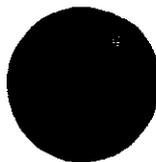


PN-ACW-584

The AIDS Surveillance and Education Project Experience in the Philippines
**Community Outreach and Peer
Education for HIV and AIDS Prevention**

August 2003

path
Program for Appropriate Technology in Health



This publication was made possible through support to the AIDS Surveillance and Education Project (ASEP) by the U.S. Agency for International Development (USAID) under the agreement number 492-A-00-93-00107-00. The opinions expressed herein are those of the author and do not necessarily reflect the views of USAID.

Copyright © 2003, Program for Appropriate Technology in Health (PATH). All rights reserved. The material in this document may be freely used for educational or noncommercial purposes, provided that the material is accompanied by an acknowledgement line.

table of contents

| | |
|----------------------------------------------------------------|----|
| | |
| | |
| | |
| | |
| Evolution of Community Outreach and Peer Education | 5 |
| Partner-NGOs: The Frontline of COPE | 8 |
| ASEP Participation: Effect on NGOs | 11 |
| High Risk Groups and Settings | 13 |
| The COPE Strategies | 20 |
| Key Findings | 32 |
| Constraints | 36 |
| Keeping HIV/AIDS Prevalence Low through Combination Prevention | 37 |
| | |
| | |

acknowledgements

This report synthesizes the experiences of the community outreach and peer education (COPE) efforts of the 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 information, education, and communication (IEC) Specialist. Program for Appropriate Technology in Health (PATH) Consultant Karen Schmidt wrote this report in close collaboration with PATH Program Officer Kirrin Gill, based on ASEP project documentation and interviews with ASEP staff, partners, and clients.

This report also cites findings from several external evaluation reports and draws on the work, ideas, and contributions of local nongovernmental organizations (NGO) partners who made ASEP Education possible. Also invaluable were inputs from local government officials and health workers, as well as staff and consultants of PATH Philippines, particularly Lyn Rhona Montebon, the ASEP Program Monitoring Specialist, and Cristina Mutuc, ASEP Program Associate.

Over the life of ASEP, PATH collaborated with 49 different private-sector groups in the delivery of human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) and STD prevention education to target groups. Foremost amongst these were 12 NGO partners who made significant contributions to the development, testing, and refinement of ASEP's COPE strategies. They include:

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

list of acronyms

| | |
|----------|-------------------------------------------------------------|
| AIDS | Acquired Immune Deficiency Syndrome |
| ASEP | AIDS Surveillance and Education Project |
| BLAaCP | Barangay Legal Action Against Child Prostitution |
| CDLMIS | Condom Distribution Logistics Management Information System |
| CHOW | Community Health Outreach Worker |
| COPE | Community Outreach and Peer Education |
| DOH | Department of Health |
| FFSW | Freelance Female Sex Worker |
| FreeLAVA | Free Rehabilitation, Economic, Education & Legal Assistance |
| HDES | Human Development & Empowerment Services |
| HIV | Human Immunodeficiency Virus |
| HRA | Harm Reduction Advocate |
| HRP | Harm Reduction Program |
| IDU | Injecting Drug User |
| IEC | Information Education and Communication |
| ISAC | Iloilo STD/AIDS Council |
| LGU | Local Government Unit |
| MSM | Men who have Sex with Men |
| NGO | Nongovernmental Organization |

| | |
|---------|----------------------------------------------------|
| PATH | Program for Appropriate Technology in Health |
| PCM | Prevention Case Management |
| PE | Peer Educator |
| PoCoMon | Policy Compliance Monitoring |
| PSA | Public Service Advertising |
| PSBI | Pearl S. Buck International Inc. |
| RFSW | Registered Female Sex Worker |
| SECUS | Sexually Exploited Children Under Sixteen |
| SHC | Social Hygiene Clinic |
| STD | Sexually Transmitted Disease |
| USAID | United States Agency for International Development |
| USPF | University of Southern Philippines Foundation |

introduction

In 1992, the United States Agency for International Development (USAID) authorized the AIDS Surveillance and Education Project (ASEP), designed to prevent the rapid increase of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) in the Philippines by reducing HIV and sexually transmitted disease (STD) risk behaviors and by promoting collaboration between non-governmental organizations and city health departments. 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 elevated despite low prevalence.

ASEP, a ten-year, \$19 million project, began in 1993 with two components. The surveillance component, including HIV Sentinel Surveillance and Behavioral Surveillance Systems, was carried out by the Department of Health (DOH) and local government partners with funding through a grant from USAID to the World Health Organization. The education component was carried out by Program for Appropriate Technology in Health (PATH) and local partner NGOs through a cooperative agreement with USAID. [1] By the end of the project, surveillance activities were being carried out in ten cities, and education activities were underway in eight of those sites. Both components focus on those most at risk of contracting and transmitting HIV, especially sex



workers, their customers, men who have sex with men (MSM), and injecting drug users (IDUS).

The Philippines' first AIDS case was diagnosed in 1984. By 1992, 84 cases of AIDS had been reported, and screening in a few cities had identified fewer than 300 people seropositive for HIV. Nonetheless, certain high-risk behaviors were believed to be widespread, including unprotected commercial sex, unprotected gay sex, and injecting drug use. Although data on HIV prevalence and risk behavior were sketchy, the potential for further spread of HIV was evident. In addition, although many Filipinos had heard of HIV, they lacked specific knowledge about the disease, its transmission modes, and how best to protect themselves. [1] For example:

- A 1993 study found that 63 percent of male respondents had never used a condom; among women respondents in the 1993 Demographic and Health Survey, fewer than 1 percent said their partners recently used a condom. A 1994 study of condom use among high-risk groups in Manila, Cebu, and Davao found condom use to be low across sites and groups. [28]
- In 1994, a survey of 1,000 urban men revealed that 25 percent of married men reported at least one extramarital partner in the previous year. The same survey reported that 72 percent of respondents never used condoms with their extramarital partners. [2, 30]
- In Metro Manila, casual and commercial sex were reported to be common, with up to 12 percent of males aged 20 to 24 paying for sex and 27 percent of males in the same age group reporting casual sex in the previous year. [28]

- 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.

In its final evaluation in May 2001, ASEP was deemed a “highly successful project that has accomplished a great deal at a relatively low cost.” [14]

The evaluation cited three major accomplishments:

- ASEP’s surveillance determined that HIV prevalence remained low, less than 1 percent of adults, even among high-risk groups. However, behavioral surveillance showed that high-risk behaviors were still common, creating a potential for rapid increase in infections.
- ASEP demonstrated that local NGOs can develop effective education programs for hard-to-reach groups at highest risk of HIV infection, and progress was made toward promoting risk reduction behaviors.
- ASEP showed that local governments can be actively engaged in supporting and conducting STD/HIV/AIDS prevention programs, particularly surveillance. [14]

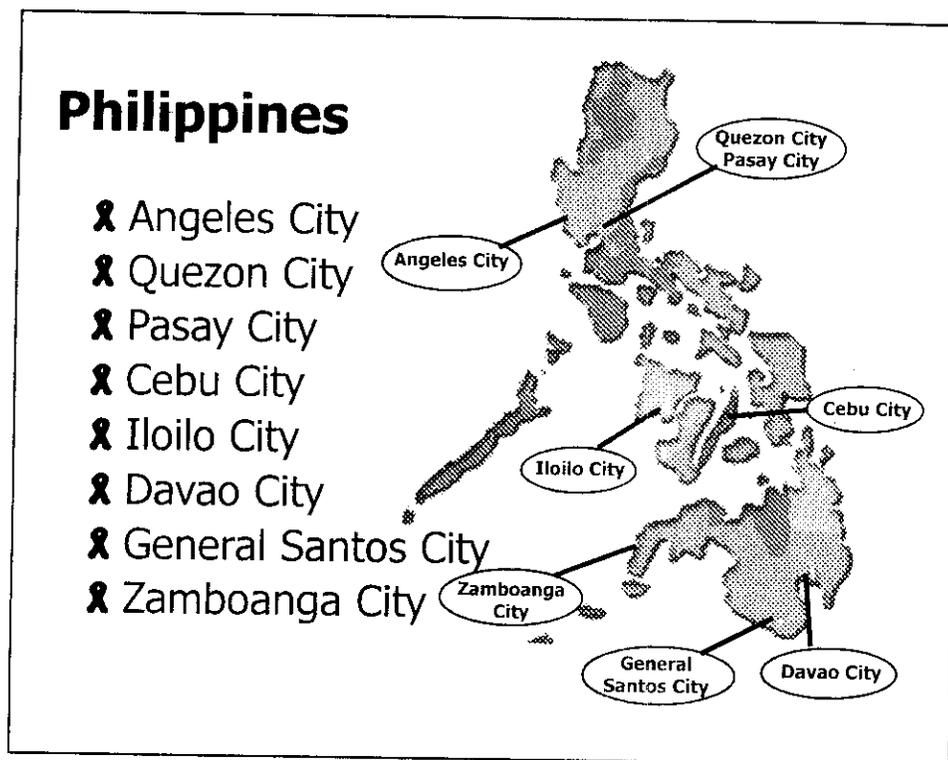
Despite such achievement, local governments requested more time to assume full responsibility for the program, and a two-year phase-out plan was supported by USAID to facilitate the transition (2001-2003).



