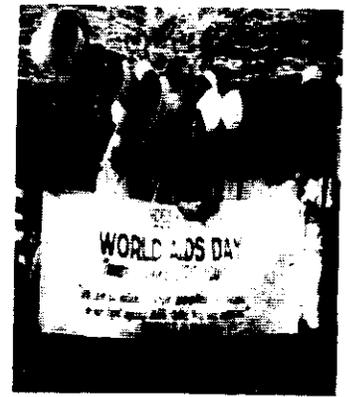
# list of acronyms

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AIDS	Acquired Immune Deficiency Syndrome
ASEP	AIDS Surveillance and Education Project
BCC	Behavior Change Communication
BCPC	Barangay Council for the Protection of Children
BLAaCP	Barangay Legal Action Against Child Prostitution
BMS	Behavioral Monitoring Surveys
BSS	Behavioral Surveillance System
CDLMIS	Condom Distribution Logistics Management Information System
CHOW	Community Health Outreach Worker
COPE	Community Outreach and Peer Education
CPA	City Plan of Action
DOH	Department of Health
RFSW	Registered Female Sex Worker
FFSW	Freelance Female Sex Worker
HDES	Human Development and Empowerment Services Inc.
HIV	Human Immunodeficiency Virus
HRP	Harm Reduction Program
HSS	HIV Sentinel Surveillance System
IDU	Injecting Drug User
IEC	Information Education and Communication

KAP	Knowledge, Attitudes and Practices
LAC	Local AIDS Council
LGU	Local Government Unit
LALS	Living Giving and Live Saving Foundation
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NAC	National Advisory Council
NGO	Non Governmental Organization
PATH	Program for Appropriate Technology in Health
PE	Peer Educator
PNAC	Philippine National AIDS Council
PoCoMon	Policy Compliance Monitoring
PSA	Public Service Advertising
SHC	Social Hygiene Clinic
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
WAVES	Wo/Men's Access to Vital Education and Services Inc
WHO/WPRO	World Health Organization/Western Pacific Regional Office

## executive summary



In 1992 the Philippines seemed to be on the verge of a crisis. Thailand was experiencing an HIV epidemic of calamitous proportions, and some experts were predicting similar projections for the Philippines. There was no sentinel surveillance in the country, so the extent of the epidemic was unclear. Official speculations on infection levels were as high as 50,000 HIV-positive cases throughout the country. Certain high-risk behaviors were believed to be widespread, including unprotected commercial sex work and needle sharing among injecting drug users (IDUs). Although many Filipinos had heard of HIV, they lacked specific knowledge about the disease, its transmission modes, and how best to protect themselves. Experts cautioned that the window of opportunity to prevent extensive spread of HIV infection to the general public was “closing fast.”

Ten years later, the level of seroprevalence in the country has remained well below one percent. The predicted catastrophe was averted. How did this come about? Various factors – some of which are not well understood – helped avoid a disastrous epidemic in the Philippines. While much remains unanswered, this report looks at one well-recognized factor: HIV prevention education efforts. This report examines the education component of the AIDS Surveillance and Education Project (ASEP) and its role in helping to keep the Philippines AIDS epidemic low and slow.

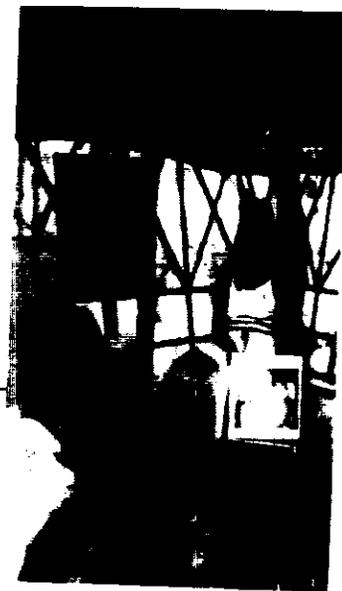
In 1992, the United States Agency for International Development (USAID) authorized the ASEP to help prevent the rapid increase of HIV and AIDS in the Philippines by instituting mechanisms to monitor HIV prevalence and risk behaviors through surveillance activities and by encouraging behaviors that reduce individual risk through education activities. To realize these objectives, ASEP promoted public-private partnerships between city health departments and NGOs, between government social hygiene clinics (SHCs) and private pharmacies and their professional associations, and between local AIDS councils (LACs) and private media concerns.

Although initially focused solely on surveillance and education, over the course of the program the scope and coverage of ASEP was expanded to include other high-impact prevention strategies that were brought to scale in the Philippines eight largest cities. The complementary science-based interventions used by ASEP include community outreach peer education (COPE), condom access, STD case management, harm reduction programs for injecting drug users, public service advertising (PSA), and STD social marketing. In addition to supporting the delivery of targeted and combined prevention interventions, ASEP provided extensive additional support to develop long-term human capacity and infrastructure in the public and private sector in ASEP's eight urban sites.

ASEP was faced with one primary challenge: mobilizing Filipinos, from the highest levels of politics to the most vulnerable people, to recognize that despite apparently low levels of HIV, Philippines was, and remains, at risk of a rapid spread of HIV. As a low-prevalence country, the Philippines challenge is to keep risk perception high even though prevalence is low.

# introduction

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In 1993 the Philippines seemed to be on the verge of a crisis. Thailand was experiencing an HIV epidemic of calamitous proportions, and some experts were predicting similar projections for the Philippines. There was no sentinel surveillance in the country, so the extent of the epidemic was unclear. Official speculations on infection levels were as high as 50,000 HIV positive cases throughout the country. Certain high-risk behaviors were believed to be widespread, including unprotected commercial sex work and needle sharing among IDUs. Although many Filipinos had heard of HIV, they lacked specific knowledge about the disease, its transmission modes, and how best to protect themselves. Experts cautioned that the “window of opportunity” to prevent extensive spread of HIV infection to the general public was closing fast as commercial and sexual behaviors that contribute to high levels of STDs continued with relatively low condom use rates (Chin 1993).

Ten years later, the level of seroprevalence in the country has remained well below one percent. The predicted catastrophe was averted. How did this come about? Various factors – some of which are not well understood – helped avoid a disastrous epidemic in the Philippines. While much remains unanswered, this report looks at one well-recognized factor: HIV prevention education efforts. This report examines the education component of ASEP, and its role in helping to keep the Philippines AIDS epidemic low and slow.

A bilateral agreement executed in 1992 by the United States and the Republic of the Philippines preceded the official launch of the project in 1993, when USAID entered into a Cooperative Agreement with PATH and a grant agreement with the World Health Organization/Western Pacific Regional Office (WHO/WPRO) for provision of technical support to the Department of Health (DOH) for implementation of ASEP. The project established two components:

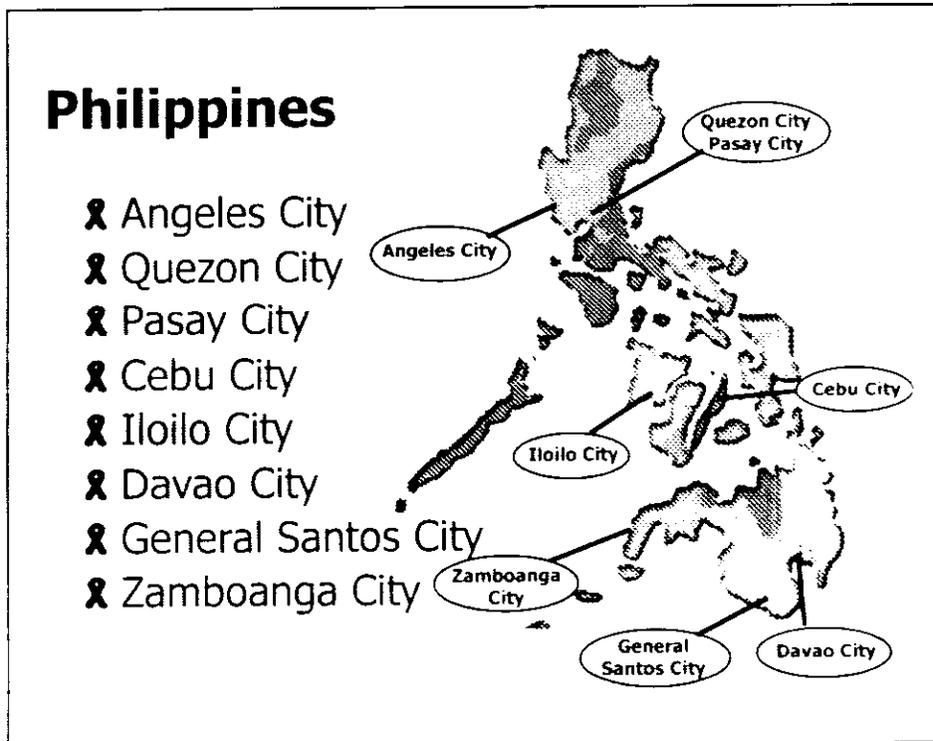
- **Surveillance** to establish an early warning system at strategically located geographic sites to detect and monitor the spread of HIV among groups most at risk. The HIV Sentinel Surveillance System (HSS) was subsequently complemented by a Behavioral Surveillance System (BSS) to track risky behaviors and knowledge, attitudes and practices (KAP) of the same groups in the same sites. WHO/WPRO and the DOH implemented this component with local government partners.
- **Education** to encourage behaviors that reduce the risk of HIV transmission among groups at risk. This component was designed to strengthen the capacity of the DOH to develop, monitor, and evaluate a national AIDS information, education and communication strategy and the capacity of private-sector organizations to manage and implement strategy activities. This component was implemented by PATH and local NGO partners in collaboration with local governments and city health offices.

This report reviews the achievements of the education component and the lessons learned from ten years of the ASEP experience. The Philippines DOH has adopted ASEP as the “gold standard” for the Philippines and is

replicating ASEP's interventions and strategies in other parts of the country. The aim of this report is to help the managers and staff of other programs in the Philippines and other countries understand and benefit from the ASEP experience and the best practices that evolved over the years.

This report is part of a series of publications about the AIDS Surveillance and Education Project experience in the Philippines. Other reports in the series include:

- Community Outreach and Peer Education for HIV and AIDS Prevention
- Policy and Advocacy Efforts for HIV and AIDS Prevention
- STD Management for HIV and AIDS Prevention





# the ASEP program

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## Overall Objectives

**W**hen ASEP was initiated, very little was known about HIV and AIDS in the Philippines and the contextual and behavioral factors that could fuel an epidemic. Sentinel surveillance to track the extent of the problem did not exist. Understanding of existing knowledge, attitudes, and behaviors related to HIV and AIDS was poor, and little was known about the existing resources and barriers that could affect prevention efforts. Though awareness of HIV/AIDS was high (85 percent had heard of AIDS in a 1993 survey), misperceptions were common. Many people believed HIV could be transmitted through casual contact, and even health workers were ill informed. Experts cautioned that the “window of opportunity” to prevent extensive spread of HIV infection to the general public was closing fast as commercial and sexual behaviors that contribute to high levels of STDs continued with relatively low condom usage rates.<sup>1</sup>

ASEP was designed to improve the knowledge about the extent of the epidemic in the country and to prevent a rapid increase of HIV in the

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<sup>1</sup> Letter dated December 20, 1993, from James Chin, MD, MPH, Clinical Professor of Epidemiology, University of California, Berkeley to Dr. Manual Dayrit, Assistant Secretary, FETP Program Manager, Department of Health, Manila, Philippines.

