

93683

# **AIDS Surveillance and Education Project**

(492-0473)

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

## **Best Available Copy**

### **MID-TERM EVALUATION**

**USAID/Philippines  
February 1995**

**MID-TERM EVALUATION OF THE  
AIDS SURVEILLANCE AND EDUCATION PROJECT (ASEP)**

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

Evaluation Team:

Tony Bennett, MSc

James Chin, MD, MPH

Victor Ortega, MD

Anne Scott, PhD (Team Leader)

## TABLE OF CONTENTS

Glossary of Acronyms	
Executive Summary.....	i-vi

### I. Introduction.....

A. AIDS Surveillance and Education Project (ASEP).....	1
B. ASEP Midterm Evaluation.....	1

### II. Technical Evaluation of the ASEP Surveillance Component.....

A. Surveillance of HIV Infection and AIDS Cases in the Philippines.....	3
B. Accomplishments Since the Beginning of ASEP.....	4
C. Key Findings.....	5
D. Conclusions and Recommendations.....	7

### III. Technical Evaluation of the ASEP Education Component.....

A. Background.....	11
B. Accomplishments Since the Beginning of ASEP.....	12
C. Key Findings.....	12
D. Recommendations.....	18

### IV. Organizational Evaluation of the ASEP Project.....

A. Key Findings.....	20
B. Recommendations.....	23

### V. Annexes

One: List of People Visited by the Evaluation Team.....	25
Two: List of Project Documents and Other Relevant Reports.....	28
Three: USAID/Manila ASEP Midterm Evaluation Scope of Work.....	34
Four: Uses and Limitations of HIV/AIDS Surveillance, Including Behavioral Surveillance.....	39
Five: AIDS Case Reporting and HIV Serosurveys in the Philippines.....	44
Six: Summary of the Data Most Relevant Survey Data for ASEP.....	45
Seven: Developing Priorities among Primary Risk Populations for Sexual Transmission of HIV.....	51
Eight: Range of Sexual Behavior Change Options in the AIDS Era.....	56

### VI. Figures

One: Female Commercial Sex Workers Who Report "Always" Using Condoms.....	59
Figure Two: Males With Multiple Sex Partners Who Report "Always" Using Condoms.....	59

## GLOSSARY OF ACRONYMS

ACE - Angeles City Entertainers  
ADB - Asian Development Bank  
AIDAB - Australian International Assistance and Development Bureau  
AIDAB/SEARP - AIDAB Southeast Asia Regional Program  
AIDS - Acquired Immune Deficiency Syndrome  
AIDSCAP - AIDS Control and Prevention Project  
ASEP - AIDS Surveillance and Education Project  
BRL - Bureau of Research and Laboratories/DOH  
BSS - Behavioral Surveillance Survey  
CA - Cooperating Agency  
CSW - Commercial Sex Worker  
DOH - Department of Health/Philippines  
EOP - End of Project  
FCSW - Female Commercial Sex Worker  
FETP - Field Epidemiology Training Program  
GO - Government Organization  
GOP - Government of the Philippines  
GPA/WHO - Global Programme on AIDS/World Health Organization  
HIS - Health Information Service  
HIV - Human Immunodeficiency Virus  
HSS - HIV Sentinel Surveillance  
IDU - Intravenous Drug User  
IEC - Information, Education and Communication  
JICA - Japan International Cooperation Agency  
JHU/PCS - Johns Hopkins University/Population Communication Services  
KfW - Kreditanstalt fur Wiederaufbau  
LOP - Life of Project  
LGU - Local Government Unit  
MOUA - Memorandum of Understanding and Agreement  
MSM - Men who have Sex with Men  
MTP1 - First Medium Term Plan for HIV/AIDS  
MTP2 - Second Medium Term Plan for HIV/AIDS  
NAMRU2 - Naval Medical Research Unit Two/United States  
NAPCP - National AIDS/STD Prevention and Control Program/Philippines  
NCR - National Capital Region (Metro Manila)  
NEDA - National Economic Development Authority  
NGO - Non-governmental Organization  
OCW - Overseas Contract Worker  
OFM - Office of Financial Management, USAID/Manila  
OPHN - Office of Population, Health and Nutrition, USAID/Manila  
OSC - Office of Special Concerns/DOH  
PATH - Program for Appropriate Technology in Health  
PIHES - Public Information and Health Education Service  
PNAC - Philippines National AIDS Council  
PP - Project Paper  
PWA - People with AIDS  
RAFI - Ramon Aboitiz Foundation, Inc.  
RITM - Research Institute for Tropical Medicine