ASEP education component

The education component focused on three main areas: COPE, STD case management, and policy and advocacy. This document describes the activities of the COPE component and is part of a series designed to highlight the best practices and lessons learned from ASEP's experience in HIV prevention in a low-prevalence country. The series also includes:

- Best Practices in HIV and AIDS Prevention
- STD Management for HIV and AIDS Prevention
- Policy and Advocacy Efforts for HIV and AIDS Prevention



Evolution of Community Outreach and Peer Education

From the start, ASEP's education component focused on people at highest risk of HIV, primarily registered and freelance female sex workers¹ and their customers, partners, and managers. Other key target populations were MSM, IDUS, and later, children and youth (under age 18) in sex work.

For core groups at highest risk, interpersonal communication was the focus: ASEP supported work to help individuals recognize and modify their HIV risk-taking behaviors. Education interventions were based on theories of social learning, community and peer support for incremental risk reduction, and understanding that behavior change occurs slowly and in stages. In developing COPE, PATH relied on the principles of the Indigenous Leader Outreach Model that utilizes intrinsic leaders within targeted sub-populations to facilitate behavior change. One-on-one contacts and guided group interactions were combined to foster solidarity and skills building for condom use, safer sex negotiation, refusal of uncooperative partners, and appropriate STD treatment seeking. [34]

At the same time, the general public, while at low risk of contracting HIV, was a target for mass media messages designed to raise awareness about HIV and AIDS, to promote condom use, to encourage prompt and correct treatment for STDs, to combat child prostitution, and to reduce discrimination and stigmatization against people living with HIV and AIDS.

¹ Sex work is illegal in the Philippines, but it is not uncommon for women employed in entertainment establishments such as night clubs, saunas, or videoke/karaoke bars (which are regulated and taxed by local governments) to offer their services to customers during or after working hours. ASEP refers to these sex workers as registered female sex workers (RFSWs). Freelance female sex workers (FFSWs) work on the street or in unregistered establishments.



The ASEP education strategy was regularly reviewed and revised. The goal of the first strategy was to increase and support behaviors which prevent HIV infection, especially among the most vulnerable groups and their intimate and commercial partners, and to improve general public understanding of HIV and AIDS and social issues related to the disease. [10] The strategy was revised in 1996 to incorporate a focus on institutionalizing public- and private-sector mechanisms that encourage protective individual behaviors, and that modify social norms that promote individual and collective vulnerability to

HIV and STDs. [11] Two years later, the focus was sharpened to strongly target those who, because of a combination of risky behaviors and large sexual networks, are at highest risk of transmitting HIV and other STDs.

[6]

A 2003 review of ASEP's behavior change communication (BCC) activities concluded that, "...by emphasizing community outreach and peer education (COPE), ASEP has made an intelligent use of behavior change theory for the prevention of HIV and STDs in the Philippines. COPE is based on best practices for interpersonal communication and is an effective BCC approach in communities at high risk of HIV/STDs." [40]

Achievements of COPE

Output results through March 2003:

- CHOWs, PEs, and public and private STD service providers trained: 4,300
- Clients reached with BCC: 423,093
- Total repeat contacts: > 1,038,229
- STD/HIV referrals: 33,177
- Condoms distributed: 7,477,361
- Entertainment establishments promoting 100percent condom use: >500
- Amount of pro bono advertising placement leveraged for television PSAs and other mass media: \$11 million
- Number of different IEC materials developed: 122
- Total pieces of IEC materials distributed: 1,674,290

Behavioral Monitoring Survey results from 1999 to 2002:

- Reported condom use with most recent sexual partner increased from 1999 to 2000 among all client groups surveyed, but the rates remained stable from 2000 to 2001, prompting NGOs to strengthen their efforts to encourage consistent condom use. As a result, condom use was dramatically higher in 2002, topping 60 percent for FFSWs and high-risk females under age 18. [38]
- Across all risk groups, respondents with exposure to ASEP (defined as having received information on STDs or HIV/AIDS from a peer educator (PE), community health outreach worker (CHOW) or NGO) were more likely to have used a condom at last sex. Odds ratios ranged from 1.4 for men in red-light districts to 3.0 for FFSWs whose last partner was commercial.
- All female respondents with exposure to the program were more likely to report refusing unprotected sex, with odds ratios ranging from 2.9 for FFSWs to 4.8 for high-risk females under age 18.
- Respondents who received advice or information from ASEP were also more likely to seek appropriate treatment for STD symptoms and to use condoms as contraception. [2002 BMS]

Specific achievements cited in a 2003 review of ASEP's behavior change communication activities include:

- CHOWs and PEs came from the community and remained integrated in it, so they could communicate effectively and inform the project. PEs were motivated by respect and recognition more than money and enjoyed upward mobility .
- Regular feedback from CHOWs, PEs, and the community kept the NGOs in touch with changes in the community, allowing for a flexible program response.
- COPE extended STD services into the community through outreach posts and mobile clinics and brought people at risk, especially FFSWs, to clinic services.
- Appropriate messages were developed, based on ongoing audience research, and media choices grew out of community preferences.
- Synergy developed in ASEP's work from multiple, overlapping interventions to complementary target groups and the judicious combination of BCC and advocacy.
- IDU behavior change has been noteworthy; an epidemic may have been prevented in Cebu.

Partner NGOs: The Front Line of COPE

COPE was the core of ASEP's education component, and ASEP's NGO partners were at the heart of this effort. Over the life of the project, 25 COPE subprojects were completed in the eight ASEP sites. [14] The implementing NGOs developed dynamic teams of paid CHOWs and volunteer PEs to provide behavior change interventions directly to vulnerable groups, including education, risk reduction counseling, condom promotion, and referral for STD diagnosis and treatment. [27] The CHOWs and PEs served as ASEP's front line, constantly seeking out and interacting with the people at highest risk of HIV. Between April 1994 and March 2003, more than 423,093 at-risk individuals completed one

or more prevention sessions with a trained ASEP outreach worker. [PATH, Quarterly Report January-March 2003]

In the 1997 ASEP evaluation, PATH was recognized as being “highly effective” in identifying and supporting NGOs to develop and implement COPE. [34, 13] PATH selected partner NGOs based on each organization’s knowledge of the community and its willingness and ability to work with the local government since building partnerships between NGOs and the local government units was a key goal for ASEP. The most successful NGOs did not necessarily have experience in health care; in fact, PATH discovered that more important success factors were community knowledge and connectedness and especially grass roots community organizing abilities. The NGOs’ strong connection to the community and the CHOW and PE bonding with the target audience were crucial to the success of COPE. Since clients usually have a variety of needs, involving NGOs with experience in a variety of service areas added considerable value to the project. [27] The diverse list of NGOs included those specializing in social marketing, community organizing, social action, youth affairs, child welfare, local governance, and community development, in addition to those specializing in family and reproductive health. [33].

FreeLAVA, an NGO in Cebu, had extensive experience in the community, but its focus had been on legal aid. In fact, ASEP Sub-Project Manager Cristante Amper acknowledged that he had to convince the FreeLAVA board that working on HIV prevention fit into the organization’s mission. “We believe that HIV/STD/AIDS is not only a health problem, but a development problem,” he said. “We consider ourselves as agents of change.” The FreeLAVA board was also against the idea of condom promotion, but Cris said he and his colleagues countered those concerns by pointing out that the condom promotion was for HIV and STD prevention and not necessarily for family planning.

Despite their community experience, many ASEP-implementing NGOs were new to STD and AIDS work and were unfamiliar with the particular vulnerabilities of those most at risk for HIV. All NGOs started with community mapping, a form of rapid situation assessment and analysis that involves fieldwork and discussions with potential clients and other community members. This taught the NGOs more about their communities' demographics; social and legal context; and locations of vulnerable environments, such as entertainment establishments, bars, shooting galleries, and other centers of sex and drug activity. NGOs also learned about existing services for clients, clients' needs for services, and community beliefs and knowledge about HIV and STDs. [27]

Next, NGOs looked into their communities to recruit CHOWs and PEs, seeking people with good rapport in the community who were truly connected to the groups most at risk for HIV infection. Sometimes, CHOWs recruited new PEs directly from among their clients in the field. If not members of client population, they were still expected to be part of the community they serve: some were pimps or mamasans or worked in sex establishments as managers, security guards, or cooks. Some were not connected to the sex industry or IDU networks, but were part of the risk community, such as homemakers, barangay secretaries, vendors, students, or domestic workers, were simply unemployed. [27]

If a person was identified who was interested in becoming a PE, the candidate was interviewed and screened. If accepted, the candidate attended a training workshop on basic STD and HIV prevention messages, communication skills, and PE roles and responsibilities. After training, the PE was assigned to a CHOW and sometimes paired with a more

experienced PE. After a probationary period, the NGO's project manager, the CHOW, and the senior PE evaluated the candidate. If the candidate was a good fit, he or she was offered suggestions to improve his or her performances. If the PE was not appropriate, he or she was asked not to continue. [27]

ASEP Participation: Effect on NGOs

NGOs' participation in ASEP generated several excellent effects. For those already in the area of social services, it expanded their capacities in STD/HIV/AIDS prevention. Pearl S. Buck International Inc. (PSBI), in Angeles City, for example, was primarily providing educational support activities to young children of American military service men and local Filipino women (popularly known as "Amerasians"). With ASEP, PSBI expanded its capacities to include STD/HIV/AIDS intervention and became one of the pioneering NGOs in Angeles city that have successfully implemented STD/HIV/AIDS education and advocacy projects in collaboration with the City Health Office.