Philippines population. The project aimed to institutionalize public- and private-sector mechanisms for:

- Monitoring HIV prevalence and risk behavior through surveillance activities.
- Encouraging behaviors, which reduce individual risk for contracting and transmitting HIV, through education activities.

ASEP's education component, the focus of this publication, aimed to improve KAP related to STD and HIV prevention among groups practicing high-risk behaviors. A targeted approach to AIDS prevention was critical since interventions diminish in cost-effectiveness as the infection moves out of high-risk groups and into the general population.



# ASEP education component

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## ASEP Education

**P**ATH, a U.S.-based international NGO, developed education activities in close collaboration with local NGOs through a subgrant program aimed at changing the behavior of people highly vulnerable to HIV.

Data available at the time suggested that individuals and groups that engage in unprotected sex with multiple partners and/or share injecting equipment were at highest risk of acquiring and transmitting HIV. These groups include commercial sex workers, both female and male, men who have sex with men (MSM), IDUs, and members of the sexual networks of each of these groups. Other audiences such as pimps and owners of entertainment establishments were also the focus of behavior change communication (BCC) activities. The project worked with these groups to:

- Increase awareness of STDs and HIV
- Encourage partner reduction
- Increase consistent and correct use of condom
- Build self-efficacy to refuse unprotected sex
- Improve STD care-seeking behavior

ASEP created a coordinating mechanism between PATH, which managed the project, and the local City Health Offices (CHO), which provided

clinical services to sex workers employed in registered establishments (RFSWs), and local NGOs, which provided outreach services in the communities where freelance sex workers, MSM and IDUs live and work. The collaboration with NGOs was intended to engage communities practicing risk behaviors in education strategies to encourage protective behaviors such as condom use, partner reduction, and utilization of available STD treatment services. The project relied on a network of volunteer peer educators (PEs) who were selected for their influence within these communities. ASEP's education component covered eight cities, which were also the sites where HIV surveillance activities were being conducted.

### **Evolution of the Project**

During 1993-1995, ASEP's targeted intervention program focused primarily on registered sex workers and MSM, although other sentinel groups such as IDUs were prioritized for prevention education in some sites. NGO partners accessed individuals from these groups mainly by going to their place of employment, where project staff would deliver basic HIV and AIDS presentations and condom demonstrations to the employees, owners and managers of establishments registered with the local government.

Over the decade of ASEP's implementation, the design of the project evolved in response to changes in the understanding of the HIV/AIDS epidemic and of the best ways to address the problem in the local context. A series of evaluations, conducted by external experts at periodic intervals over the course of the ten years, helped to identify other vulnerable subpopulations (e.g., freelance sex workers) and highlight promising strategies and new directions.

### The Evolution of the Project

Sept 1993	Cooperative Agreement between USAID and PATH for HIV and AIDS prevention education
Feb 1995	Mid-Term Evaluation of ASEP (USAID)
May 1995	Phil-Thai Technical Exchange and STD Management
Feb 1997	ASEP Assessment (USAID)
Mar 1998	Social Mobilization for Creation of Multisectoral Local AIDS Councils
Aug 2000	Policy Advocacy and Community-level Interventions
Mar 2001	Final Evaluation (USAID)
Aug 2002	Sustainability and Phase Out
Sept. 2003	End of Project

In response to the 1995 evaluation, the targeting and scope of ASEP Education was refined and expanded to include freelance sex worker groups and members of their sexual and social networks. This encouraged NGOs to utilize and develop COPE approaches and service delivery mechanisms. Training in STD syndromic management for private and public providers was also added, and the project sponsored a technical exchange to Thailand for executives from local governments and NGOs to examine Thailand's AIDS prevention and control program, including its 100 percent condom use policy. The exchange inspired a series of follow-up activities. Participants initiated pilot social mobilization efforts in two of the ASEP sites to create LAC to advocate for policy reforms, including 100 percent condom use in establishments registered with the local government. The 1997 evaluation reviewed these initiatives and recommended an expansion of policy and advocacy efforts to other sites.[37]

In 1998 ASEP officially expanded its policy and advocacy efforts under the project. In addition to individual behavior change initiatives, ASEP

aimed to address the structural and environmental factors that create the context for HIV and STD prevention. Advocacy and policy efforts were intended to stimulate the involvement of local government units (LGUs) and the entertainment sector in prevention efforts. ASEP's activities focused on forging a partnership among LGUs, NGOs, health staff, and the private sector that would sustain ongoing prevention initiatives in the Philippines.

Following other recommendations of the 1997 Assessment, PATH and partners initiated ethnographic research on child prostitution in ASEP sites and developed HIV prevention strategies and materials tailored to the needs of prostituted children. Results of legal studies, also supported by ASEP, helped to guide the design of community-level interventions and the establishment of local mechanisms to suppress child prostitution, called the Barangay Legal Action against Child Prostitution (BLAaCP). In addition, the project initiated monitoring to assess compliance with policy changes.

By 2000, the project interventions fell into three categories: individual level strategies, structural/environmental interventions, and community-level strategies. Individual strategies included Education, consisting of COPE, Mass Media, Behavioral Change Monitoring and STD Case

<p style="text-align: center;"><b>ASEP Education and Policy Strategies</b></p> <p style="text-align: center;"><b>Individual level</b> Community Outreach Peer Education Mass Media Behavioral Change Monitoring STD Case Management</p> <p style="text-align: center;"><b>Structural/Environmental level</b> Policy and Advocacy STD Social Marketing</p> <p style="text-align: center;"><b>Community level</b> Legal Literacy Social Mobilization</p>
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Management. At the structural and environmental level, the project involved Policy and Advocacy efforts to develop institutional capacity, city plans for HIV and STD prevention, and multisectoral councils to mobilize and synchronize the resources and efforts of government, NGOs, and the private sector. It also involved social marketing efforts to reduce the STD burden on the public sector and improve target groups' STD-care seeking behavior and access to affordable drugs. Community-level strategies incorporated social mobilization efforts to suppress child prostitution and legal literacy training for barangay officials and parents in red light districts.

### **Community Outreach and Peer Education**

The COPE strategy, initiated in 1996, revolved around the roles of the PE and the Community Health Outreach Worker (CHOW) who worked closely with individuals at risk, in the communities where they lived and worked. NGOs selected CHOWs and PEs with influence and rapport in the communities at risk. Most PEs were members of communities at risk – entertainers, pimps, and security guards in entertainment establishments. PEs and CHOWs worked with clients through a series of one-on-one contacts and guided group interaction to encourage the development of skills for condom use, safer sex negotiation, and appropriate STD seeking. PEs initiated contact with communities practicing risk behavior, conducted counseling, demonstrated condom use, and referred clients to CHOWs for further help. The CHOW provided at risk counseling, STD screening, harm reduction information and referral services. Each CHOW helped to oversee and mentor the work of six to eight PEs. This enabled PEs to get a great deal of personal attention and support from their CHOW mentors.

*“I feel good about all the people I’ve been able to refer to the clinic, especially those individuals who can’t afford to buy medicine for themselves or their children. They don’t know where to get free services. Their ‘thank you’ means a lot to me.”*

Gloria Olivar, CHOW, Bidlisiw, Cebu

During the initial contact, the PE established rapport with the client and provided information on HIV and STD prevention. The contact usually took place in the streets or in other venues where members of groups at risk were likely to be found. In subsequent sessions, the NGO worker provided clients with more in-depth counseling and individualized prevention information, including STD referral. CHOWs helped the clients to establish a risk reduction goal (e.g., next week I will try to use condoms every time I have sex with a new customer). The goal started at whatever level the client felt was reasonable and progressively increased over time toward the ultimate goal of 100 percent condom use with all partners, both commercial and intimate. During each repeat contact session, NGO workers monitored the progress of the client towards his or her personal goal. They also promoted condoms and provided educational materials.

NGOs tailored their efforts to the needs of different groups at risk. Sex workers learned how to negotiate for safer sex and condom use. MSM were encouraged to reduce partners, use condoms consistently, and seek care for symptoms of STD. IDUs learned how to clean their injecting equipment with bleach and water.

While RFSWs were required by law (Sanitation Code) to come to government SHCs at frequent intervals for STD screening, reaching

female freelance sex workers (FFSWs) was more difficult. The Philippines' government clinics usually provided services only to female employees of entertainment establishments registered with the city government. Freelancers and minors (<18 years) engaged in sex work were ineligible for services offered at the SHCs. Even when some government clinics established special hours for their attendance, many FFSWs did not avail themselves of the services because they were wary of government initiatives and their staff. Government health workers also had little experience with marginalized groups.

The 1995 ASEP assessment recommended that PATH and NGO partners focus their efforts on this neglected group. PEs and CHOWs in the eight project sites identified where freelancers worked and sought to gain their trust. The NGOs also worked with other marginalized groups practicing high-risk behaviors, particularly MSM, male sex workers, and IDUs. In 1995, two local NGOs working with IDU communities in Cebu and Quezon City were exposed to a successful harm reduction project in Nepal. The ASEP partners applied and tested needle exchange and teach-and-bleach interventions in their localities, with commodities donated from the JICA and other contributors.

### **Mass Media**

ASEP's mass media efforts involved several campaign waves focused on different critical issues: basic AIDS information, linking STDs with HIV and AIDS, condom promotion, STD awareness, child prostitution, STD symptom recognition, and partner notification. The program used PSA approaches and raised approximately \$11 million dollars in pro bono ad placement. Activities generated multiplier effects for the program in terms

of investment leveraged for AIDS and STD information dissemination. ASEP demonstrated that public service advertising could be an effective mechanism for increasing private investment in HIV and STD prevention.

### **Behavioral Change Monitoring**

PATH's program monitoring for ASEP included Behavioral Monitoring Surveys (BMS) to look at the behaviors of people at risk related to partner screening, condom use, STD care-seeking, and injecting drug use. The aim of the surveys was to help partner NGOs understand how to monitor changes in behavior and to tailor their program efforts to better meet the needs of groups at risk. Survey questions covered the number and type of sex partner, recent condom use, signs and symptoms of STDs, health-seeking behavior, injecting drug use, and sharing of injecting equipment, as well as exposure to ASEP programs. The BMS was intended to complement the information in the BSS which was carried out by the surveillance component of ASEP) by providing additional information on risk groups relevant to NGO prevention efforts, particularly about how behavior differed with exposure to ASEP.

PATH worked in close collaboration with NGO partners to build their capacity in conducting these surveys. PATH developed the survey instrument and trained the NGO interviewers. Each NGO recruited respondents and conducted the interviews. PATH then analyzed the information and provided individual reports to each NGO. NGOs were also trained about potential biases of the data caused by self-reported behaviors and non-random selection of respondents and other limitations. BMS results were only one part of ASEP program monitoring. Other monitoring include quantitative output data for outreach efforts,

qualitative information gathered from individual and group discussions, and qualitative information from mystery shopper surveys. [43]

## **STD Prevention and Control**

Due to the low prevalence of HIV in the Philippines, it was a constant challenge to create a sense of urgency about the potential of an epidemic. Few people were aware of anyone who was HIV positive, and there were no statistics available to generate concern. Studies on STDs, however, showed high rates of infection, particularly among sex workers, and there was a growing body of evidence showing sexually transmitted infections (STIs) as co-factor for HIV transmission. The high rates of STDs substantially increased the likelihood of an AIDS epidemic in the country. ASEP staff recognized that linking HIV and AIDS to the existing apprehension about STDs would stimulate interest in HIV prevention efforts.