SHC - Social Hygeine Clinic

SOMARC - Social Marketing Company

SOW - Scope of Work

STD - Sexually Transmitted Disease

UNICEF - United Nations Children's Fund

WHO - World Health Organization

WHO/WPRO - World Health Organization/West Pacific Regional Office

## EXECUTIVE SUMMARY

### Introduction.

The USAID/Manila AIDS Surveillance and Education Project (ASEP) is a five-year, \$10 million dollar project being implemented by the Government of the Philippines (GOP) Department of Health (DOH). The goal and purpose of the project are to control HIV transmission within the Philippines population by institutionalizing public and private sector mechanisms for monitoring HIV prevalence, and encouraging behaviors which reduce individual risk for contracting or transmitting HIV. A sentinel surveillance system for monitoring HIV sero-prevalence in the Philippines is being implemented under the surveillance component of ASEP. Mass media, and information, education and communication (IEC) programs which help reduce HIV transmission among individuals at risk are being implemented under the education component of the project.

The ASEP midterm evaluation was conducted in February, 1995 by a four person team composed of an epidemiologist/surveillance analyst; an information, education and communication specialist; and two public health technical advisors. The evaluation team was asked to recommend actions for improving the effectiveness and sustainability of the project, and to determine whether the surveillance system needs to be expanded further.

This document contains a progress report on ASEP, and presents key findings and recommendations regarding the technical components and overall organization of the project. Major points discussed in the report are summarized here.

### Summary of Accomplishments to Date.

#### Surveillance.

Since 1993, three rounds of HIV sentinel surveillance (HSS) have been conducted among six target groups in six geographic sites. Data on risk behavior were collected in all three rounds. Serologic testing for syphilis was added in the third round.

At the local level, staff of public sector Social Hygiene Clinics (SHCs) have been trained by the Field Epidemiology

Training Program (FETP) staff to carry out the sampling and data collection needed for each HSS round.

The DOH has, within two to three months after completion of a surveillance round, prepared and distributed a clear and concise report of the findings to policy makers, and all persons and agencies who participate in the collection of the data.

### Education.

ASEP has active projects through local non-government organizations (NGOs) in Pasay City, Quezon City, Cebu City, Angeles City, and Davao. Project expansion to one additional city is under development. The sites and target groups for education match those of the surveillance component.

Local NGOs have received technical assistance from lead NGOs in grant management, and in identifying target populations, message development and outreach.

The full range of communication strategies are being utilized. Communication materials that are being used and developed offer a range of behavior change choices and do not prescribe any single action. A variety of approaches to outreach are being implemented in the field.

A complete package of interpersonal, mass media and public relations interventions will be in place in at least three of the sites in 1995.

A desk review of recent studies on social and behavioral factors relevant to HIV prevention has been completed and published. Local NGOs in Metro Cebu have completed an analysis of focus group discussion data which made recommendations for AIDS programming.

An inventory of vulnerable populations and access points has been conducted in at least three of the sites, and sub-projects are being tailored to each of the groups most at risk of HIV/STD.

NGOs are providing regular and extensive output data to partner NGOs in their quarterly progress reports. The above sources of quantitative and qualitative data, combined with an expanded behavioral surveillance tool, should provide adequate process, outcome and impact data to evaluate the ASEP education component.

### Summary of Key Findings.

## Surveillance.

There has not been a marked increase in HIV prevalence during 1993 and 1994. HIV prevalence remains less than 1% in all of the high risk "groups" included in the three HSS rounds supported by ASEP.

As of 1995, given the current low prevalence of HIV detected, the HIV risk "groups" selected for HSS remain the most appropriate target groups for public health surveillance in the Philippines.

The requisite sample size of about 300 has been attained for registered female commercial sex workers (FCSWs) at almost all of the HSS sites. However, the sample sizes of most of the other high risk "groups", especially high risk male "groups", are less than the requisite 300.

Relatively high seropositive rates for syphilis (5-12%) were found in many of the risk "groups". The highest rates were generally found among the freelance FCSWs, but a very high rate (close to 10%) was found among registered FCSWs in Angeles City.

Among the FCSWs, reported condom use is increasing. The highest reported rates are seen in registered sex workers. Much lower, but rising, rates are seen in the freelance sex worker "groups". In contrast, reported condom use in the male risk "groups" has remained very low.