For NGOs who were not previously involved in health-related projects, ASEP helped develop and build up their capacities. A clear example is FreeLAVA of Cebu City. FreeLAVA is an NGO with expertise in paralegal issues and had long been working in the area of community organization and development. Before ASEP, FreeLAVA had no experience in health-related projects. It was tapped by PATH because of its skills in community organizing and strong connection to Barangay Kamagayan, an ASEP project site. FreeLAVA was involved with ASEP since 1994, and today has one of the strongest capacities in the area of STD/HIV/AIDS

education, policy formulation, and advocacy. FreeLAVA has gained the respect of the Cebu City Local AIDS Council (LAC) and served as a key player in the passage of the Local AIDS Ordinance in Cebu.

ASEP NGO partners also gained new and meaningful partnerships with local government units (LGUs). Previously, LGUs tended to view NGOs as competitors without legitimacy to work in areas that “rightfully” belonged to the government. Similarly, NGOs learned what constructive things could be facilitated and accomplished by working with the government. The association with government also gave them a heightened credibility. Today, some ASEP partner NGOs are recipients of STD/HIV/AIDS projects awarded by the government. PROCESS Inc., in Iloilo City, for example, has just received over 500,000 pesos for an STD/HIV/AIDS project from the Iloilo STD/AIDS Council (ISAC). FreeLAVA also got funding support from the Cebu City government for a project targeting street children because of its previous work on ASEP’s Barangay Legal Action Against Child Prostitution (BLAaCP) project.

Most ASEP partner NGOs also learned new marketable skills. In Zamboanga City, HDES - one of the youngest NGO partners of PATH, implemented all ASEP strategies: COPE, PoCoMon, BLaACP and Triple S. HDES’ experience tremendously enhanced the organization’s skills and capacities in implementing multiple projects at the same time. HDES’ reputation as an emerging NGO partner, staffed with competent development workers, has been commended by the local media and captured the attention of the city government. Eventually, HDES was appointed by the City Mayor as Executive Director of the Zamboanga AIDS Council with over 2 million pesos appropriated for its STD/HIV/AIDS prevention activities.

Over the life of ASEP, PATH collaborated with 49 different NGO and private-sector organizations across the eight sites. The Appendix presents a list of these organizations and summarizes their previous involvement in public health and HIV/AIDS prevention work.

High-Risk Groups and Settings

Registered Sex Workers

Prostitution is illegal in the Philippines. Nonetheless, a large “entertainment” industry, clustered in urbanized centers, is regulated and taxed by local governments. Entertainment establishments such as bars, massage parlors, karaoke or videoke bars, saunas, and beer gardens employ women known as “guest relation officers” or “entertainers,” and it is well known that these establishments are venues for commercial sex. Under the Philippines Sanitation Code, entertainers registered at these establishments are required to submit for STD testing, usually every two weeks, at the city health department’s Social Hygiene Clinic (SHC). The test is usually a cervical smear that is examined under a microscope after gram staining, and the yield is only 15 percent for gonorrhea (when a correct specimen is collected). Entertainers with negative results have their health cards signed by the local SHC physician, which allows them to work until their next scheduled test. Those who are diagnosed with gonorrhea are given drugs (if they are available) and are not allowed to “work” until the treatment is completed and next test is negative. Of the estimated 42,000 females involved in sex work in



the eight ASEP cities, about one-third are registered. [33] The rest, who work in unlicensed brothels or on the street, are referred to as freelance.

Freelance Sex Workers

Freelance sex workers can be found in most urban areas. They may be streetwalkers, who provide services in cars, hotels, parks, or rented cubicles, or they may live in brothels where a “maintainer” takes care of food and shelter. Since registered establishments are not supposed to employ entertainers under the age of 18, underage sex workers are usually



freelancers. Prior to ASEP, in most places the SHC did not serve freelance or underage sex workers, leaving these women and girls with virtually no access to STD services. Before the mid-project review in 1995, ASEP focused primarily on registered sex workers and their customers. However, results of the mid-term assessment showed that freelance sex workers were at higher risk than their registered counterparts, so the education strategy was refined to focus more interventions

on freelance sex workers and their sexual networks, including paying customers, regular partners, and pimps.

Life on the Street

Sheila, wearing a bright yellow tank top, heart-shaped pendant necklace, and low slung jeans, doesn't have much time to chat: her pimp is negotiating with a potential customer. For the past month, she's been working on the street in the Rotunda area of Pasay City in Metro Manila; before that, she worked in a nearby beer garden. She's 19 and a high school graduate, but needs the 5,000 pesos a week she is earning to put her younger brother through high school. Asked if she uses condoms with her clients (on average seven per night²), Sheila immediately reaches into a front pocket of her girlish backpack purse, and pulls one out: her pimp (a 50 year old woman and former sex worker) insists that she always use one, even if a customer offers 1,000 pesos (\$20) to have unprotected sex. Another freelance sex worker in the area, Maritess, wearing jeans, a flowered t-shirt, and pale blue toenail polish, admits she is taking risks by occasionally having sex without a condom. She estimates that one or two out of every five customers refuses condoms. "Some customers don't like it, and we need the money," says Maritess, 21, who uses her earnings to buy food for her family, since her father has no job. If a customer is willing, she asks him to buy a condom at the hotel, in addition to her 200 to 500 peso fee. Maritess says she doesn't carry condoms in her pocket because of a friend who was picked up by the police, and the condoms she was carrying were used as evidence of prostitution.

Condom use among FFSW's in ASEP sites has gradually increased over time. While before they were among those least likely to practice safer sex, today positive behavior change is very evident. Clearly, the intensive outreach work of the NGOs has facilitated this behavior modification. Following ASEP, without NGO work and with new, highly mobile FFSW's entering the trade, it is highly possible that condom use will go on a downward trend again. The new FFSW's are not exposed to the information and follow-up of the CHOW's and PEs are wanting.

Men at Risk

This group is defined as men who have multiple different partners on a regular basis, either serially or concurrently. They may be commercial or noncommercial partners of sex workers, or other members of their sexual networks such as pimps. Some NGOs reached this elusive target group by working with pimps and “mamasans” to access customers directly when they were procuring a sex worker’s services. Others, such as Kabalikat ng Pamilyang Pilipino, an NGO working in Metro Manila, decided that instead of trying to reach men either directly before or after contact with a sex worker, a better strategy would be to consider the usual profile of the male customers of sex workers and target men at their workplaces, such as the highways department or the truck drivers’ association. The total population of male patrons of sex workers in ASEP sites is estimated at about 1 million. [33]

Men who have sex with men

This group includes a small population of male sex workers, but mostly refers to groups of men and boys who self-identify as gay or bisexual. Homosexual and bisexual transmission is estimated to account for more than one-fourth of reported HIV cases in the Philippines. The ASEP 2001 evaluation noted that MSM are at particular risk: they practice anal intercourse more often than previously assumed, have significant sexual links with men and women in the general population, do not use condoms often, and are the least likely among high-risk groups to consider themselves at personal risk of HIV infection. Some of the MSM are quite young and report multiple partners.

² This number is high. Typically freelance sex workers report an average of 5-6 new partners per week.

Sexually Exploited Children Under Sixteen

An estimated 60,000 children nationwide engage in sex work [36], and most of the sexually exploited children under sixteen (SECUS) helped by ASEP worked in the informal sex sector. ASEP supported targeted SECUS activities after the 1997 evaluation reported seeing girls as young as 11 and 12 as members of freelance sex worker groups. Some of them appeared to have been sold into the sex industry, or forced from their homes because of poverty; they receive their primary social and emotional support from pimps, “mamasans,” or older sex workers. In addition to the usual risks faced by freelance sex workers, these very young girls (and occasionally, boys) face special risks because of their age and developmental stage. [13] After formative research, ASEP developed a program to address the special needs of children in sex work.

Injecting Drug Users

IDUs: Reaching the Hardest to Reach with a Groundbreaking Harm Reduction Approach

In Cebu in 1992, a strange thing happened: an epidemic of malaria seemed to be sweeping through the area. Since Cebu had never been a malarial area, health officials were puzzled. Then they realized that the infection was not being spread by mosquitoes, but by needles shared among drug users. The malaria outbreak among IDUs was a wakeup call to the presence of injecting drug use and risky injecting practices that could pose a serious risk of HIV spread.

³ Unpublished report. Cebu Social Hygiene Clinic. 2002.