By late 1996, ASEP had integrated STD interventions into the project by initiating a program of improved STD management. The program included:

- **Syndromic Case Management:** ASEP provided training in syndromic case management for STD treatment to government and nongovernmental partners to create a cadre of trained government health care providers, community pharmacists, NGO front line workers, private physicians, and paramedical personnel near red light districts.
- **An effective, affordable package for STD treatment:** Since irregular supply of STD drugs severely undermined the effectiveness of STD management efforts, PATH mobilized funding from the

Dutch Government to establish a social marketing campaign to pilot an effective and affordable treatment kit (Triple S) to sex workers, clients, and MSM in red light areas. The Triple S pack was designed to facilitate the four Cs of STD case management: compliance, condom use, counseling, and contact tracing/partner notification. The program developed two treatment packs, a Green Pack for men to treat urethral discharge and a Blue Pack for women to treat vaginal or cervical discharge. Each pack contained a full course of treatment, information about STDs and prevention practices, seven condoms, and two partner notification cards with a consultation voucher. Triple S was distributed in pharmacy outlets and NGO clinics at subsidized prices. A year later, JICA contributed commodities that enabled PATH to develop similar pre-packaged syndrome treatment kits (SafePack) that were provided free of charge to government clinics in three sites.

**Private sector involvement in STD prevention and treatment:**

Private pharmacies provided prevention information and outlets for the treatment packs. Pharmaceutical companies supplied discounted drugs for the Triple S Pack, packaging and IEC materials. Local pharmaceutical associations identified coordinators to resupply and monitor participating pharmacies. NGOs disseminated STD prevention information, made referrals and/or sold Triple S packs, and, in some cases, employed program coordinators. Private physicians and SHC staff referred STD cases to Triple S outlets. [27]

Cost of STD treatment was a very real concern for many people at risk. Rather than completing an entire course of medication, clients would try to save money by buying only one or two pills at a time and waiting to see

if the symptoms subsided. This practice meant they may not have been fully cured of the disease and were likely to develop a resistance to the drug. To ensure that the Triple S packs were affordable to a range of people, PATH sourced drugs at a discount and provided the packs to the pharmacies below cost; the pharmacies were allowed a 10 percent markup. NGOs sold the packs at half the pharmacy cost since their clients typically came from poorer socio-economic groups. To encourage partners of STD clients to seek treatment, pharmacies and NGOs charged them half the normal price. To ensure adequate demand for Triple S pack, the project developed an advocacy packet targeted to LGUs and the entertainment industry to help them answer basic questions about STDs and Triple S.

### **Policy and Advocacy**

Since the Philippines health system had been decentralized, Local Government Units LGUs were responsible for health services. ASEP's policy and advocacy efforts focused on creating institutional mechanisms that would allow LGUs to sustain HIV and STD prevention beyond the project period. Although policy and advocacy efforts officially began several years into the implementation of ASEP, earlier initiatives had already laid the groundwork for action at the policy level. In 1995, ASEP sponsored the Philippines-Thailand exchange to give policy makers, local government representatives and NGO leaders exposure to innovative prevention efforts underway in Thailand. The exchange served as a catalyst for the project. Members of Congress, NEDA, the Philippine National AIDS Council (PNAC), and LGUs and NGOs were introduced to policies, particularly 100 percent condom use, and some began advocating for similar policy reform in the Philippines soon after their return from the exchange trip. Others followed the initial exchange for both government

and NGO representatives, who traveled and worked together throughout the course of the trips and established bonds that would foster their future partnerships. During these trips, ASEP partners developed city action plans and set the stage for institutionalization of other HIV prevention mechanisms, particularly the multi-sectoral LACs.

ASEP mobilized key stakeholders by giving them orientations on the HIV and STD situation at the local and national levels. These sessions tried to highlight local concerns that would most affect a political actor by using site-specific data and examples, particularly syphilis seroprevalence results from the HSS. ASEP NGOs identified potential 'champions' on STD/AIDS issues from various sectors who led policy and advocacy efforts. To institutionalize the policy effort, the project created multi-sectoral task forces or local STD/AIDS councils in each site. The task forces took part in a series of activities intended to inform their understanding of the issues and help them develop practical approaches to address prevention in the context of their locality. The activities included exposure visits to other sites, consultations with other sectors such as entertainment establishment owners and other people in the sex industry, and photo exhibits in government halls. The project also facilitated technical support from local and international experts and created linkages with other partners.

[26]

In each site the task forces worked to enact five HIV and STD prevention policies:

- Condom availability and 100 percent use in registered establishments
- Mandatory AIDS and STD prevention education
- Improved SHC examination for entertainers

- Establishments' health policy for workers
- Non-hiring of minors

All eight sites were able to pass legislation on all these policies, with the exception of Davao, which did not pass the condom policy

Advocacy efforts were expanded in 1997 to involve LGUs in continuing HIV surveillance and education activities after the project end. ASEP helped its partners update their City Plans of Action for STD/AIDS Prevention in each site, design City-Wide Condom Promotion campaigns and estimate costs for drugs, condoms, and NGO services. Implementing rules and regulations and Policy Compliance Monitoring (PoCoMon) guidelines and tools were also developed to monitor the entertainment industry's compliance with the new policies established under local ordinances. Five LGUs earmarked a combined total of Pesos 3.4 million (US\$68,000) for ASEP activities in 2002 but only 7 percent was for Education activities implemented by NGOs and LACs. Most of the funds were appropriated

### **The Value of Persistence**

*In Pasay, Kabalikat (NGO partner) staff learned the value of persistence: it took months for their policy advocate (Noel Dionisio) to get a meeting with the mayor. The meeting, when it finally happened, lasted just five minutes, but that was enough to obtain the mayor's full support for a draft ordinance mandating five basic HIV and STD prevention strategies. The ordinance was eventually fast-tracked, with the help of a local champion, and passed in 2002. Now, the city is funding the development of implementing rules and regulations, and the city health office holds mandatory HIV and AIDS education each week for new entrants to the entertainment industry.*

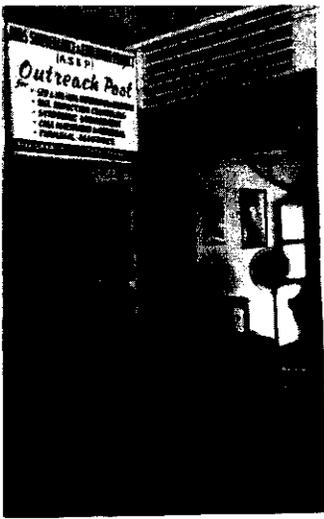
for honoraria, surveillance activities, and STD treatment delivered by government health workers. Although LGU allocations for AIDS prevention activities increased somewhat in 2003 (Pesos 4.4 million), the amount earmarked for Education was less than 9 percent.

## **Community-level Interventions**

PATH and its partners also tested a strategy to address child prostitution in ASEP sites through the BLAaCP. Republic Act 7610 enabled barangay captains and /or four or more citizens to apprehend any person in their community who is suspected of child sexual abuse or exploitation. The BLAaCP strategy helped to mount a local response to the sexual trafficking of children in the ASEP sites by reviving defunct barangay councils for the protection of children (BCPCs). The project organized a legal literacy-training program for NGO partners on the provisions of RA 7610. The NGOs, in turn, trained a cadre of community leaders and volunteers and mobilized efforts to establish a local response mechanism in red light districts. Advocacy was also targeted to local businessmen and government officials to improve compliance and enforcement of the labor code that prohibits employment of minors in entertainment establishments.

“Today is Human Rights Day and as Vice President of the Philippines...I am happy to be with you in a meeting which seeks to prevent the incidence of AIDS to our countrymen who are most susceptible to the dreaded disease, especially women and children who are not only engaged in sex trade, but also victims of poverty...Unlike other parts of the world, it is not so much the lifestyle of the culture but rather poverty that places women and children at risk of acquiring HIV and STD. And you know better than I do, that appropriate measures need to be instituted to arrest the proliferation of minors working in entertainment establishments.”

*Vice President Gloria Macapaga-Arroyo's keynote speech at the ASEP Re-entry Night in Angeles City (11 February 2003).*



## program achievements

The achievements of ASEP's education component considerably exceeded project plans and targets. The project worked with 49 different private-sector organizations, some of which had little or no prior experience with health or AIDS prevention. The Annex presents the list of collaborators and summarizes the activities they undertook on behalf of the project. Under ASEP, the following achievements were accomplished:

- Approximately 4,300 personnel from the public and private sectors received training in BCC, outreach education, STD management, policy advocacy, and legal literacy (Table 1).
- The COPE Program reached more than 423,000 clients with HIV prevention education.
- ASEP's STD program trained over 900 pharmacy staff in STD counseling.
- The project's policy and advocacy efforts helped establish local AIDS councils and pass laws mandating HIV and STD prevention policies in all eight ASEP sites, established five citywide campaigns to support 100 percent condom use, and engaged 500 entertainment establishments in campaign activities.

For the relatively modest annual budget of about \$1.5 million, these outputs are a substantial accomplishment. The project also leveraged its funds by raising more than \$11 million in free media time on television, radio, electronic billboards, newspapers, and other media. Some of the

Philippines most creative private sector companies volunteered their time to help develop ASEP's PSAs, which won two national and one international awards.

**Table 1.** Results of ASEP's Education and Policy Component, 1994-2003

<b>ACTIVITIES</b>	
<b>Collaborating Organizations</b>	
Collaborating Private Sector Organizations and NGOs	55
<b>COPE</b>	
CHOWs, PEs and Public and Private STD service providers trained	4,300
New clients reached with behavior change interventions	423,093
Number of follow-up contacts with clients	>1,038,229
Clients referred for STD/HIV testing and care	33,100
<b>Private Sector</b>	
Number of Triple S Packs sold	8,282
Number of pharmacy staff trained to provide counseling	902
Participating Triple S pharmacies	133
Customers screened in drugstores	10,051
<b>100 percent Condom Use</b>	
Number of establishment owners supporting 100 percent condom use	>500
Number of establishment owners co-funding peer educators to monitor 100 percent condom use.	90
Citywide promotion campaigns implemented	5
<b>Mass and Small Media</b>	
Value of free media time raised for HIV and STD IEC (TV, radio, etc.)	> \$11 million
Mass media PSA campaign waves	5
Radio soap operas with HIV/STD messages 1999 (50 percent pro bono) 2000 (100 percent pro bono)	9 each year
Number of IEC materials developed/number of copies distributed	122/1.6 million
Skills-building manuals and training curricula developed	15
<b>Local Financing</b>	
Amount of funds allocated by LGUs via ordinances for HIV prevention activities (2002/03)	Pesos 7.8 million

ASEP's efforts to create institutional mechanisms profoundly changed the context of HIV prevention efforts in the Philippines. PATH facilitated the birth of an active local partnership between NGOs, government health workers, and LGUs. ASEP also drew on the resources and networks of the private sector to expand activities. New city ordinances created local institutional structures to sustain ongoing prevention activities.

While education activities alone do not account for maintaining the low and slow status of the AIDS epidemic in the Philippines, they helped change

the knowledge, attitudes, and behavior of high-risk populations, thereby reducing the opportunity for the spread of the disease to the general population. The HIV seroprevalence in all sentinel groups has remained below 1 percent. This is below project goals, especially for RFSWs in HSS sites, for which the goal was a prevalence of less than 3 percent.