## Education.

ASEP implementation uses a three-tier approach that involves extensive coordination among the lead NGO Program for Appropriate Technology in Health (PATH), its Partner NGOs, and Implementing NGOs. This approach may potentially cause confusion among the partners if roles and responsibilities are not clearly defined and mutually agreed upon.

HIV is not in the general population and is not an immediate threat to the general population. Populations vulnerable to HIV/STD in the Philippines are a diverse and mobile group who are at unequal risk. Based on multiple sources of data and indicators, unregistered/ freelance CSWs are at higher risk of HIV/STD than are registered CSWs.

According to its scope of work, John Hopkins University/Population Communication Services (JHU/PCS) is required to develop a 12-month strategy and a 5-year plan. The team saw no evidence of these deliverables, even though they should be in place well before mass media activities begin in May, 1995.

A variety of brands of condoms are widely available, accessible, affordable and of good quality. Although impressive increases in condom use have been observed for some sentinel groups, consistent condom use remains dangerously low for free-lance CSWs, men who have casual sex with other men and male and female IDUs. Greater use of condoms in risk situations is demand constrained rather than supply constrained.

### Organization.

There are uncertainties regarding the respective roles and responsibilities of National AIDS Prevention and Control Program for the Philippines (NAPCP) and ASEP implementing agencies.

The DOH, having devolved functions to Local Government Units (LGUs), has had to relinquish control over the allocation of funds for health at the local level. Because of budget constraints and more immediate priorities, LGUs generally have limited funds available for health spending.

Offices in the DOH, including those responsible for implementing ASEP, have had to retool to better carry out the new DOH function of "servicer of servicers" under a devolved set-up. Reorientation from "rowing" to "steering" has had varied success.

### Summary of Recommendations.

#### Surveillance.

The initial target of 30 geographic HSS sites by the end-of-project (EOP) is not practical or needed at this stage of the HIV/AIDS epidemic, but the current number of six sites may need to be doubled as HIV prevalence increases.

As SHCs do not appear to be able to obtain adequate numbers of blood samples for many of the sentinel groups, alternative methods and time frames for collecting blood specimens from risk "groups" should be developed.

A surveillance tool for establishing baseline data on risk behavior should be developed. In coordination with the AIDS/STD Unit, FETP, PATH, and major NGOs should collectively decide what behavioral data are needed. FETP should consider contracting with a private or academic agency to develop, implement and evaluate behavioral surveillance.

ASEP should not develop a comprehensive STD surveillance system at this time. However, blood samples collected for HSS should continue to be routinely tested for syphilis.

The DOH should develop resources to assure that HSS will not be discontinued in some geographic sites because of inadequate LGU support.

### Education.

PATH needs to ensure that roles and responsibilities of each of the three tiers of project management are more clearly understood and acceptable to all partners.

The ASEP education component should maintain and refine its focus on high-risk groups. All of the highest risk populations in the project sites should be targeted for interpersonal outreach, multimedia exposure, condom access, and referral for STD diagnosis and treatment.

JHU/PCS needs to adhere more closely to its scope of work and produce a 12-month plan and evaluation strategy that can be shared with other implementing partners of ASEP.

Increased coordination of ASEP mass media activities is needed to avoid duplication of target audiences and message content. Mass media content should support social norm change which complements IEC activities.

Results from behavioral surveillance in project sites should be used for overall project assessment, rather than for evaluating sub-grantee performance.

As appropriate models and strategies for improving public and private sector STD treatment and management in the Philippines are developed, USAID/Manila should consider providing assistance in this area, in coordination with other donors.

### Organization.

The AIDS/STD Unit must be institutionalized as a permanent service in the DOH. The success of the Unit should be made to depend less on the person in charge of it, and more on resources and responsibilities associated with the position.

The specific roles and responsibilities of those involved in implementing the NAPCP must be redefined and clearly communicated. The devolution of health services and the administrative responsibilities of NGO grantees should be taken into account. While the DOH has recently developed a strategy for clarifying the roles and responsibilities of NAPCP implementing agencies, the transition from "rowing" to "steering" is ongoing.

The development of local level public and private sector partnerships must be supported. Relevant experience gained in Angeles City and Cebu City could serve as a model for other LGUs.

Plans are underway to use the 'Australian method' to develop a national AIDS strategy for the Philippines by December 1, 1995 (World AIDS Day). This process will involve all national and local level agencies involved in implementing the NAPCP, in an effort to achieve consensus on key issues that are still unresolved. The development of a national AIDS strategy represents an important opportunity to put much needed legal/regulatory framework in place, and galvanize political commitment to addressing HIV/AIDS issues at all levels of government.