The extent of drug use in the Philippines is difficult to gauge, but estimates suggest that one million people are drug users. The drug of choice, crystal methamphetamine or shabu, is normally smoked or inhaled: injecting drug use is less common. The national health department estimates that there are 10,000 IDUs in the country, but other sources place that figure as high as 400,000. [5] In Cebu, the most popular injected drug is the analgesic Nubain, and needle and syringe sharing is common: a qualitative study conducted in 1994 found needle sharing to be the norm, even among people who recognized the danger. [28] Sex work and injecting drug use are increasingly linked: A study in Cebu showed that 27 percent of female IDUs were sex workers, and behavioral surveillance in Iloilo identified injecting drug use among freelance sex workers and MSM. [5]

Even though the Cebu malaria outbreak is history, another blood-borne disease is rampant: in one unpublished survey in Cebu, rates of Hepatitis C among IDUs topped 80 percent.³ And unlike AIDS, which remains relatively rare, most people in the IDU community know someone who has died of Hepatitis C. "AIDS does not ring a bell, but Hepatitis C does," said Honorable Christopher I. Alix, a Cebu City councilor and chairman of the City Council's Health and Hospital Services Committee.

ASEP realized from the start that injecting drug use was an issue, and that no capacity for outreach education to IDUs existed in the country. [32] ASEP adopted an approach known as harm reduction: a public health philosophy that seeks to lessen the dangers to individuals and society that drug use and other harmful behaviors may pose. Harm reduction looks for pragmatic solutions, meeting IDUs where they are and trying various interventions to reduce their risks of HIV and other dangers. Two NGO representatives, one from Cebu and one from Quezon, were sent to Nepal to be trained in harm reduction. Reaching IDUs in Quezon proved difficult, though, because the population was spread out over a large area and difficult to find; after about a year, the project was discontinued. In Cebu, where drug users are more concentrated, efforts were more successful.

⁴ The barangay is the smallest municipal unit of government in the Philippines.

The NGO in Cebu, University of Southern Philippines Foundation (USPF), engaged nurses and former IDUs as harm reduction advocates (HRA). At first, they used primary health care as an entry point, offering antibiotic ointment to treat the skin infections and wounds many IDUs suffer and referrals for minor illnesses. Later, they worked with owners of “shooting galleries,” giving them condoms and teaching them to clean needles with bleach and water. With funding from JICA, a supply of clean needles was purchased and some were distributed. Some of the efforts backfired: when the project placed locked sharps containers in shooting galleries for used needles, police used them as evidence during raids.

The project also enlisted the barangay⁴ leadership: The barangay chief called stakeholders together to talk about the epidemic and how to work together to make the barangay drug free. A technical working group was created, including the press, police, city health officer, academia, and local political leadership. Gradually, the community began to acknowledge the extent of the IDU problem in the barangay.

By hiring former IDUs, the program was better able to reach those who needed help. Moki, an HRA, said that in the past, when he was using drugs and saw someone he didn't recognize, he would run away. “Basically, I know how an IDU feels,” Moki said, “the do's and don'ts for reaching out to IDUs.” One difficulty in the project was that some trained outreach workers were discovered to be backsliding into drug use. Later, the project realized that though some HRAs may still be active users, they can serve as role models by injecting safely: using clean needles and bending the needles after use so they can't be re-used.

The program has had a measurable effect: Sharing of injecting equipment among drug users dropped from 77 percent in 1997 and 1998 to 53 percent in 1999, and one-fourth of those who shared equipment cleaned it with bleach and water. [35]

The COPE Strategies

Qualitative research early in the project showed that while awareness of HIV and AIDS was high in the Philippines, knowledge of prevention behaviors was poor. The understanding of the difference between HIV and AIDS was sketchy, and many misperceptions about ineffective prevention methods were common. Some people believed that antibiotics, vitamins, douching, or withdrawal could prevent HIV. Sex workers and MSM used ineffective partner screening methods – assuming that partners who looked clean, attractive, and healthy probably were healthy. Some sex workers and their clients believed that men do not transmit HIV. [30]

PATH developed a communication program for COPE that focused on basic information and development of skills and self-efficacy. Sex workers were taught effective risk reduction techniques, such as condom negotiation, allowing them to bargain more effectively for safer sex, and resistance skills that enabled them to refuse unprotected sex when they couldn't negotiate condom use. [33] Interventions aimed at MSM promoted three risk reduction strategies: partner reduction, consistent condom use (especially during anal sex), and refusal of unprotected sex. [33] Men at risk were encouraged to comply when a woman asked to use condoms consistently, especially during commercial sex. They were also encouraged to seek early and professional care for STD symptoms and to reduce partners. [33] IDUs and members of their social networks were targeted for interpersonal education, condom access, primary health care, and referral for STD symptoms; NGOs also conducted limited needle exchange and taught IDUs to clean their injecting equipment with bleach and water. [33]

In many cases, CHOWs and PEs learned that focusing on STDs or Hepatitis C rather than HIV was an effective strategy: with such a low prevalence of HIV, even among high-risk groups, self-perception of risk was higher for common STDs and Hepatitis C. Outreach workers would also use practical examples to make their case, such as pointing out to clients that preventing an STD was less expensive than treating one.

COPE strategies were modified as needed to respond to new information. For example, when some NGO surveys showed that many respondents were not aware that someone with HIV or AIDS could not be identified by appearance, NGOs went back to their CHOWs and PEs to find out why. They discovered that from learning HIV is asymptomatic and AIDS is symptomatic some clients concluded that they could tell by looking if a person had AIDS. The information helped NGOs revise their messages to make it clear only a blood test can diagnose HIV. [34]

In 1999, CHOWs were introduced to a simple protocol for HIV Prevention Case Management (PCM), a more intensive methodology to help CHOWs follow up and manage STD-positive clients providing information. To be eligible, clients had to be sex workers or MSM, engage in high-risk behavior, have tested positive for an STD, have already met with a CHOW at least once, and be willing to enroll in PCM. Those who didn't meet the requirements were still offered normal counseling and referrals. CHOWs used an assessment tool to design a written, individualized PCM plan; components included demographic and medical information, present behaviors, the client's readiness to change risky behavior, and his or her willingness and ability to participate in PCM. The CHOWs also considered the client's existing risk reduction skills and the client's social and environmental support structure, including family,

peer, workplace, and partner support; sources of income; and community involvement.

Each client's plan included services normally offered under COPE, including risk reduction counseling and management of symptomatic STDs. But PCM added defined risk reduction strategies and behavior change objectives, individualized interventions that require minimal effort for maximum behavior change and a plan that prioritized the client's most immediate need. CHOWs were expected to meet with clients at least twice a week and to monitor the client's progress points, such as self-reported and validated frequency and consistency of condom use, utilization of STD and HIV prevention and management services, or self-reported opinion change. Some NGOs, however, reported difficulties in following up with clients, especially female sex workers who are highly mobile.

In the Field

Nearly every day in the eight ASEP education sites – or more often, at night – CHOWs and PEs were out in the community making contact with clients. Each ASEP NGO employed between three and five paid CHOWs, and each CHOW supervised six to ten volunteer PEs. CHOWs worked in the field in the same areas as their PEs, sometimes directly accompanying the PE.

During their peer education sessions, PEs would walk around their areas, talk to potential clients, distribute educational materials and condoms, and refer clients to CHOWs or other NGOs for more in-depth counseling, STD care, or other services. The CHOW was nearby to support the PEs, take referrals, and make sure appropriate messages were being delivered [27] Sometimes the CHOWs helped out with initial contacts, especially at

establishments. where the PEs had to work through gatekeepers such as security guards or managers. The PEs and CHOWs were careful not to interfere with business: for example, since most establishments get busy late in the evening, the PEs tried to make their contacts earlier.

Experienced ASEP PEs described their usual preparations before heading out. They made sure they had a good supply of condoms, IEC materials, and pens to make journal entries. One PE in Cebu, Dodie Quiro-Quiro, always checked the mirror to make sure he looked pleasant and pretty. Another, Chamberlein Lozano, said he made sure he had a peaceful mind and a calm mood – since some clients could be very rude. Zenon E. Tolelis always read through brochures before a session, so he'd be sure to be able to answer questions.

The PEs might first approach a street contact with *chica-chica* (casual conversation): asking the time, or asking a man if he is married or has a girlfriend. Sometimes they just observed, striving to be visible and ready to help. Clients were sometimes suspicious, taking them to be thieves, or pimps, or even other sex workers. PEs and CHOWs might build rapport by singing karaoke with potential contacts or playing sports: Ralph Luto, a CHOW at Bidlisiw Foundation, started by playing basketball with potential clients. Now, he even goes to play when he is not on duty. “They no longer look at me as a CHOW,” he said, “but they look at me as a member of their barangay.”