**“The continued low/slow pace of the HIV/AIDS epidemic is in part due to the accomplishments of ASEP, and all participants in the project should share in this success. Infections have been averted in the high-risk groups as a direct result of ASEP.”**

*—AIDS Surveillance and Education Project Final Evaluation, May 2002*

Results from the BSS (see Table 2 below) show improvement in knowledge among both registered and freelance sex workers from 1997 to 2002, which represent the years for which data are available. Most importantly, ASEP education efforts are associated with changes in the behavior of groups at risk. Consistent condom use among freelancers also increased, and condom use with a non-regular partner increased among both registered and freelance sex workers. Sharing of needles among IDUs in Cebu City declined, while cleaning of injection equipment increased. Among MSM, condom use with a non-regular partner increased, although consistent condom use decreased. Results of focus group discussions conducted with MSM in 2002 suggest that some men were dissuaded from buying and using condom because of the attitude and behavior of drugstore clerks, who chide and embarrass customers seeking condoms. Training workshops designed to desensitize sales clerks to condom and improve their interpersonal skills were subsequently supported by ASEP to address this obstacle.

**Table 2.** Knowledge and Practices Related to HIV/AIDS Among Groups Practicing High Risk Behaviors in the eight Education and Policy Component Sites (BSS results)

Indicators & Group	1997	2002
Know three ways to prevent transmission		
RFSW's	64 percent	73 percent
FFSW's	54 percent	64 percent
MSM	72 percent	64 percent
IDUs	NA	78 percent*
Consistent (always) condom use with partner at risk in the past week		
RFSW's	48 percent	34 percent
FFSW's	28 percent	35 percent
MSM	15 percent	12 percent
IDUs	NA	15 percent*
Condom use during the last sexual encounter at risk with non-regular sex partner		
RFSW's		
FFSW's	77 percent	87 percent
MSM	65 percent	84 percent
IDUs	29 percent	36 percent
	NA	56 percent*
IDUs in Cebu City who report sharing injection equipment	77 percent	69 percent
IDUs in Cebu City who report cleaning needles/syringes before use	73 percent	87 percent

\*1999 BSS results; NA – not available from the BSS

Results from the BMS, implemented by PATH and partner NGOs confirm the association between program interventions and increases in safer sexual practices and appropriate STD care-seeking (see Table 3). The indicator for exposure to ASEP's COPE was whether respondents said they received personal information or advice regarding HIV and STD prevention from peer educators, community health outreach workers, or ASEP partner NGOs. Across the four last survey rounds, the data showed that individuals who were reached by ASEP's NGO programs were more likely to use condoms with commercial partners, to refuse unprotected sex (for men – to comply when asked to use a condom), and to seek appropriate STD care compared to counterparts with no program exposure. Respondents with exposure to ASEP NGO programs also reported higher levels of contraceptive use (for females) and HIV knowledge and self perceived risk (all groups).

**Table 3. BMS Trends in Desired Outcomes by Program Exposure of Respondents with Commercial Partners. ASEP NGOs Behavioral Monitoring Surveys 1999-2002.**

		1999		2000		2001		2002	
		Non ASEP	ASEP info						
<b>Percent Condom Use</b>	FFSWs	53.3	83.4	62.4	84.4	66.7	82.7	67.4	86.4
	MEN	57.1	78.3	37.9	62.8	54.1	68.1	73.0	79.2
	YFHRs	58.1	81.8	65.1	90.3	47.3	81.4	75.6	86.7
<b>Percent Seeking Appropriate Treatment</b>	FFSWs	54.5	62.8	60.0	79.7	65.5	67.1	100.0	67.9
	MEN	42.9	29.4	20.0	73.1	56.5	50.0	50.0	69.1
	YFHRs	62.5	80.0	44.4	61.5	50.0	60.0	50.0	77.4

### **Innovations and Institutional Mechanisms**

ASEP's accomplishments are also evident in the skills and experience developed among its local partners. The project demonstrated the effectiveness of working in close collaboration with NGOs, local governments, and the private sector. COPE showed that local NGOs could conduct education programs for high-risk groups. ASEP's policy and advocacy efforts established that local governments can actively support and implement HIV/AIDS prevention programs. ASEP's Triple S, PSAs, and collaborations with the entertainment industry established that the private sector can significantly broaden the reach of HIV/AIDS prevention efforts. These partnerships have built the capacity of local partners and the private sector and enabled them to become active participants in HIV/AIDS prevention, leaving a lasting legacy in the country that will help to ensure the sustainability of program efforts.

The project developed numerous innovations and institutional mechanisms to involve both the private and public sector in HIV/AIDS/STD prevention activities (see Table 4). These mechanisms have created a solid foundation

for sustainable prevention efforts in the future. The next section of this publication further explores innovations and mechanisms and their implications for best practices in other HIV prevention programs worldwide.

**Table 4. Public- and Private-Sector Mechanisms Established to Prevent HIV Transmission, 1993-2002 [38]**

Intervention	Established Mechanism	ASEP Innovations
Outreach education targeted to vulnerable groups	<ul style="list-style-type: none"> <li>Partnership between local NGOs, City Health Offices (CHO) and Barangay Captains</li> </ul>	<ul style="list-style-type: none"> <li>Outreach posts established in red light districts and staffed by NGO workers and volunteer PEs from the target groups. e.g., Commercial Sex Workers (CSWs), pimps, male customers, MSM, IDUs</li> </ul>
STD screening and referral for hard-to-reach groups	<ul style="list-style-type: none"> <li>Service delivery nexus between NGO outreach post and government SHC and barangay health stations</li> <li>Referral mechanism</li> </ul>	<ul style="list-style-type: none"> <li>NGOs screen clients at outreach posts and link with SHC for laboratory and treatment support</li> <li>NGOs link with unlicensed brothels, pimps, CSW collectives, barangay captains, police, youth centers etc. for referrals</li> <li>SHC refer low-income clients to NGO clinics for Triple S</li> </ul>
STD treatment for groups ineligible for government services (Unregistered CSW, freelancers MSM, adolescents)	<ul style="list-style-type: none"> <li>Partnership between drugstore owners, government SHC and pharmacists' associations</li> <li>Treatment cost-recovery mechanism (50-90 percent)</li> <li>Referral mechanism</li> </ul>	<ul style="list-style-type: none"> <li>STD symptomatic cases screened and managed in drugstore settings, under supervision of SHC physician</li> <li>Triple S treatment packs approved by Philippines-FDA for marketing and distribution in drugstores</li> <li>NGO clinics dispense Triple S to low-income groups</li> <li>Referrals from NGO outreach posts, SHCs, barangay health stations, private practitioners</li> </ul>
Condom access	<ul style="list-style-type: none"> <li>Partnership between local NGOs and condom social marketers (DKT)</li> <li>Partnership between DOH and local NGOs for Condom Distribution Logistics Management Information System (CDLMIS)</li> </ul>	<ul style="list-style-type: none"> <li>NGO outreach workers extend condom social marketing to street level</li> <li>NGOs distribute free government condoms to indigent individuals at risk of HIV and unwanted pregnancy</li> <li>Condom social marketing expanded to non-traditional outlets for better access</li> </ul>
Local financing for HIV prevention	<ul style="list-style-type: none"> <li>Multi-sectoral LACs organized and instituted at municipal levels</li> <li>City Plan of Action (CPA) for STD/HIV prevention formulated and endorsed to local government for co-financing.</li> </ul>	<ul style="list-style-type: none"> <li>NGOs identify and work through local champions to lobby for passage of local ordinance mandating LAC and CPA. Once ordinances are in place, local governments can appropriate city funds for HIV prevention activities</li> </ul>
HIV prevention policies	<ul style="list-style-type: none"> <li>LACs lobby for passage of ordinances mandating condom access and use in registered sex establishments, non-hiring of minors in red light districts etc.</li> </ul>	<ul style="list-style-type: none"> <li>Arrangement between LAC and entertainment establishment associations for policy compliance and monitoring</li> </ul>
Public education	<ul style="list-style-type: none"> <li>Partnership between NGOs and media concerns for development and placement of public service advertising campaigns in tri-media</li> </ul>	<ul style="list-style-type: none"> <li>Pro bono services valued at over \$11 million mobilized from media broadcasters, advertising agencies and public relations firms (1995-2002)</li> </ul>
Behavioral monitoring	<ul style="list-style-type: none"> <li>BMS developed by local NGOs</li> </ul>	<ul style="list-style-type: none"> <li>Low-cost method of monitoring trends in HIV risk taking and prevention practice among target groups</li> </ul>



## best practices

### Establishing Institutional Mechanisms

**M**id-way through ASEP's implementation, its managers, building on evaluation recommendations, made a fundamental change to the design of the project. The original design focused solely on individual behavior change. The project component was limited to education activities that aimed to encourage individuals practicing high-risk behaviors to change their practices. However, ASEP recognized how difficult it would be to achieve change in individual behavior without a supportive environment. The project sponsored a study that identified a number of local laws, policies, and institutional mechanisms that severely hindered efforts to prevent an HIV/AIDS epidemic. These included:

- Local ordinances that limited SHC services to registered female “entertainers,” thus excluding freelance and underage sex workers, who are at higher risk.<sup>2</sup>
- Standard operating procedures of law enforcement agencies that provide for the closure of entertainment establishments found with condoms, which are considered evidence of prostitution.

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<sup>2</sup> Sex work is illegal in the Philippines, but it is common for women and men employed in entertainment establishments such as nightclubs, saunas, or videoke/karaoke bars to offer their services to customers during or after working hours. These workers are registered as “entertainers,” “hospitality workers,” “bar girls,” or “guest relations officers.” They are required to undergo regular STD testing at government SHCs.

- Clauses in collective bargaining agreements for factory workers providing for possible termination of workers with STDs, providing a disincentive to seek diagnosis and treatment.
- Law enforcement procedures providing for the arrest of individuals buying syringes without a prescription. [33]
- Poor access to STD treatment.
- Failure of the legal system to suppress child sex work.
- Sex establishment managers who discourage condom use.
- Inadequate financial support for HIV and STD prevention. [34]

In 1998, the aim of addressing structural and contextual issues was formally added to the ASEP objectives. The project design now focused on synergistic interventions to address both individual and structural levels. Subsequent addition of community-level interventions in 2002 furthered the comprehensiveness of the program design.

Throughout the course of the project, ASEP established institutional mechanisms that created the foundation for long-term sustainability for HIV/AIDS prevention efforts in the country. Some of these efforts began well before the official addition of the structural and environmental issues to the ASEP agenda.

Among the most important policy and institutional mechanisms established by ASEP were:

- **Local AIDS Councils:** To ensure the sustainability of HIV prevention efforts, ASEP organized multi-sectoral LACs to bring together key stakeholders and local champions.

- **City Plan of Action:** The LAC lobbied for the passage of local ordinances and developed a CPA for STD/HIV prevention that could be endorsed by local governments for co-financing of future program efforts.
- **HIV/AIDS/STDs Prevention Policies:** ASEP partners successfully lobbied for the passage of five policies to promote HIV/AIDS/STD prevention efforts. The ordinances made it possible for local governments to appropriate city funds for STD/HIV prevention activities.
- **Policy Monitoring Tools:** Project staff and partners also created simple monitoring tools to help LGUs, NGOs, and the entertainment establishments assess progress in compliance with these policies in their localities.
- **Behavioral Monitoring Systems:** PATH helped its NGO partners conduct low-cost surveys on risk and prevention behavior in ASEP sites. As a result, NGOs were able to monitor and refine their program efforts on an ongoing basis.
- **Cost Recovery for STD Treatment:** NGOs and pharmacies recovered 50-90 percent of the cost of STD treatment, while ensuring that clients from a range of socioeconomic groups could afford the cost of treatment.