Mechanisms need to be devised to increase public and private sector investments in health. As ASEP represents a major proportion of the NAPCP, there may be a need to reassess the balance between short-term funding of direct services and longer-term investments in building local capabilities. For example, it was originally envisioned that the Public Information and Health Education Service (PIHES) would play a role in implementing the education component of ASEP. In reality, PIHES has not been involved, deferring instead to the AIDS/STD Unit to provide guidance on IEC activities. USAID/Manila may want to consider whether the involvement of PIHES in ASEP should be strengthened, in order build the capability of this unit of the DOH.

## I. INTRODUCTION

### AIDS Surveillance and Education Project

The AIDS Surveillance and Education Project (A.I.D. Project No. 492-0473) was authorized on July 20, 1992. The five-year bilateral project will extend from 1992 to 1997. USAID/Manila will provide \$10 million in Development Assistance grant funds, and the Government of the Philippines (GOP) will contribute the Peso equivalent of \$2.3 million over the life-of-project. The GOP Department of Health (DOH) is the lead implementing agency.

The goal of ASEP is to control HIV transmission within the Philippine population. The project purpose is to institutionalize public and private sector mechanisms for monitoring HIV prevalence, and encourage behaviors which reduce individual risk for contracting or transmitting HIV. The goal and purpose of ASEP support the objectives of the first and second Medium Term Plans (MTP1, MTP2) of the National AIDS Prevention and Control Program for the Philippines (NAPCP).

A sentinel surveillance system for monitoring HIV seroprevalence in the Philippines is being implemented under the surveillance component of ASEP. Mass media, and information, education and communication (IEC) programs which help reduce HIV transmission among individuals at risk are being implemented under the education component of the project.

As stated in the Project Paper (PP), it was expected that ASEP would put in place over the life-of-project: (1) a surveillance system yielding statistically reliable time series data on HIV prevalence among high risk "groups" in thirty geographic sites in the Philippines, (2) IEC intervention activities in (at least) four sentinel sites which are effectively encouraging behavior change among individuals within targeted risk "groups", and (3) an institutionalized network of non-government organizations (NGOs) with the financial and technical capacity to implement effective IEC interventions among risk "groups" in sentinel sites.

### ASEP Midterm Evaluation

The ASEP midterm evaluation was conducted by Tony Bennett, MSc, Senior Program Officer for the AIDS Control and Prevention Project (AIDSCAP), Asia Regional Office, Bangkok, Thailand; James Chin, MD, MPH, Clinical Professor of Epidemiology at the University of California, Berkeley, School of Public Health; Victor Ortega, MD, Head of Technical Staff, Philippines Senate

Committee on Health; and Anne Scott, PhD, HIV/AIDS Coordinator for the Asia/Near East Bureau, USAID/Washington. The team spent from February 6 to February 28, 1995 in the Philippines interviewing representatives of ASEP implementing agencies (Annex One) and reviewing project documents and other relevant research reports (Annex Two). In addition, the team made site visits to observe the implementation of IEC and surveillance activities in Quezon City, Pasay City, Angeles City, and Cebu City.

The evaluation team was asked to recommend actions to improve the effectiveness and sustainability of the project, determine whether the surveillance system needs to be expanded further, and provide an overall assessment of the response to HIV/AIDS in the Philippines. USAID/Manila provided the team with a detailed scope of work (SOW) containing priority questions about ASEP education and surveillance activities, ASEP organization and management, donor assistance for HIV/AIDS programming, and the NAPCP (Annex Three). Answers to the SOW questions are contained in this report of the team's findings and recommendations.

The team faced some minor constraints in carrying out the evaluation. The team was unable to locate current documentation of the GOP allocation of funds for HIV/AIDS. Little documentation was made available concerning progress under the JHU/PCS mass media cooperative agreement, making it difficult to assess this project activity. Time did not allow for visits to two sentinel sites, Davao and Iloilo. The evaluation report will therefore avoid cross-site comparisons. It is premature to assess the impact and sustainability of the project since it is still in a start up phase, and implementing agencies may change over the life-of-project. Finally, the team representative from AIDSCAP could not contribute any findings or recommendations on improving STD services since awards to AIDSCAP in this area are pending. These constraints notwithstanding, the team was able to carry out a comprehensive examination of the project, thanks to the assistance of the USAID/Manila Office of Population, Health and Nutrition (OPHN) and ASEP implementing agencies.