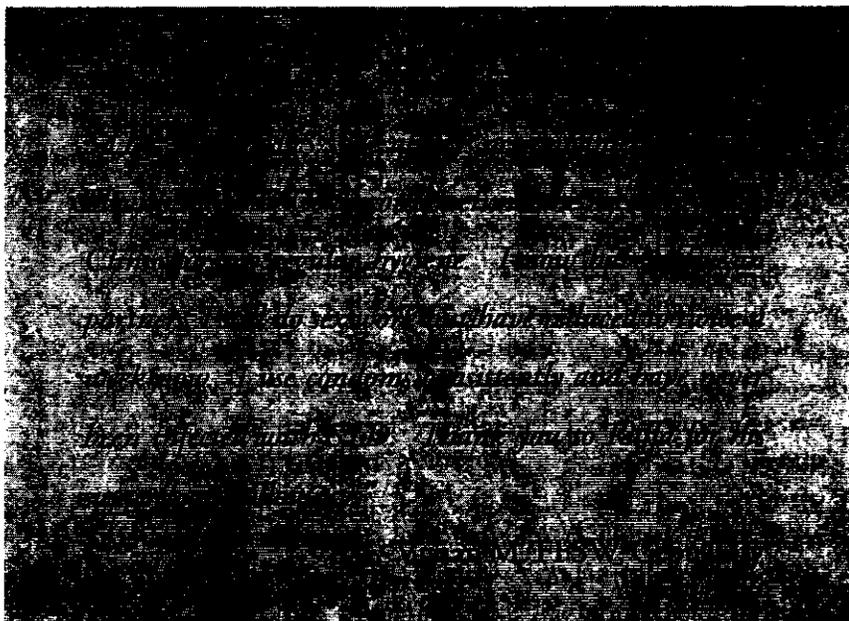
Normally, one PE reached eight to ten peers a month, starting with brief one-on-one contacts and then, on repeat meetings with a client, moving to extended one-on-one contacts that went into more depth. PEs also conducted guided group interactions, designed to help provide clients

with social support for condom use and refusal of unprotected sex. These were generally informal, though in some cases they evolved into regular “study circles” in which the clients met to discuss issues of concern to them, ranging from human rights to housing and childcare. [27] PEs promoted condom use, demonstrated the proper use of condoms, and promoted appropriate STD diagnosis and care. Each PE was expected to keep a daily dairy or journal with short written reports, which were submitted weekly to their CHOW. The diary included the date, time, place and description of contact, and notes needed for follow-up. [27]



Sometimes the CHOWs and PEs went well beyond the focus on HIV and STDs, doing whatever was needed to help the clients improve their lives. Many reported personally escorting individuals to service points for STD treatment. One CHOW reported being approached by a girl who wanted to leave sex work and go home, but her maintainer did not want her to leave. He referred her to another ASEP NGO that could help. Some PEs reported helping sex workers save money so they could continue their education or start small businesses:

One PE knew a particular sex worker was making good money, and convinced her to bank some of it, even walking her to the bank the first few times.



Condom Promotion

ASEP used a variety of strategies to promote condom use in addition to interpersonal communication with high-risk groups through COPE. The project supported DKT, an organization conducting condom social marketing in the Philippines, to create more nontraditional outlets in ASEP sites: condoms were distributed through street vendors, gas stations, and other street-level outlets to make them more affordable and accessible, especially at night when most commercial sex occurs. In some sites, peer educators sold socially marketed condoms, earning a small commission. DKT also routinely visited owners and managers of brothels, saunas, and other sex establishments to encourage them to stock condoms for their workers' and customers' use. In a single year (1998), DKT reported that condom promoters had 19,000 contacts with establishment owners or managers. [34]

In 2002, ASEP instituted two complementary strategies to increase condom demand and access. Demand creation was facilitated by citywide condom promotion campaigns spearheaded by LACs (many of them newly created through ASEP's policy and advocacy efforts). At the same time, the Philippines Department of Health designated ASEP partner NGOs as Condom Distribution Logistic Management Information Systems (CDLMIS) distribution points, enhancing access by eliminating the need for NGOs to source condoms on their own. And despite the increased availability of free condoms through the CDLMIS mechanism, DKT reported that condom sales remained strong, meaning the total number of condoms being distributed or sold increased overall. [38] By early 2003, more than 500 establishment owners in seven ASEP cities were implementing the 100 percent condom use policy, five citywide condom promotion campaigns had been implemented, and eight ASEP NGOs had been approved as CDLMIS distribution points. [41]

Condom distribution and sales in ASEP sites topped 7.4 million over the life of ASEP project, and increased over the course of the project from a low point of 117,000 in 1996 to a high of 1.5 million pieces in 1999, the year ASEP supported the highest number of NGO projects and nighttime DKT promoters [37].

The Challenge of Supervision and Retention

In addition to the support that CHOWs offered to PEs in the field, regular supervision was a critical factor in the success of COPE. Within each NGO, PEs and CHOWs met regularly – at minimum once a month – to discuss and process issues that come up in the field, solve problems, brainstorm new strategies, and for specific training in new areas. Following the meeting with the PEs, the project manager and CHOWs normally met to discuss concerns that had been raised. [27]

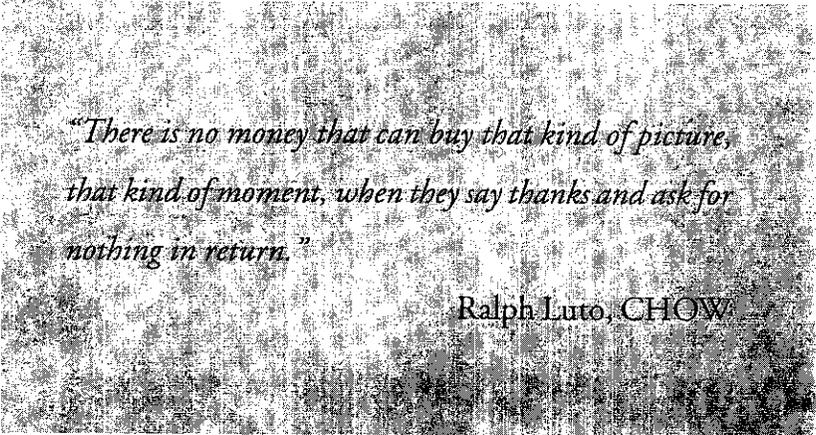
In many peer education programs, retention of volunteer PEs is a challenge. ASEP experienced the same problem: the annual report for 1997 reported that 15-20 percent of trained PEs had dropped. [33] ASEP dealt with this in a variety of ways, including continual review and improvement of selection, training and supervision procedures. Since CHOWs were full-time paid staff, they were strongly retained and able to provide continuous support to their PEs. PEs were offered a small transport allowance, bags, T-shirts, certificates, and ID cards, which were both practical and fostered a sense of belonging. Some NGOs had PEs sign a document detailing their roles and responsibilities. In an effort to make working conditions less difficult, NGOs coordinated with local police and city governments to make sure PEs and CHOWs were not arrested with others during police raids. PEs also received regular education and the chance to travel to other places in the country for ASEP meetings or workshops. In some cases, the NGO became their family: Many become involved in other programs of the NGO, and several PEs were promoted to positions as CHOWs.

When asked why they stayed with the program, PEs and CHOWs cited their pride being recognized and respected in the community. “It makes me feel light,” said Julie



Generalardino, a CHOW for Bidlisiw. “It relieves my stress.” They said they gained the self-confidence to talk to people, and most important, they said they were happy to be able to help people and make a difference in the community. “There’s fulfillment in trying to reach the hard-to-reach,” said Melchor Suguran, a CHOW for FreeLAVA. Although their salaries were modest, CHOWs nevertheless were compensated for their services and this, undoubtedly, contributed to job satisfaction and high retention rates, which enhanced the cost-effectiveness of the targeted intervention program.

PEs and CHOWs contended with a lot: clients who were evasive, unfriendly, or under the influence of drugs or alcohol; establishment managers who thought they were spies; police who thought they were sex workers or drug users; clients who took them to be thieves or pimps. The PEs responded with persistence and patience, coming back over and over until the client was willing to talk and moved through the stages of behavior change.



*“There is no money that can buy that kind of picture,
that kind of moment, when they say thanks and ask for
nothing in return.”*

Ralph Luto, CHOW

Outreach Brought Services to the Community

Implementing NGOs learned that services must be convenient to the clients if they are to be used. Outreach posts were opened in the red light districts or nearby to give PEs and CHOWs a base from which to work and give the project a presence in the community. STD clinics were located in places convenient to the sex industry, including freelance and underage sex workers or education services were brought to locations convenient to the existing SHCs. Some examples of outreach:

- USPF opened the Crying Room, a day care and drop-in center down the hall from the Cebu SHC. The Crying Room was a place where registered sex workers could leave their children in a child-friendly environment while they complied with government rules on STD screening. [27]
- MSUF (later known as SHED Foundation Inc.) set up an outreach post in the beach area outside General Santos City, serving as a field office for the CHOWs and PEs. One day a week, the SHC physician conducted STD screening. [27]
- Bidlisiw's Health Resources Center, located adjacent to the Cebu's red light district, provided STD testing and care services to men, freelance sex workers and minors, with less stigma and more convenient hours than the city SHC. [27]
- A mobile clinic at Rajah Motel in Angeles City was set up by PSBI in collaboration with SHC. STD screening, counseling, and condom distribution were provided to freelance sex workers while they were waiting for their clients.

Public Service Advertising Through Mass Media

Though interpersonal communication was the mainstay of the ASEP education component, mass media played an important supporting role. Between 1994 and 2000, PATH and ASEP collaborators ReachOut and McCann Erickson Philippines Inc. designed five public service advertising (PSA) campaign waves that were aired on national television. Although the early waves focused on HIV and AIDS, the strategy shifted to a focus on STD prevention and treatment, a more “real” issue for most Filipinos. Later spots dealt with generic condom promotion, child prostitution, the link between STDs and HIV/AIDS, and psychosocial issues related to STDs. Two STD campaign waves received awards for creativity, including the prestigious Gold World Medal award at the 1997 New York Television Advertising Festival. [33] In one of the ads encouraging treatment for STD symptoms, a white woman’s slip hanging on a clothesline develops a yellow stain that spreads until the slip tears and is blown away; in a similar ad aimed at men, a pipe develops rust that quickly spreads. One of the condom promotion ads simply shows different varieties and sizes of bananas, ending with a shot of a condom and the message, “one size fits all.”