These mechanisms created the policies and structures and tools to facilitate ongoing HIV prevention activities, thereby strengthening the sustainability of ASEP's program efforts.

## **Fostering Effective Partnerships**

ASEP created a culture of partnership in HIV prevention efforts in the Philippines. The project established numerous mechanisms for partnerships that created the backbone of project interventions. In particular, ASEP strengthened collaboration between NGOs, government health workers, and local government units. Private-sector actors, such as entertainment establishments, pharmacies, and media companies, also figured prominently in ASEP's innovative initiatives.

ASEP partnerships took on many forms:

### **With Private-sector Collaboration:**

- LGUs, NGOs, entertainment establishments, and media concerns established multi-sectoral LACs.
- Pharmacists, pharmacists' associations, and NGOs collaborated to extend affordable STD treatment (Triple S) to freelance sex workers, MSM, adolescents, and other groups ineligible for government services.
- NGOs and a condom social marketing group improved the availability of condoms.
- Pharmacy personnel learned social marketing techniques and implemented STD social marketing activities in ASEP's red light districts.
- NGOs and media companies developed public service advertising campaigns on STD and HIV prevention and related issues.

### Government-NGO Partnerships:

- Local NGOs, CHOs and Barangay Captains expanded outreach education for groups at risk. NGOs worked with Barangay Captains to establish outreach posts in red light districts and the communities where CSWs, their customers, MSM, and IDUs lived and work.
- Government SHCs provided STD screening for hard-to-reach groups. NGOs screened clients and referred them to SHCs for STD testing and treatment services.
- DOH and NGOs distributed free government condoms to individuals at risk of HIV.
- DOH and NGOs jointly estimated STD drug requirements and mobilized commodity contributions for free distribution of SafePack to low-income clients.

### Sharing of Experiences and Tools

PATH facilitated collaboration and exchange among its partners to encourage sharing of experiences, strategies, and tools among partners and sites. PATH encouraged cross fertilization by initiating a series of exposure visits at every level of the project:

- *Across countries:* The project sponsored the Philippines-Thailand exchange and a series of other technical exchange trips between Thailand and the Philippines to give Filipino policy makers, local government staff, NGOs, and private-sector representatives exposure to the range of individual behavior and structural change strategies of Thai HIV prevention efforts. PATH and partner NGOs

also shared ASEP's experiences with several different delegations that visited the Philippines from Cambodia, Mongolia, Indonesia, Myanmar, and Laos.

- *Across ASEP sites:* PATH gave special recognition to NGOs that developed model approaches and tools. For example, the NGO, FreeLAVA, developed an operating manual for setting up an outreach system, which included all the forms needed to monitor HIV prevention outreach. PATH adapted the manual for use as the project's standard operating procedure. FreeLAVA facilitated training workshops with PATH to help the other NGOs learn how to use the manual and its monitoring and reporting forms.
- *Within ASEP sites:* ASEP supported exposure visits between different local partners to strengthen understanding and skills among LGUs, government health staff, NGOs and the private sector. For example, ASEP brought government SHC staff to project catchment areas to see how PEs and CHOWs interacted with clients. This helped reinforce the concept of a client-centered approach and foster collaboration between government health workers and PEs and CHOWs.
- *Between project headquarters and sites:* All PATH staff at every level were encouraged to work in the field and take on a different role.

ASEP also facilitated exchanges between ASEP sites and cities that were not part of the original program but were later incorporated in the extension phase. The Philippines National AIDS Council (PNAC) facilitated the study tours with logistical support from PATH and The Future's Group. Participants in the study tours traveled to Cebu to see firsthand

ASEP strategies in action. From each city, the following personnel participated in the exposure visit: the Mayor, Member of Local Health Board, City Health Officer, SHC Physician, and NGO representative.

*“We asked ASEP to support our exposure trip to other sites. Now we have a network of NGOs.”*

Charlene Taboy, Executive Director, Kabalikat, Quezon City

PATH ensured that creative strategies and tools were shared across sites. Innovations developed in one city were refined and passed on to other ASEP sites. In one site, a local association of entertainment establishments developed a system to monitor its members' compliance with 100 percent condom use policy, which was shared with other groups at the annual ASEP National Review Meeting.

## **Creating Strategies for a Low prevalence Context**

### *Raising political will*

One of the ongoing challenges faced by the project was how to create the momentum for action, without the urgency of an epidemic in the country. While the threat of an epidemic might be real, it was difficult to bring that reality home to policy makers and people at risk.

To raise awareness and political will, ASEP and its partners highlighted problems related to HIV and AID that were of more immediate relevance to political leaders and those at risk, such as the rising incidence of syphilis. Prevalence rates had reached up to a level of 20 percent in some cities. ASEP's advocacy and media efforts presented the growing problem of

STDs, its links to HIV/AIDS, and the need for a syndromic approach to STD management in the country. They also galvanized the support of politically powerful communities likely to be affected by STDs – the entertainment establishment in particular.

ASEP and its partners mobilized sex workers and other affected groups and worked to raise the risk perception of individuals. ASEP's programs integrated STDs with HIV prevention education and later incorporated other high-impact interventions including STD case management and harm reduction programs for IDUs. NGO partners tailored their efforts to the concerns of different groups. Among IDUs, Hepatitis C was at epidemic proportions. NGOs adopted messages and program strategies to help IDUs protect themselves from Hepatitis C and used these efforts as an entry point for HIV prevention.

### *Defining focus*

The Philippines government was keenly aware that early and effective focusing of prevention efforts was needed to prioritize allocation of project resources. AIDS spreads rapidly in groups practicing high-risk behaviors and then moves on to the general population. Focusing on groups at risk enabled the project to reach, with limited resources, a large concentration of individuals most likely to be infected. For a low-prevalence country with a constrained budget, this was the most cost-effective approach. [11] Initially, ASEP defined groups practicing high-risk behaviors to include registered female sex workers (RFSWs), freelance female sex workers (FFSWs), men who have sex with men (MSM), and IDUs.<sup>2</sup>

Over time, the focus of ASEP program efforts changed to complement existing needs and programs. Surveillance data showed RFSWs had greater awareness of disease prevention and higher levels of condom use than FFSWs. Government clinics were treating RFSWs and ensuring that they received periodic or frequent STD exams. FFSWs had few health service options available. Government clinics were generally not open to them, so they were forced to resort to expensive private services. FFSWs were often teenagers with limited education and a poor understanding of prevention practices for HIV and STDs. Young FFSWs were also at a greater disadvantage negotiating condom use with their customers. [16] BMS results also showed that young FFSWs had higher sex partner turnover rates than adult CSWs. To fill the existing gap, ASEP NGOs began to focus on the needs of FFSWs, which necessitated combined prevention efforts: outreach education, empowerment, STD treatment and prevention case management, and policy advocacy.

### **Engaging Stakeholders in Policy Change**

ASEP and its NGO partners recognized the importance of enabling local stakeholders to lead policy change in each site. For HIV prevention efforts to succeed in the Philippines, ASEP needed the support of many groups. Stakeholders, such as entertainment establishments and the church, had widely divergent visions and interests. ASEP's social mobilization efforts sought to bring together the different mandates and needs of these groups. ASEP supported local leaders and groups to drive advocacy initiatives and the policy change process. PATH facilitated a part-

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<sup>3</sup> While overseas workers were originally included, they were later dropped due to lack of evidence to suggest that they were more at risk than the general population. [12]

nership between a political champion, NGOs, and the local health department to enable a coordinated approach to advocacy for HIV prevention. PATH and its local partners conducted education and awareness raising activities using local risk data to bring home the reality of the STDs and HIV to local groups. The local AIDS council and the process of establishing local ordinances galvanized other stakeholders. [47]

*“Working with NGOs is a plus factor. They know the communities and have their own funding. Our objective is the same... We in the city are very thankful to the NGOs. We are able to make this possible because of the NGOs.”*

Chrisopher Alix, City Councilor, Cebu

ASEP’s experience demonstrated the effectiveness of involving influential stakeholders in policy and advocacy efforts. Policy and advocacy initiatives tapped the particular skills and influence of many individuals and groups: [26, 47]

- *Policy champions*, generally from government or the private sector, to spearhead advocacy efforts.
- *City Mayor* to galvanize support for HIV and STD prevention and encourage local authorities to enact and implement local health policies.
- *Key staff members of the mayor or city councilors* to gain the ear and support of the mayor and other policy makers, and to ensure the delivery of documents requiring timely action.
- *Local Health Board members, City councilors* and other opinion leaders to support the passage of an HIV/AIDS prevention ordinance.

- *Privat-sector actors*, such as entertainment establishment owners, to form an influential core constituency to put pressure on policy makers to ensure the passage of the ordinance.
- *ASEP partner NGOs* to initiate policy advocacy efforts, stimulate local leadership, and conduct education and advocacy activities to increase stakeholders' knowledge about the benefits of proposed policies.

### **Recommendations for Policy Change for HIV Prevention**

ASEP's efforts to pass local ordinances and monitor their compliance suggest other useful ideas about strategies to involve stakeholders in policy and advocacy for HIV/AIDS prevention. The final evaluation of PoCoMon included the following recommendations: [24]

- Encourage city government to contract out components on surveillance, advocacy, training, and education for HIV/AIDS/STD prevention to accredited NGOs.
- Organize stakeholders in the community into "facilitative teams" to stimulate and mobilize for change at the field level.
- Pave the way for a horizontal sharing of AIDS competence by linking up the efforts of the local AIDS councils to the PNAC.
- Provide incentives (e.g., study tours) to city government officials, especially the local chief executive, to promote a local response to HIV/AIDS prevention.
- Enlist new champions or advocates from the private sector to galvanize other stakeholders.
- Build up capabilities of LGUs, NGOs, and other institutions in the community in navigating the political landscape.
- Expand awareness-building efforts and establish an effective public education program on HIV/AIDS/STDs.

- *Local health officer* to act as a key ally in the government health sector to coordinate advocacy and policy efforts.
- *Multi-sectoral LAC* to ensure inclusion of HIV prevention as priority for local government and private-sector groups and passage of local ordinances and local budget for HIV prevention.
- *Barangay leaders* to ensure a solid grassroots foundation for political change in the communities where the individuals at highest risk reside.

*“We need to try to get local government to understand the problem as well as help them prepare for it. The experience of ASEP has been, and continues to be, a major source of guidance – the advocacy tools, the institutional mechanisms that have been put in place.”*

Austere Panadero  
Assistant Secretary, Department of Interior of Local Government,  
and Co-Chair of Philippines National AIDS Council

## **Empowering Peers to Change Behavior**

*“PATH and its NGO partners use peer education approaches very effectively to communicate prevention information to difficult-to-reach groups. The impact of IEC efforts is measurable – data show that they have promoted knowledge, attitudes, and practices necessary for risk reduction.”*

Final Evaluation of ASEP  
May 2001

What explains the effectiveness of COPE program? Many programs throughout the world have used a peer education approach, yet few have been able to demonstrate changes in behavior. What are the factors that distinguish the COPE approach? [46, 44]

*Careful selection criteria for PEs and CHOWs ensured that leaders in the risk communities were chosen.* ASEP NGOs used an indigenous leader approach to choose peer educators. CHOWs befriended the group and identified leaders within the community with influence and a wide array of contacts. Selection was also based on interpersonal relationship skills, socio-cultural background, self-confidence, and potential for being a “safer-sex” role model for peers. Since PEs and many CHOWs came from the communities at risk, they were able to penetrate these otherwise hard-to-reach groups.

*“It is a challenging world to work with MSM, but it changed my life. Before, I didn’t even know what was safe sex. Now I practice safe sex”*

Julie Generalao, CHOW, Bidlisiw, Cebu

*Supportive systems were designed to build self-esteem and self-efficacy and to create a sense of reward and fulfillment to reinforce volunteerism.* Training and monitoring systems for CHOWs and PEs were consistent across sites. NGOs used a sexual network map to identify high-risk groups and influence sexual behavior. CHOWs provided oversight and support for the PEs by working closely with them throughout the week and holding regular meetings. Upward mobility was built in. PEs became CHOWs and CHOWs became project coordinators. Since PEs were leaders within their communities, they were motivated more by respect than by any kind of compensation. Volunteers were reimbursed for travel expenses.

*Ongoing audience research led to a flexible behavior change communication response.* All the sites had regular meetings: CHOWs “ weekly; PEs “ monthly; and the community “ yearly. Meetings had

community feedback built in. Group-guided interaction (GGI) is a more formal type of audience research that also facilitates feedback.

*Facilities and services came increasingly to the communities.*

Outreach posts were set up by NGOs, often within the community, to give information and counseling. SHC services were also extended into all kinds of places – *barangays*, hotels, and sex work sites and even a chapel so that they came to the people. SHCs changed their hours of service to improve their convenience for clients. CHOWS referred freelance sex workers to the clinics for counseling and other services.

*Objectives and messages matched and met real needs.*

Audience feedback was ongoing. Sex workers and MSM were more interested in STDs than in HIV, so the project changed its entry point focus to STDs. IDUs were more worried about Hepatitis C than by HIV, so the project gave them information about their concerns. Over time, most sites have focused less on awareness than on attitudes and skills such as condom use.

*Media services grew out of community preferences. ASEP NGOs conceptualized and implemented a number of innovations:*

- Radio dramas for modeling behavior change.
- Comic books for sex workers.
- Diaries with ‘contracts’ for sex workers, with carbon pages so copies of the contract could go back to the CHOWs.
- Contests such as Miss Gay Universe and Mr. Kabalaka, a take-off from a popular prime time quiz show for adult MSM and male sex workers (MSWs).

- Dancing contests for young MSM and MSWs.
- Music competitions and T-shirts for IDUs.

*Multiple and overlapping interventions increased chances for behavior change. For example:*

- Sex workers were targeted for training in negotiation skills for safer sex and access to regular STD checks.
- Male customers received risk perception, compliance messages, and access to syndromic treatment through Triple S.
- Entertainment establishment owners received support for 100 percent condom use.

### **Recommendations for HIV Prevention Outreach**

An evaluation of COPE suggested recommendations that are relevant to HIV prevention efforts in other sites and countries. Among the key lessons that emerged from the experiences of COPE in the Philippines are the following:

- Contract NGOs to develop community-based HIV/AIDS outreach programs.
- Focus on attitude change and skills development in communities at risk, rather on than medical facts about STD/AIDS.
- Emphasize STD prevention for those at sexual risk and harm reduction for IDUs.
- Seek out any new IDU communities and prioritize them for immediate research and intervention. They represent the greatest danger of HIV/AIDS for the country. [46]

## Improving Health and Education Services

### *Expanding Outreach*

ASEP significantly expanded the reach of health services to the population at risk of HIV/AIDS in the Philippines. The program initiated a close collaboration between NGOs and government SHCs to increase the coverage of government health services and establish NGO outreach posts in areas of particular need. NGOs helped SHCs gain access to communities at risk for surveillance activities. SHCs were able to go into the red light districts where sex workers, MSM, and IDUs lived and worked. NGOs provided services to freelance sex workers and their customers and others who did not access government services. They also referred individuals to SHCs for laboratory work and treatment, increasing the utilization of government services.

The integration of STD and HIV prevention activities created more visibility for both STD and HIV prevention efforts. ASEP's adoption of the syndromic approach to STD management and efforts to train private- and public-sector practitioners in the approach enabled STD treatment to reach unprecedented numbers of Filipinos. The collaboration with pharmacies and NGOs enabled STD treatment to be available to groups who could not access government services, such as freelance sex workers, MSM, and adolescents.

### *Providing affordable STD treatment*

The cost of STD treatment in the Philippines was prohibitive. For someone in the lowest economic groups, a seven-day treatment using branded antibiotics could represent 5 to 10 percent of monthly income. To make

**Government-NGO Partnership for Outreach:  
The Government Health Workers' Perspective**

*"Having a CHOW is very helpful. The CHOW taught us to befriend the sex workers, not to intimidate them. Before we were having a hard time to reach them in the community and to communicate with them. Now we talk to them under the tree, in the mall. Now many more freelancers and MSM are coming into the SHC. The CHOWs bring them to the STD clinics."*

Liliberth Ortega, Midwife, Pasay City

*"Before the program, we went into the community, but it was hard to pinpoint the freelancers and hard to communicate with the community. People kept their distance. We had an experience once when we had to chase them into a hotel for the behavioral surveillance. You could feel they wanted to talk to you, but they were afraid. Now they are more accommodating and friendlier, and they call us ate (big sister), a sign of respect."*

Gigi Zapanta, Medical Technologist, Pasay City

*"MSM and freelancers were neglected before ASEP. Before the program, there were no programs or IEC materials for them. Now we can deal with them appropriately."*

Resty Cruz, Nurse and  
Health Education and Promotion Officer, Pasay City

STD treatment affordable for high-risk individuals who couldn't afford these costs, ASEP developed several strategies. PATH aggressively negotiated significant discounts with pharmaceutical companies to reduce the cost of the STD drugs by 60 percent. To encourage sales, Triple S packs were provided at a very low introductory price of Pesos 200-250, which was increased over time. The cost of the Triple S pack varied according to the outlet and the socio-economic groups it was likely to reach. Pharmacies that served clients with disposable income sold the pack at 10 percent above the cost price, while NGOs sold it to low-income clients at half the cost price.

### *Improving quality*

PATH developed a series of training modules for ASEP's local partners to improve their ability to promote safer sexual practices among groups at risk. The curricula covered information about reproduction and sexuality and emphasized the development of practical skills, such as condom negotiation, risk reduction counseling, verbal and non-verbal communication, and prevention case management. PATH also developed job aids for CHOWS and peer educators, to refresh their memory and provide simple directions on when and how to perform on the job. The job aids developed for the CHOWS and PEs incorporated their suggestions on how to improve their performance and included a pre-outreach checklist, core HIV risk reduction messages, standard HIV/STD prevention messages, and guidance on new tasks such as counseling adolescents on dual protection. ASEP monitoring and reporting tools were also designed to improve the performance of ASEP's partners and encourage behavior change in clients. For example, the daily planner and diary used by PEs helped them plan and track their activities and record problems encountered, solutions and actions, and lessons learned. The planner also included a contract format for clients, which enabled PEs to record behavior change objectives of their clients and monitor progress towards their self-assigned goals.

### **Building NGO Capacity**

PATH's partnership with NGOs was central to the ASEP effort. But it took time to test approaches and build capacity to develop effective NGO activities. ASEP experience shows that it takes about four years for an NGO to build sufficient rapport with a community to effectively lead education and policy activities for HIV prevention. PATH developed

criteria to select appropriate NGOs and required NGOs to report their activities on a quarterly basis. NGOs that were not able to perform to standard were dropped from the project. Over the course of the ten years of the program sub-grants to seven NGOs were discontinued.

PATH facilitated a participatory process of program development to tap the creativity of its partners. NGOs were encouraged to develop their own approaches appropriate for their particular sites. PATH provided consistent training and monitoring activities to all NGOs and shared effective approaches and tools across sites. Upward mobility within the program – volunteers became program staff and program staff became management – encouraged all individuals to do their best.

Training and technical assistance in financial management and accountability was another input that the program supported. With the increase capacity to accurately document and report expenses, NGOs are better able to comply with financial reporting requirements of government and donor agencies and leverage financing for their programs.

### *Flexibility*

PATH's management of the program balanced direction with creativity and flexibility. ASEP provided a clear program structure, but USAID's project design and management allowed for a good deal of flexibility. PATH administered the sub-grant program to enable NGOs to adjust specific aspects of the program to the context of their sites. For example, the program initially specified that NGOs should have health experience to take part in the project. However, in some areas there were no NGOs with health experience. Even when health-related NGOs did exist, they were not always the best prepared groups to work with the project. PATH

established new criteria for the selection of NGOs: interest in learning, established presence and already operating in community, willing to collaborate and coordinate with the City Health Office and SHCs, good standing in the community, and compliance with Philippines regulations for non-profit organizations. In the end, ASEP's experience showed that the most important criteria were established presence and good standing in the community.

*“ASEP provided me with training that makes me a more effective worker and person. ASEP is unique because it serves the marginalized among the marginalized – freelance sex workers. There is fulfillment in being able to reach the hard to reach.”*

Chris Amper, Program Manager, FreeLAVA, Cebu City

Flexibility in the program design allowed NGOs to adjust their target groups according to their skills and experience and the groups practicing high-risk behaviors in their sites. Some NGOs focused only on a single group at risk, while others provided outreach services to all groups. NGOs were able to add new activities and focus to the project such as an emphasis on child prostitution or on STD treatment. These flexible structures enabled ASEP to continually refine and improve its interventions and program approaches.

PATH's flexible approach also facilitated a participatory materials development process. Each NGOs developed IEC materials specific to their site and tested them within their communities. For example, NGO partner Bidlisiw developed comic books that proved to be popular among target audiences in Cebu. PATH screened the final materials for content and acceptability.

NGOs were given freedom to design their programs according to the needs to their communities. While each NGO was required to conduct COPE, they could also do other activities as well. In most sites, the NGO partners were tapped by the CHO to provide AIDS and STD education seminars for new clientele seeking services at SHCs. NGOs also orchestrated special events for World AIDS Day and Candlelight Memorials.

ASEP program guidelines specified processes for selecting and screening NGO staff, but these allowed for exceptions. For example Kabalikat wanted to promote a peer educator who had performed particularly well under the project but who did not have the skills or experience to be a CHOW. ASEP created the position of junior CHOW to enable the PE to advance and become program staff.

### *Piloting approach*

PATH developed a piloting approach to test new ideas in one or more sites before expanding them to all sites. The pilots encouraged creativity and fostered a sense of healthy competition among the ASEP sites. Pilot approaches were often tailored to the context of different sites, which sometimes resulted in several variations on the model pilot intervention. For the Triple S program, ASEP tested three pilot models: NGO, pharmacy, and integrated. No one model proved most effective in all places, although a 1999 evaluation suggested that the community pharmacy model is most sustainable, particularly for symptomatic males who comprised the bulk of Triple S consumers. Whether intentional or not, the Triple S project tapped the strong sense of community involvement to deal with social problems so characteristic of the Philippines. With Triple S, the pharmacists acquired new capacities as implementers of public health and strength-

ened linkages between their associations, the local government offices and the NGOs.

Other pilot efforts include the harm reduction program (HRP), implemented by the University of the Southern Philippines Foundation (USPF) in Cebu. This program was initiated in 1995 when two NGOs visited Nepal to learn from the experience of the Living Giving and Live Saving Foundation (LALS), which had successfully pioneered harm reduction outreach services to IDUs in Katmandu. The ASEP partners adapted similar outreach approaches in Cebu and Quezon City. In an effort to improve compliance for needle hygiene, the Cebu-based NGO partner piloted several approaches including needle exchange, teach-and-bleach, and the introduction of a harm reduction “kit” containing a disposable syringe, alcohol swabs, and antibiotic cream for treatment of skin lesions.