PATH and its partners leveraged more than \$11 million in free tri-media placement, including TV, radio, billboards, cinema screen time, and newspaper and magazine space; this allowed considerable exposure for each of the spots for a minimal outlay of resources.

Media Campaign

The PSAs did more than provide information: Each one included a call to action. Viewers with STD symptoms were urged to seek professional care at government or private clinics, the child prostitution campaign encouraged viewers to report suspected child molesters to a well-known child-watch number, and other PSAs referred viewers to telephone hotlines. Evaluation results from the first two waves showed a strong increase in the number of callers to HIV/STD telephone counseling services during the campaigns: The AIDS HelpLine in Metro Manila, for example, documented an 884 percent increase in the number of callers during and after the launch of the PSAs. [32]

A 2003 review of ASEP's BCC strategies called the TV spots "an attempt to raise awareness and change the discourse on STDs, HIV, condoms, and sexual ethics in the Philippines. By changing how people talk and think about these subjects, these spots helped create a climate of change to support direct interventions on the local level – a sound strategic choice and good application of behavior change theory in a low-prevalence setting." [40]

ASEP bought into a Neilson Omnibus survey in 1999 to measure exposure and message recall for the television spots. Among the findings:

- 35 percent of TV viewers, 45 percent in Metro Manila, remembered seeing STD advertisements on TV.
- Of those who saw the ads, 55 percent remembered the content.
- 79 percent of those who saw the ads gave correct answers when asked what they would do if they had an STD or learned that their partner had symptoms. [14]

Key Findings

From ASEP's inception, COPE for people at high risk of HIV has served as its centerpiece. Though COPE was supported by selective mass media campaigns, its focus remained in interpersonal communication: the efforts of scores of dedicated PEs and CHOWs who went out into the communities where individuals at greatest risk could be found and used all the tools and ingenuity they had to help people reduce their risk. PATH provided project-wide direction, standardized interpersonal communication formats such as Risk Reduction Counseling, PCM, and Guided Group Interactions, and skills training on a wide variety of topics. The NGOs brought enthusiastic staff, comprehensive understanding of the communities where they worked, and the ability, supported by PATH, to devise creative solutions to issues that arose in the field.

The focus on interpersonal communication is well supported by behavior change theory. According to diffusion research, though people in a community may learn about a new behavior (such as condom use) from outsiders or the mass media, when they are ready to make a personal decision about the behavior, they depend more on their peers. Theories of social support and efficacy reinforce this finding, showing the key role of peers in modeling, supporting, and reinforcing the decision to change. [40]

PATH also made good use of behavior change theory in its work with partner NGOs to develop messages and find the best media choices based on audience needs and preferences. Audience research included formal methods, such as focus groups to find answers to specific program questions, and informal methods, such as regular meetings NGOs held with their outreach workers and with the communities. These meetings provided opportunities for the implementers to gather feedback, anchored ASEP

in the reality of the community, and helped PATH and NGOs make good program decisions. [40]

Along the way, PATH and ASEP partner NGOs developed key best practices and learned important lessons for future programs, especially for settings with low HIV prevalence. A list of key lessons follows.

- **Select implementing NGOs for their core values and strong grass roots community organizing skills.** Though some ASEP partner NGOs already had a focus on health, this was found to be less important for success than connection to the communities where HIV and STD risk behavior is most prevalent. The ASEP experience showed that community connectedness and organizing skills are most important.
- **Recruit CHOWs and PEs with strong connections to the populations at risk.** In some cases, PEs were current or former sex workers, IDUs, or MSMs. Others were members of sexual networks, such as pimps or mamasans, or worked in sex establishments as managers, security guards, or even cooks. Still other PEs or CHOWs were former customers of sex workers or simply residents of the community that includes people at high risk. As members of the community, these frontline staff were best equipped to interact with clients and also to find creative ways to reach the hardest to reach. For example, customers of sex workers may be difficult to reach directly. But based on their detailed knowledge of the communities, NGO staff was able to reach men at risk on the street, through workplaces, or at other sites.
- **Retaining volunteer PEs takes ongoing support and efforts.** PEs were given strong support, and many opportunities to discuss and process what was happening in their work. PEs and CHOWs also had the opportunity for training, travel, and possibilities of advancement within the project. NGOs worked with local authorities to make sure PEs and CHOWs were not arrested in police raids, which made their working conditions less hazardous. Most important, NGOs learned that PEs were most motivated by pride and respect, so anything to emphasize those factors was helpful in retention.

- **Take services to the community.** NGO outreach posts and clinics offered alternative and convenient access for hard-to-reach communities. Outreach workers brought services to the client, whether in the street, at outreach posts, at the SHC, or at entertainment establishments, shooting galleries, or other centers of risk activity. ASEP encouraged SHCs to make services more available in the community, in some cases setting up mobile clinics. ASEP worked with the condom social marketing contractor to increase the type and numbers of outlets in high-risk communities. These efforts supported interpersonal communication efforts by making protective behaviors easier to implement and maintain and by creating an environment that supports behavior change.
- **Meet people where they are and with services they need.** In addition to meeting clients where they were geographically, outreach workers also met people wherever they were on the behavior change continuum: For example, if a sex worker was not prepared to reduce partners, but was ready to learn skills to negotiate condom use, the outreach worker focused on the most likely opportunity for behavior change. Outreach workers for IDUs in Cebu started outreach efforts with a service the IDUs needed – antibiotic ointment for skin abscesses at the injection sites – building rapport in the IDU community before moving to more intensive behavior change efforts.
- **Use mass media selectively to support a targeted education program.** Though targeted interpersonal communication was selected as the prime approach for ASEP, selective mass media helped support the person-to-person efforts by changing the public discourse about STDs, HIV, and related topics, helping to create a

climate of change. The mass media campaigns raised awareness in the general public about the link between STDs and HIV, about the need for STD treatment, and the problem of child prostitution; generic condom ads effectively used humor to relax and lighten the discourse about condoms.

- **Focus messages on issues that seem most “real” and acceptable to the audience.** ASEP effectively used STDs to approach HIV and AIDS issues. Since STDs are seen as less remote than HIV, the project was able to promote the idea of safer sex more effectively. However, one concern with this approach is that the focus on curable STDs could lead individuals to depend on treatment, rather than prevention. Since HIV is not curable, even STD control should be presented in the context of promoting prevention. [29] ASEP used a similar tactic among IDUs in Cebu, focusing safer injecting messages in part on Hepatitis C, which was rampant in the community.
- **Be persistent: effective behavior change for most at risk groups takes time.** Even the best-connected NGOs had to invest up to four years to win the acceptance and trust of client groups. NGOs found that building rapport took as much as two years to become accepted and another two years to build a critical mass of contacts and clients. [29, 36] On an individual level, NGOs found that on average, four to five interactions within two weeks were needed to transfer the essential information and support needed to enable a client to modify his or her risk behavior [36]. In many cases, simply having an outreach worker take an interest in them and their health served as a powerful message to the clients and helped the clients begin the process of adopting protective behaviors.

Constraints

The greatest constraint ASEP experienced in its COPE program was one inherent to any behavior change effort for HIV and STD prevention: the type of behavior change sought is complex and difficult. Changes involving sensitive, personal behaviors such as sexual behavior or drug use can be very slow in occurring. For that reason, the project was constrained in trying to change attitudes and behavior during its 10-year term.

In addition, although ASEP education activities were undertaken in eight densely populated and highly urbanized cities, it was not possible to cover all risk sites or individuals at risk even in those eight places. Given the necessarily intensive and personal nature of the individual interactions between outreach workers and clients, maintaining sufficient coverage to affect community-wide outcomes was a challenge. In addition, the at-risk populations, in particular sex workers, are highly mobile and transient. Maintaining a high level of coverage is difficult when there are constantly new entrants into sex work.

Although ASEP mostly used interpersonal communication, print materials can be helpful in supporting one-on-one contact. However, print materials were always in short supply in some sites and varied in terms of design quality, targeting of message, or appropriateness for the audience. The more resourceful NGOs leveraged additional IEC materials from national and regional health offices, where available. Although PATH trained the partners on IEC materials development process, some NGOs did not apply lessons or created materials that were not as fully developed as they could have been. This limitation was mostly due to time constraints and, in some

cases, budgetary constraints. Some creative materials were not shared between sites as well as they could have been, largely because of the different dialects used in the materials and lack of staff to assist with translation.

Keeping HIV/AIDS Prevalence Low through Combination Prevention

The UN Technical Working Group on HIV/AIDS has attributed the “low and slow” nature of the Philippines epidemic “to early investments in the program.”⁵ Being the single largest component of the government’s HIV/AIDS effort, ASEP contributed to this result by bringing a combination of high-impact prevention strategies to scale in the Philippines. The complementary science-based interventions used by ASEP include COPE as well as condom access, STD management, harm reduction programs (HRPs) for IDUS, PSA, and surveillance (both serological and behavioral). 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 ASEP’s eight urban sites.