### **Leveraging Private-sector Resources**

ASEP leveraged the resources of several different private-sector groups for HIV prevention activities. It worked with groups who would be most affected by an HIV epidemic in the country or who could influence prevention activities – media companies, pharmacies, private physicians, pharmaceuticals, and the entertainment industry.

#### *Public Service Advertising*

ASEP worked closely with top marketing and media companies to develop award winning PSA campaigns. This mass media effort paved the way for more communication and awareness about STDs/HIV/AIDS.

The PSA development process included:

- Criteria established regarding persuasion and other desired behaviors
- Problem and call to action in each ad
- Top-notch ad design
- Pre-testing using professional agencies

“PATH and partners raised on their own more than \$11 million in pro bono advertising using a wide range of media that increased awareness about HIV/AIDS infection, child prostitution, and the need to destigmatize people with HIV/AIDS. PATH initiative proved to be very effective.”  
[14]

The project did not pay for the creative services for the development of the ads, nor for the placement of the ads. NGOs monitored the ads on television, radio, and other media, kept records on their airtime, and estimated the dollar value of the ad time. Mass media reinforced interpersonal communication efforts. ASEP's efforts showed that public service announcements could be an effective mechanism for increasing private-sector investment in HIV/AIDS/STD prevention. The millions of dollars donated in pro bono ads enabled the project to generate a multiplier effect for its information dissemination activities. ASEP's mass media efforts were recognized for their creativity and excellence. The PSAs received two local awards and one international award.

### *STD management*

The Triple S program demonstrated that the private sector can and will work together with local government in developing an effective response

### Description of PSAs

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

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

Five separate waves of public service advertising (PSAs) were developed and placed in the tri-media (TV, radio, print) during 1995-2000. More than US\$ 11 million in pro bono media and space on TV, radio, electronic billboards, cinema screen time, newspaper space, billboard space, signboard space and magazine space were donated.

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

Final Evaluation Report of ASEP  
May 2001

to STD control. With the help of both the government and private-sector partners, the program was able to provide expanded access to information, diagnosis, and affordable STD treatment to low socio-economic status groups practicing high risk behaviors. It augmented local government services and extended services to groups who would normally bypass government facilities. According to the ASEP final evaluation, “PATH and its partners – NGOs, private pharmacies, and local health offices – developed a highly effective approach to providing treatment for STDs. The Triple S and Safe Pack programs definitely warrant expansion.”

*“After the training I can give advice on how to advise people and how to avoid diseases. It has refreshed my studies and helped me learn more and counsel people.”*

Pharmacy staff, Carasco Pharmacy, Pasil, Cebu City

### *Policy and Advocacy*

ASEP brought the entertainment industry on board with STD and HIV prevention by using local risk data to convince entertainment establishments of the real threat to their businesses. To promote the involvement of the private sector in prevention efforts, ASEP developed the message, “What’s good for entertainers is good for customers is good for business.” The idea was to let private establishments know that the project was there to support their interests, as well as those of groups at risk, and that the project was not expecting them to act out of good will only. ASEP institutionalized private-sector involvement in HIV/AIDS prevention through the creation of multi-sectoral LACs, which were formalized by law and came with budget appropriation.

### **Linking Data and Decision Making**

Both the design of ASEP and its education and policy strategies created a process of linking data and decision making, enabling its local partners to constantly improve their efforts. Program and management decisions were based on evidence from project surveillance and monitoring. The surveillance component of the project meant that education and policy efforts could be tailored according to the HSS and BSS in each site. The project also promoted participatory monitoring efforts at all levels of the project.

*“ASEP enabled knowledge about the problem through surveillance. The education side enabled us to do something with the data.”*

Dr. Rhoderick Poblete, Medical Specialist III,  
Philippines National AIDS Council, Secretariat

To inform education efforts, PATH empowered NGOs to conduct regular BMS among ASEP’s target groups to track changes in risk taking behavior over time, particularly use of condoms with commercial and regular partners, number of new sex partners, refusal of unprotected sex with uncooperative partners, STD care-seeking behaviors, and use of contraceptives to prevent unwanted pregnancy. As a result, NGOs in ASEP sites took part in on-going refinement of strategies, using results of BSS, HSS, and BMS, in addition to evaluations, subproject reviews, and formative research shared by PATH with the NGOs.

ASEP’s data collection and monitoring efforts also benefited policy initiatives. According to the final evaluation, “PATH and its partners develop an excellent participatory process for using Behavioral Monitoring Systems to guide programming and engage LGUs.”

Under PoCoMon, PATH and partner NGOs used the results of an ASEP-supported study conducted by a legal association to identify local ordinances that worked counter to AIDS prevention and formulate agendas and plans to advocate for policy reforms and development of more effective strategies and guidelines.

ASEP encouraged a process of participatory monitoring by creating structures and mechanisms for monitoring:

- Technical staff provided periodic site visits and monitoring visits and ad hoc technical assistance.
- PATH provided on-site financial capacity building and monitoring every six months.
- NGO project manager and supervisors monitored CHOWs and PEs regularly.
- CHOWS supervised and monitored PEs every week.
- PEs recorded their activities in log books.
- PEs recorded client commitments to behavior change through the use of contractual forms in their log books. Some of the log books contained a carbon copy of the contracts to allow PEs to give a copy of the contract to the client.

PATH's efforts to promote participatory monitoring were successful not just because of the monitoring tools and mechanisms created under the project, but because ASEP partners were given the freedom to develop their own strategies to respond to findings from the data. The project provided NGOs with the flexibility to respond to data. NGOs were empowered to come up with creative strategies to deal with newly recognized issues in the field.

# remaining challenges

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## **Keeping the Epidemic Low and Slow**

**D**espite ASEP's impressive achievements in the Philippines, the threat of an HIV/AIDS epidemic in the country remains real. Keeping the epidemic "low and slow" continues to be an on-going challenge. In the Philippines and other low HIV prevalence countries, effort is needed to maintain comprehensive prevention activities and combat complacency in the absence of a crisis. Staying ahead of the epidemic requires strengthened political will to scale up a multi-sectoral response and sustain the collaborative relationship between LGUs, NGOs, health workers, and the private sector. This means keeping the possibility of the epidemic alive in the minds of the public by finding new ways to present risk data and increase awareness. Influential leaders and locally specific data are important to such efforts.

## **Institutionalizing Effective Strategies**

Now that ordinances and financing mechanisms for HIV prevention have been put in place, the difficulty is to make them meaningful by getting legislators to commit funds for HIV/AIDS interventions. Budgetary support is needed to give functional meaning to these ordinances. While mechanisms for budget appropriation to support HIV and STD prevention have now been put in place, in practice, LGUs allocate a minimal

amount of funding and most of it does not go toward prevention activities. Current budgets primarily support honoraria for government workers, surveillance activities, and STD treatment rather than the education efforts needed to help prevent an AIDS epidemic. In the future, LGU financing will be needed to contract NGOs to sustain outreach to groups at risk. Support from international donors is unlikely to continue indefinitely, so the Philippines needs to commit its own funding. NGOs have experience initiating and facilitating prevention efforts, so they have the skills to continue to take the lead in future activities. Maintaining a vibrant partnership between LGUs and NGOs will be a challenge. When LGUs begin to provide funding for prevention activities, NGO independence and flexibility may be threatened. Local AIDS councils can help by setting priorities for HIV/STD prevention efforts and coordinating all relevant activities within a particular locality. Local government needs to integrate and institutionalize HIV prevention in its health and social development plans and programs. Government can also advocate for more support and involvement from other sectors, particularly the private sector. [45] Other low HIV prevalence countries also need to do long-term planning for HIV prevention and institutionalize local funding mechanisms.

#### *Addressing the Changing Needs of Groups at Risk*

The needs of individuals practicing high risk behaviors change over time. According to the final evaluation of ASEP, “high risk behaviors among sex workers, male clients, MSM and IDUs create the potential for a rapid increase in HIV/AIDS infections. **The risk of a rapid acceleration remains quite real, requiring continued assistance for HIV/AIDS prevention.**” There is a constant need for surveillance and updating materials and training over time. If an epidemic starts, it is most likely to spread quickly among

IDUs and MSM. Yet these groups are particularly difficult to reach. Addressing either group has the potential to be politically sensitive in the Philippines. And neither group is large enough nor vocal enough to form a significant political constituency or to justify a specialized large-scale program approach. For example, IDUs are not a large enough group in the Philippines to justify a needle exchange program. [USAID 2002 strategy] The population of these groups is likely to rise with time, further stretching the resources and capacity of prevention efforts.



# replicability and sustainability

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**A**SEP's education initiatives have made great strides in the project sites, but how relevant are they for other sites and countries? What are the lessons other projects need to understand to replicate the ASEP experience and develop sustainable HIV prevention efforts?

## **Strategic focus on institutional arrangements**

Two strategies used in ASEP's education efforts can be replicated in any context and have important implications for program sustainability. First, ASEP made arrangements for the institutionalization of HIV prevention. Core institutionalization efforts included the formal establishment of a LAC, local ordinances to support HIV prevention and a local budget dedicated to program activities. To establish a foundation for such institutionalization, the project built wide and strong political support from local coalitions of different stakeholders, with local NGOs as initiators and guides for the process, and local political champions to provide leadership. [47]

## **Project design facilitates capacity building**

Second, since local partners were the initiators and leaders of the HIV prevention efforts, the project design was oriented toward the capacity building of these local actors. ASEP experience shows that it takes time to

prepare NGOs for their roles within the project. Timelines for HIV prevention projects need to allocate adequate time for preliminary capacity building, as well as for the implementation of program strategies. Thus, projects need to have a timeframe of at least 8-10 years. ASEP's project design was flexible enough to adapt to the problems, resources, and needs of different local partners and sites. The project provided guidance through selection criteria, training curricula, model legislation, and other documents, but allowed for modifications and exceptions to each rule, given justification. Project design facilitated a learning environment with opportunities for ongoing feedback, reflection and analysis, and refinement of project strategies. Mechanisms for gathering evidence about local risks and the effects of interventions informed the decision making of partners. All partners participated in monitoring project efforts, had regular opportunities to jointly analyze results, and planned actions to improve program performance in collaboration with project management. To stimulate innovation and recognize promising approaches, partners were encouraged to develop their own approaches and tools, pilot strategies tailored to site needs, and successful approaches, tools, and strategies were expanded to other sites.

These efforts to build the capacity of local partners and develop institutional mechanisms laid the groundwork for sustainable HIV/AIDS prevention efforts in the Philippines and are relevant to all contexts. HIV prevention efforts need to invest resources in the people and structures that will enable prevention programs to function in the future. ASEP's strategies addressed the immediate needs of the Philippines by focusing on reducing risk behaviors, while also providing a foundation for long-term change.



# appendix

AIDS Surveillance and Education Project/Education Component  
Cooperative Agreement 492-0473-A-00-3107-00  
**SUBGRANTS TO NGOs FOR HIV/AIDS/STD EDUCATION PROJECT**

ITEM	SUBGRANTEE	PROJECT SITE	DATE PARTICIPATED DURATION	PREVIOUS INVOLVEMENT IN PUBLIC HEALTH		PREVIOUS INVOLVEMENT ON HIV/AIDS WORK		CURRENT STATUS AS OF JULY 2003
				YES	NO	YES	NO	
1	Health Action Information Network (HAIN)	Metro Manila Quezon City Pasay City	15 Apr 94-31 Jul 95 01 Aug 94-31 Jul 95	✓		✓		Project Completed
2	Cebu Youth Center (CYC)	Cebu City	15 Apr 94-15 Aug 94 15 May 95-14 Nov 96					Project Completed NGO dissolved
3	Kabalikat ng Pamilyang Pilipino Foundation, Inc.	Metro Manila Angeles City	01 Mar 94-30 Sep 96 01 Apr 95-30 Sep 96 01 Jan 97-31 Oct 97 01 Nov 97-31 Oct 99 01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03	✓		✓		Project Completed
4	Remedios AIDS Foundation, Inc.	Metro Manila	15 Jun 94-17 Aug 95 15 Jul 94-15 Jul 95	✓		✓		Project Completed
5	Reachout AIDS Education Foundation, Inc.	Pasay City Quezon City Angeles City	15 Jun 94-15 Jun 96 01 Sep 94-31 Dec 95 16 Sep 95-15 Sep 96 01 Aug 96-31 Jul 97 16 June 98-15 Jun 99 16 Nov 98-30 Jun 99 01 Nov 96-31 Oct 99 16 Jun 98-31 Aug 00 01 Jul 99-31 Mar 99 01 Jul 99-31 Jan 01 01 Apr 00-31 Aug 00	✓		✓		Project Completed
6	Foundation for Adolescent Development, Inc. (FAD)	Metro Manila	01 Jul 94-30 Jun 96	✓		✓		Project Completed
7	Alliance Against AIDS in Mindanao	Davao City	23 Jun 94 -23 Jun 95 01 Sep 94-28 Feb 95 01 Sep 95-31 Aug 96 01 Sep 96-31 Aug 97 16 Sep 98-31 Aug 99	✓		✓		Project Completed

ITEM	SUBGRANTEE	PROJECT SITE	DATE PARTICIPATED DURATION	PREVIOUS INVOLVEMENT IN PUBLIC HEALTH		PREVIOUS INVOLVEMENT ON HIV/AIDS WORK		CURRENT STATUS AS OF JULY 2003
				YES	NO	YES	NO	
8	Talikala Foundation, Inc	Davao City	24 Jun 94-24 Aug 95 01 Aug 97-31 Jul 98	✓		✓		Project Completed
9	Tri-Dev Specialists Foundation, Inc.	Pasay City	01 Jul 94-1 Jul 95 01 Jan 96-15 Sep 96 01 Aug-96-31 Jul 97 01 Oct 98-31 Aug 99 10 Sep-31 Aug 00 01 Sep 00-30 Jun 02	✓		✓		Project Completed
10	Institute for Social Studies & Action (ISSA)	Quezon City	01 Jul 94-30 Jun 96	✓		✓		Project Completed
11	LUNDUYAN (formerly Children's Laboratory Foundation, Inc.)	Quezon City	01 Jul 94-15 Aug 95 15 Nov-95-15 Sep 96 01 Feb 97-31 Jan 98	✓			✓	Project Completed
12	Remedios AIDS Foundation, Inc.	Metro Manila	15 Jul 94-15 Jul 95	✓		✓		Project Completed
13	In-touch Foundation, Inc.	Metro Manila	15 Jul 94-15 Oct 94	✓		✓		Project Completed
14	Banwang Tuburan, Inc. - Hegala Program	Davao City	01 Sep 94-15 Oct 94					Project Completed
15	Barefoot Media Initiative	Cebu City	06 Jul 94-6 Sep 96					Project Completed
16	Health All Development International	Metro Manila	15 Sep 94-15 Dec 95	✓		✓		Project Completed
17	DKT International, Inc.	Metro Manila Cebu City Davao City Iloilo City GenSantos City Zamboanga City Angeles City	01 Jan 95-30 Jun 96 01 Sep 96-31 Aug 97 01 Dec 98-30 Jun 99 01 Jan 99-Dec 99 01 Jun 99-31 Dec 99 01 Jul 99-31 Mar 00 01 Jan 00-31 Aug 00 01 Apr 00-31 Aug 00	✓		✓		Project Completed
18	Free Legal Assistance Volunteers Association, Inc. (FreeLava)	Cebu City	01 Jun 96-14 Nov 96 15 Sep 96-14 Sep 97 01 Sep 98-31 Aug 99 01 Jan 99-31 Dec 99 01 Sep 99-31 Sep 00 01 Jan 00-31 Aug 00 01 Sep 00-30 Jun 02 16 Sep 02-31 Aug 03		✓		✓	On-going

ITEM	ORGANIZATION	ADDRESS	DATE IMPLEMENTED PERIOD	PREVIOUS INVOLVEMENT IN PUBLIC HEALTH		PREVIOUS INVOLVEMENT ON OTHER WORK		CURRENT STATUS AS OF JULY 2003
				YES	NO	YES	NO	
19	Fellowship for Organizing Endeavors, Inc. (FORGE)	Cebu City	01 May 95-14 Nov 96 15 Nov 96-30 Sep 97 01 Sep 98-31 Aug 99 01 Oct 99-30 Oct 00		✓		✓	Project Completed
20	Bidlisiw Foundation, Inc.	Cebu City	15 May 95-14 Nov 96 15 May 96-31 Aug 97 15 Nov 96-30 Sep 97 01 Sep 98-31 Aug 99 16 Nov 98-31 Sep 99 01 Jul 99-31 Mar 00 01 Sep 99-31 Aug 00 01 Apr 00-31 Aug 00 01 Sep 00-30 Jun 02 16 Sep 02-31 Aug 03	✓			✓	On-going
21	New Tropical Medicine Foundation, Inc. (NTMFI)	National	01 Jun 95-30 Nov 96	✓		✓		Project Completed
22	Philippine Business for Social Progress	- National w/ field visit to Thailand - STD/AIDS in the Work Site Intervention (Davao City)	15 Jun 95-14 Jun 96 15 Sep 97-31 Jul 98	✓		✓		Project Completed
23	Social Action for Life Upliftment Foundation, Inc. (SALU)	Angeles City	16 Sep 95-15 Sep 96 01 Sep 97-31 Jul 98 01 Jan 99-31 Dec 99					Project Completed NGO dissolved
24	Center for Multi-Disciplinary Studies & Health Development (CMSHD)	Quezon City	15 Jan 96-30 Sep 96					Project Completed
25	Community Health & Development, Inc. (COMDEV)	General Santos City	01 Sep 96-31 Aug 97	✓		✓		Project Completed
26	Mahintana Foundation, Inc.	Gen. Santos City	01 Dec 96-30 Nov 97 01 Jan 99-31 Dec 99 01 Jan 00-31 Aug 00 01 Sep 00-30 Jun 02	✓			✓	Project Completed

ITEM	SUBGRANTEE	PROJECT SITE	DATE PARTICIPATED DURATION	PREVIOUS INVOLVEMENT IN PUBLIC HEALTH		PREVIOUS INVOLVEMENT ON HIV/AIDS WORK		CURRENT STATUS AS OF JULY 2003
				YES	NO	YES	NO	
27	SHED Foundation (formerly Mindanao State University)	Gen. Santos City	15 Dec 96-14 Dec 97 01 Sep 98-31 Aug 99 01 Oct 99-3 Sep 00 01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03		✓		✓	Project Completed
28	Social Development Research Center/DLSU	Metro Cebu	01 Jan 97-31 Dec 97	✓				Project Completed
29	Process Foundation, Inc.	Iloilo City	15 Feb 97-15 Jul 98 1 Sep 98-31 Aug 99 1 Sep 99-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03	✓		✓		Project Completed
30	University of Southern Philippines Foundation, Inc. (USPF)	Cebu City	1 Jun 95-31 May 96 15 Nov 96-14 Dec 96 15 Feb 97-15 Aug 98 1 Sep 98-31 Dec 99 1 Sep 98-31 Aug 99 16 Oct 98-31 Dec 99 16 Sep 99-31 Aug 00	✓			✓	Project Completed
31	CPU/Kabalaka Repro Health Center	Iloilo City	16 Jul 97-15 Jul 98 1 Sep 98-31 Aug 99 16 Nov 98-30 Jun 99 1 Jul 99-31 Mar 99 1 Sep 99-31 Aug 00 1 Apr 00-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03	✓			✓	Project Completed
32	Neighbor's Population & Development Services (NPDS)	Zamboanga City	16 Jul 97-15 Jul 98 01 Sep 98-31 Aug 99 16 Nov 98-30 Jun 99 01 Jul 99-31 Mar 99 01 Sep 99-31 Aug 00 01 Apr 00-31 Aug 00	✓		✓		Project Completed
33	IWAG- Dabaw, Inc.	Davao City	16 Jul 97-15 Jul 98 01 Sep 98-31 Aug 99 16 Oct 99-31 Aug 00 01 Sep 00-30 Jun 02	✓		✓		Project Completed
34	Zamboanga Medical Research Foundation	Zamboanga City	01 Aug 97-31 Jul 98	✓			✓	Project Completed

ITEM	SUBGRANTEE	PROJECT SITE	DATE PARTICIPATED DURATION	PREVIOUS INVOLVEMENT IN PUBLIC HEALTH		PREVIOUS INVOLVEMENT ON HIV/AIDS WORK		CURRENT STATUS AS OF JULY 2003
				YES	NO	YES	NO	
35	University of the Philippines (UP) Foundation	Quezon City Angeles City Cebu City Davao City	01 Feb 98-14 Sep 98 16 Oct 98-31 Dec 99					Project Completed
36	General Santos City Pharmaceutical Association	General Santos City	16 Nov 98-30 Jun 99 01 Jul 99-31 Mar 00 01 Apr 00-31 Aug 00 01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03	✓			✓	Project Completed
37	Kaugmaon Center for Children's Concerns Foundation, Inc	Davao City	01 Jan 99-31 Dec 99	✓		✓		Project Completed
38	Human Development & Empowerment Services (HDES)	Zamboanga City	01 Mar 99-28 Feb 00 01 Jan 00-31 Aug 00 01 Sep 00-30 Jun 02 16 Sep 02-31 Aug 03		✓		✓	On-going
39	Pearl S. Buck International, Inc (PSBI)	Angeles City	01 May 99-30 Apr 00 01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03	✓		✓		Project Completed
40	APLX Home Care & Medical Services	Iloilo City	16 May 99-15 May 00		✓		✓	Project Completed
41	Taurus Media, Inc.	National	16 May 99-15 Oct 00					Project Completed
42	Salinlahi Foundation, Inc.	Quezon City	16 May 99-15 May 00	✓			✓	Project Completed
43	Angeles University Foundation	Angeles City	01 Aug 99-31 Aug 00					Project Completed
44	Philippine Educational Theater Association (PETA)	Angeles, Cebu, Davao, Gen Santos, Zamboanga Quezon	01 Sep 99-30 Apr 00		✓	✓		Project Completed
45	Pampanga Pharmaceutical Association	Angeles City	01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03		✓		✓	Project Completed
46	Zamboanga Pharmaceutical Association	Zamboanga City	01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03	✓			✓	Project Completed

ITEM	SUBGRANTEE	PROJECT SITE	DATE PARTICIPATED DURATION	PREVIOUS INVOLVEMENT IN PUBLIC HEALTH		PREVIOUS INVOLVEMENT ON HIV/AIDS WORK		CURRENT STATUS AS OF JULY 2003
				YES	NO	YES	NO	
47	Wo/Men's Access to Vital Education & Services, Inc. (WAVES)	Davao City	01 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03		✓		✓	Project Completed

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