PATH estimates that 35 percent of subpopulations most at risk of HIV in urban Philippines have been reached with ASEP’s prevention messages. This compares favorably with other countries in Asia and the Pacific, where fewer than 10 percent of the most vulnerable populations are reached by prevention interventions.⁶

In the 2001 final evaluation, independent reviewers lauded ASEP's peer education effort, and the dynamic partnerships with NGOs that made it possible. The evaluation noted that "ASEP has demonstrated that local NGOs can develop effective education programs targeted on difficult to access high-risk groups." [14] Although the reasons for the Philippines continued low-and-slow pace of HIV are complex and not fully understood, the evaluators stated that "the DOH, USAID, ASEP partners and others working on HIV/AIDS prevention should take credit for mounting an effective response that has contributed to this low prevalence."
[14]

⁵ UN TWG on HIV/AIDS Meeting Notes, 29 June 2000.

⁶ Global HIV Prevention Working Group. Access to HIV Prevention: Closing the Gap. Supplement to Foreign Affairs. May 2003

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

| | | | | YES | NO | YES | NO | |
|---|---------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|-----|----|------------------------------------|
| 1 | Health Action Information Network (HAIN) | Metro Manila Quezon City Pasay City | 15 Apr 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 | 1 Mar 94-30 Jun 03 1 Apr 95-30 Sep 96 1 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 | ✓ | | ✓ | | Completed |
| 5 | Reachout AIDS Education Foundation, Inc. | Pasay City Quezon City Angeles City | 15 Jun 94-15 Jun 96 1 Sep 94-31 Dec 95 1 Aug 96-31 Jul 97 16 June 98-15 Jun 99 16 Nov 98-30 Jun 99 1 Nov 96-31 Oct 99 16 Jun 98-31 Aug 00 1 Jul 99-31 Mar 99 1 Jul 99-31 Jan 01 1 Apr 00-31 Aug 00 | ✓ | | ✓ | | Completed |
| 6 | Foundation for Adolescent Development, Inc. (FAD) | Metro Manila | 1 Jul 94-30 Jun 96 | ✓ | | ✓ | | Completed |
| 7 | Alliance Against AIDS in Mindanao | Davao City | 23 Jun 94 -23 Jun 95 01 Sep-28 Feb 95 1 Sep 95-31 Aug 96 1 Sep 96-31 Aug 97 | ✓ | | ✓ | | Completed |
| 8 | Talikala Foundation, Inc | Davao City | 24 Jun 94-24 Aug 95 1 Aug 97-31 Jul 98 | ✓ | | ✓ | | Completed |

| ITEM | SUBGRANTEE | PROJECT SITE | DATE PARTICIPATED DURATION | PREVIOUS INVOLVEMENT IN PUBLIC HEALTH | | PREVIOUS INVOLVEMENT ON HIV/AIDS WORK | | STATUS AS OF JULY 2003 |
|------|---------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----|---------------------------------------|----|------------------------|
| | | | | YES | NO | YES | NO | |
| 9 | Tri-Dev Specialists Foundation, Inc. | Pasay City | 1 Jul 94-1 Jul 95 1 Jan 96-15 Sep 96 1 Aug-96-31 Jul 97 1 Oct 98-31 Aug 99 10 Sep-31 Aug 00 | ✓ | | ✓ | | Completed |
| 10 | Institute for Social Studies & Action (ISSA) | Quezon City | 1 Jul 94-30 Jun 96 | ✓ | | ✓ | | Completed |
| 11 | LUNDUYAN (formerly Children's Laboratory Foundation, Inc.) | Quezon City | 1 Jul 94-15 Aug 95 15 Nov-95-15 Sep 96 1 Feb 97-31 Jan 98 | ✓ | | | ✓ | Completed |
| 12 | Remedios AIDS Foundation, Inc. | Metro Manila | 15 Jul 94-15 Jul 95 | ✓ | | ✓ | | Completed |
| 13 | In-touch Foundation, Inc. | Metro Manila | 15 Jul 94-15 Oct 94 | ✓ | | ✓ | | Completed |
| 14 | Banwang Tuburan, Inc. – Hegala Program | Davao City | 1 Sep 94-15 Oct 94 | | | | | Completed |
| 15 | Barefoot Media Initiative | | 6 Jul 94-6 Sep 96 | | | | | Completed |
| 16 | Health All Development International | Metro Manila | 15 Sep 94-15 Dec 95 | ✓ | | ✓ | | Completed |
| 17 | DKT International, Inc. | Metro Manila Metro Cebu Davao City Iloilo City | 01 Jan 95-30 Jun 96 1 Dec 98-30 Jun 99 1 Jan 99-Dec 99 1 Jun 99-31 Dec 99 1 Jul 99-31 Mar 00 1 Jan 00-31 Aug 00 1 Apr 00-31 Aug 00 | ✓ | | ✓ | | Completed |
| 18 | Free Legal Assistance Volunteers Association, Inc. (FreeLava) | Cebu City | 1 Jun 96-14 Nov 96 15 Sep-14 Sep 97 1 Sep98-31 Aug 99 1 Jan 99-31 Dec 99 1 Sep 99-31 Sep 00 1 Sep 00-30 Jun 02 16 Sep 02-31 Aug 03 | | ✓ | | ✓ | On-going |
| 19 | Fellowship for Organizing Endeavors, Inc. (FORGE) | Cebu City | 1 May 95-14 Nov 96 15 Nov 96-30 Sep 97 1 Sep 98-31 Aug 99 1 Oct 99-30 Oct 00 | | ✓ | | ✓ | Completed |

| ID# | SUBGRANTEE | PROJECT SITE | DATES OF PROJECT IMPLEMENTATION | PERIODIC EVALUATION IN PUBLIC HEALTH | | PERIODIC EVALUATION ON FINANCIAL WORK | | STATUS AS OF JULY 2003 |
|-----|--------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----|---------------------------------------|----|------------------------------------|
| | | | | YES | NO | YES | NO | |
| 20 | Bidlisiw Foundation, Inc. | Cebu City | 15 May 95-14 Nov 96 15 May 96-31 Aug 97 1 Sep 98-31 Aug 99 16 Nov 98-31 Sep 99 1 Jul 99-31 Mar 00 1 Sep 99-31 Aug 00 1 Apr 00-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep 00-31 Aug 03 | ✓ | | | ✓ | On-going |
| 21 | New Tropical Medicine Foundation, Inc. (NTMEI) | National | 1 Jun 95-30 Nov 96 | ✓ | | ✓ | | Completed |
| 22 | Philippine Business for Social Progress | National w/ field visit to Thailand | 15 Jun 95-14 Jun 96 | ✓ | | ✓ | | Completed |
| 23 | Social Action for Life Upliftment Foundation, Inc. (SALU) | Angeles City | 16 Sep 95-15 Sep 96 | | | | | Project Completed NGO dissolved |
| 24 | Center for Multi-Disciplinary Studies & Health Development (CMSHD) | Quezon City | 15 Jan 96-30 Sep 96 | | | | | Completed |
| 25 | Community Health & Development, Inc. (COMDEV) | General Santos City | 1 Sep 96-31 Aug 97 | ✓ | | ✓ | | Completed |
| 26 | Free Legal Assistance Volunteers Association, Inc. (FreeLava) | Cebu City Lapu Lapu City | 15 Sep 96-14 Sep 97 1 Jan 99-31 Dec 99 1 Sep 99-31 Sep 00 1 Sep 00-30 Jun 02 16 Sep 02-31 Aug 03 | | ✓ | | ✓ | On-going |
| 27 | Mahintana Foundation, Inc. | Gen. Santos City | 1 Dec 96-30 Nov 97 1 Jan 99-31 Dec 99 1 Jan 00-31 Aug 00 1 Sep 00-30 Jun 02 | ✓ | | | ✓ | Completed |
| 28 | SHED Foundation (formerly Mindanao State University) | Gen. Santos City | 15 Dec 96-14 Dec 97 1 Sep 98-31 Aug 99 1 Oct 99-3 Sep 00 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | | | ✓ | ✓ | Completed |
| 29 | Social Development Research Center/DLSU | Metro Cebu | 1 Jan 97-31 Dec 97 | ✓ | | | | Completed |

| | | | | YES | NO | YES | NO | |
|----|------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|-----|----|-----------|
| 30 | 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 | ✓ | | ✓ | | Completed |
| 31 | 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 16 Sep-31 Aug 00 | ✓ | | | ✓ | Completed |
| 32 | CPU/Kabalaka Repro Health Center | Iloilo City | 16 Jul 97-30 Jun 03 1 Sep 98-31 Aug 99 16 Nov 98-30 Jun 99 1 Jul 99-31 Mar 99 1 Apr 00-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | ✓ | | | ✓ | Completed |
| 33 | Neighbor's Population & Development Services (NPDS) | Zamboanga 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 | ✓ | | ✓ | | Completed |
| 34 | IWAG- Dabaw, Inc. | Davao City | 16 Jul 97-15 Jul 98 1 Sep 98-31 Aug 99 16 Oct 99-31 Aug 00 1 Sep 00-30 Jun 02 | ✓ | | ✓ | | Completed |
| 35 | Zamboanga Medical Research Foundation | Zamboanga City | 1 Aug 97-31 Jul 98 | ✓ | | | ✓ | Completed |
| 36 | University of the Philippines (UP) Foundation | Quezon City Angeles City Cebu City Davao City | 1 Feb 98-14 Sep 98 16 Oct 98-31 Dec 99 | | | | | Completed |
| 37 | PROCESS Foundation, Inc. | Iloilo City | 1 Sep 98-31 Aug 99 1 Sep 99-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep-30 Jun 03 | ✓ | | ✓ | | Completed |
| 38 | General Santos City Pharmaceutical Association | General Santos City | 16 Nov 98-30 Jun 99 1 Jul 99-31 Mar 00 1 Apr 00-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | ✓ | | | ✓ | Completed |
| 39 | Kaugmaon Center for Children's Concerns Foundation, Inc | Davao City | 1 Jan 99-31 Dec 99 | ✓ | | ✓ | | Completed |

| | | | | YES | NO | YES | NO | |
|----|-------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------|-----|----|-----|----|-----------|
| 40 | Human Development & Empowerment Services (HDES) | Zamboanga City | 1 Mar 99-28 Feb 00 1 Jan 00-31 Aug 00 1 Sep 00-30 Jun 02 16 Sep 02-31 Aug 03 | | ✓ | | ✓ | On-going |
| 41 | Pearl S. Buck International, Inc. (PSBI) | Angeles City | 1 May 99-30 Apr 00 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | ✓ | | ✓ | | Completed |
| 42 | APEX Home Care & Medical Services | Iloilo City | 16 May 99-15 May 00 | | ✓ | | ✓ | Completed |
| 43 | Taurus Media, Inc. | National | 16 May 99-15 Oct 00 | | | | | Completed |
| 44 | Salinlahi Foundation, Inc. | Quezon City | 16 May 99-15 May 00 | ✓ | | | ✓ | Completed |
| 45 | Angeles University Foundation | Angeles City | 1 Aug 99-31 Aug 00 | | | | | Completed |
| 46 | Philippine Educational Theater Association (PETA) | Angeles, Cebu, Davao, Gen Santos, Zamboanga Quezon | 1 Sep 99-30 Apr 00 | | ✓ | ✓ | | Completed |
| 47 | Pampanga Pharmaceutical Association | Angeles City | 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | | ✓ | | ✓ | Completed |
| 48 | Zamboanga Pharmaceutical Association | Zamboanga City | 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | ✓ | | | ✓ | Completed |
| 49 | Wo/Men's Access to Vital Education & Services, Inc. (WAVES) | Davao City | 1 Sep 00-30 Jun 02 16 Sep 02-30 Jun 03 | | ✓ | | ✓ | Completed |

bibliography

1. USAID. Cooperative Agreement Number 492-A-0093-00107-00 (September 1993).
2. Brown, T. et al. *Sexually Transmitted Diseases in Asia and the Pacific*, Venereology Publishing, Australia (1998).
3. HIV/AIDS in Philippines and USAID Involvement (available http://www.synergyaids.com/documents/2983_Philippines_Brief_rev_5.pdf).
4. USAID. Bureau for Global Health, *Country Profile HIV/AIDS: Philippines*. (available at http://www.synergyaids.com/documents/Philippines_profile.pdf).
5. Reid, G and Costigan G. *Revisiting The Hidden Epidemic: A Situation Assessment of Drug in Asia in the Context of HIV/AIDS*, Center for Harm Reduction, Australia (2002).
6. USAID. *AIDS Surveillance and Education Project Modification of Cooperative Agreement No. 3*. (effective May 24, 1995).
7. USAID. *AIDS Surveillance and Education Project Modification of Cooperative Agreement No. 4*. (effective January 1, 1996).
8. USAID. *AIDS Surveillance and Education Project Modification of Cooperative Agreement No. 7*, (effective March 4, 1998).
9. PATH, *Refining the ASEP Education Strategy* (Attachment A, PATH Quarterly Report (April-June 1998).
10. PATH. *ASEP Education Strategy 1994*. PATH and AIDS Surveillance and Education Project.
11. PATH. *ASEP Education Strategy 1996-1998*. PATH and AIDS Surveillance and Education Project.
12. USAID. *Mid-term Evaluation of the AIDS Surveillance and Education Project*, Manila (1995).

13. USAID. *Assessment Report. Special Objective: Rapid Increase of HIV/AIDS Prevented*, Manila (1997).
14. USAID. *Final Evaluation of the AIDS Surveillance and Education Project*, Manila, (May 2001).
15. PATH. *Plan of Action: ASEP STD Sub-Project*. PATH and the AIDS Surveillance and Education Project (1996-1998)
16. Hermann, C. *Evaluation of the Social Marketing of STD Case*. PATH and the AIDS Surveillance and Education Project (2002).
17. Perla, I. *Evaluation of the Triple S Social Marketing Strategy*. PATH and the AIDS Surveillance and Education Project (1999).
18. PATH. *STD Syndromic Management Advocacy Packet for Local Government Unit Officials*. PATH and the AIDS Surveillance and Education Project.
19. Castro, J. et al. Abstract: *Breaking the HIV Transmission Cycle through Social Marketing of STI Management Kits in the Philippines*. PATH and the AIDS Surveillance and Education Project.
20. PATH. Abstract: *Involving Nurses and Midwives in Improved Management of Children with STD*. PATH and AIDS Surveillance and Education Project.
21. PATH. *Manual on STD Syndromic Management Trainings (Intro and TOC)*. PATH and AIDS Surveillance and Education Project (1997).
22. PATH. *Program Contribution to STD Prevention and Control in the Philippines* PATH and AIDS Surveillance and Education Project (1996-1999).
23. PATH. *A Manual of Operation for Triple S*. PATH and AIDS Surveillance and Education Project (1998).
24. Ateneo School of Government. *End of Project Evaluation, Policy Compliance Monitoring and Barangay Legal Action Against Child Prostitution*. PATH and AIDS Surveillance and Education Project (2002).

25. Center for Integrative and Development Studies, University of the Philippines. *The World of the Children Involved in the Sex Industry: Reducing the Risks and Harm of Sexual Exploitation STD, and HIV/AIDS in Filipino Children*. PATH and AIDS Surveillance and Education Project (2002).
26. PATH. *Lessons Learned: Policy Advocacy Efforts*. PATH and AIDS Surveillance and Education Project (2001).
27. PATH. *Lessons Learned: STD/AIDS Outreach Education*. PATH and AIDS Surveillance and Education Project (1998).
28. Tan, M. *A Review of Social and Behavioral Studies Related to HIV/AIDS in the Philippines*. PATH and AIDS Surveillance and Education Project (1994).
29. Taguiwalo, M. *A Review of ASEP-Assisted HIV Prevention Activities in Three Cities*. Manila: PATH and the AIDS Surveillance and Education Project (2000).
30. PATH. *First Annual Report*. PATH and the AIDS Surveillance and Education Project (1994).
31. PATH. *Second Annual Report*. PATH and the AIDS Surveillance and Education Project (1995).
32. PATH. *Third Annual Report*. PATH and the AIDS Surveillance and Education Project (1996).
33. PATH. *Fourth Annual Report*. PATH and the AIDS Surveillance and Education Project (1997).
34. PATH. *Fifth Annual Report*. PATH and the AIDS Surveillance and Education Project (1998).
35. PATH. *Sixth Annual Report*. PATH and the AIDS Surveillance and Education Project (1999).
36. PATH. *Seventh Annual Report*. PATH and the AIDS Surveillance and Education Project (2000).
37. PATH. *Eighth Annual Report*. PATH and the AIDS Surveillance and Education Project (2001).

38. PATH. *Ninth Annual Report*. PATH and the AIDS Surveillance and Education Project (2002).
39. UNAIDS. website, accessed, <http://www.unaids.org/bestpractice/collection/country/philippines/repphil.html>. (28 June 2003).
40. Franklin, B. *A Review of ASEP'S NGO Behavior Change Communication Activities (COPE)*. PATH and the AIDS Surveillance and Education Project (2003).
41. Aquino, C. *Powerpoint Presentation at AIDS Surveillance and Education Project (ASEP) Final National Program Review*, Cebu City (April 2003).
42. Congress of the Philippines. *Republic Act No. 8504*. Philippines (July 1997). <http://www.chanrobles.com/republicactno8504.htm>
43. PATH. *STD/AIDS Issues. Vol 1. No. 1*. PATH and the AIDS Surveillance and Education Project (June 1997).
44. PATH. *STD/AIDS Issues. Vol. 1 No. 2*. PATH and the AIDS Surveillance and Education Project (August 1997).
45. PATH. *STD/AIDS Issues. Vol. 1. No. 4*. PATH and the AIDS Surveillance and Education Project (December 1997).
46. Franklin, B. *Presentation at AIDS Surveillance and Education Project (ASEP) Final National Program Review*, Cebu City (April 2003).
47. Taguiwalo, M. *Impact and Lessons Learned from ASEP Implementation in Eight Cities*. Manila: PATH and AIDS Surveillance and Education Project (2002).