Before leaving the Philippines, the team presented their findings and recommendations to representatives of government and non-government agencies implementing ASEP, representatives from other donor agencies, and USAID/Manila staff. Their comments have been integrated into the final version of the report.

## II. TECHNICAL EVALUATION OF THE ASEP SURVEILLANCE COMPONENT

### Surveillance of HIV Infection and AIDS Cases in the Philippines

HIV surveys in the Philippines were started in 1985, when HIV antibody tests first became available (Annex Five). These surveys were carried out by the Department of Health (DOH) via the Research Institute for Tropical Medicine (RITM) and the United States Naval Medical Research Unit 2 (NAMRU-2), in collaboration with the DOH's Bureau of Research and Laboratories (BRL). Subsequently, five Social Hygiene Clinics (SHCs) in several regions of the country started testing for HIV infection among female commercial sex workers (FCSWs). Surveys have also been carried out among men who have sex with men (MSM) and overseas contract workers (OCWs).

Recognizing the need to support more focused efforts to prevent HIV/AIDS, the USAID/Manila initiated the technical development of ASEP in the early 1990s. Following the earmarking of funds by WHO and USAID to support surveillance activities, steps were taken by the Department of Health (DOH) to develop a National HIV Surveillance System for the Philippines. A workshop was held in August, 1991 to draft the surveillance strategy. An assessment and subsequent report of the status of HIV/AIDS surveillance in the Philippines was prepared by Drs. Detels and Frerichs of UCLA. This was followed with a series of workshops leading up to a June, 1992 workshop to finalize a five year strategy and first year operational plan.

The surveillance component of ASEP aims to establish an HIV sentinel surveillance system at strategically located geographical sites and population groups. Equipment and support for the surveillance component of ASEP are being provided through a grant to WHO. A Memorandum of Understanding and Agreement for Implementation of USAID Grant No. IA93002 (MOUA) was signed in August 1993 by the Secretary of Health Dr. Flavio and the WHO/WPRO Regional Director Dr. Han. A total of \$2,095,020 in project funds were allocated to provide for the equipment, tests and reagents; technical assistance; training; and local costs needed to carry out HIV sentinel surveillance.

The MOUA included a detailed listing of the staff and agencies involved in the National HIV Surveillance System and their specific responsibilities. The DOH AIDS/STD Unit is responsible for overseeing the implementation of ASEP and ensuring that activities are consistent with the NAPCP. The Health Information Service/Field Epidemiology Training Program (HIS/FETP) has overall responsibility for managing the surveillance system, and for the collection, analysis and

dissemination of data gathered. At each sentinel site, local government staff from the Social Hygiene Clinics (SHCs) are responsible for collecting 300 blood samples from members of target risk "groups". Regional laboratories are responsible for testing blood samples for HIV and sending positive tests to the Research Institute for Tropical Medicine (RITM) laboratory for confirmatory testing. RITM and the Bureau of Research Laboratories (BRL) are jointly responsible for quality assurance.

It was originally envisioned that ASEP HIV sentinel surveillance (HSS) would initially be developed in six geographic sites, with sequential expansion to 30 sites throughout the country by EOP. STD and behavioral surveillance were not included in the MOUA. The ASEP PP specifies that sentinel surveillance should be coordinated with interventions being conducted through the education component of the project.

### Accomplishments Since the Beginning of ASEP

\* HIV Sentinel Surveillance. Since 1993, a total of three HSS rounds have been completed. The first round was completed and reported in June, 1993. It was carried out in two geographic sites (Quezon City and Metro Cebu) and included six HIV risk "groups": registered female commercial sex workers, freelance female commercial sex workers, male commercial sex workers, male STD patients, men who have sex with other men, and injecting drug users (IDUs). Only one HIV seropositive, in a registered FCSW in Quezon City, was detected. Questions about the numbers of sexual partners and condom usage were asked. Findings indicated that the numbers of sexual partners per week in the registered FCSWs were relatively low (median of 2-3 per week). Condom usage rates were also low, especially among male CSWs and MSM. Reported injecting drug use in freelance FCSWs in Metro Cebu was very high (13%).

Experience from the first HSS round was used to refine risk "group" sample selection and expand HSS to an additional geographic site (Metro Davao). The second HSS round was carried out from April to June, 1994. Again, only one HIV seropositive was found in a registered FCSW in Quezon City. The median number of reported sexual partners per week in most of the HIV risk "groups" remained relatively low (1-5), but was relatively high (14) in freelance FCSWs in Metro Cebu. Reported injecting drug use in FCSWs in Metro Cebu continued to be high (14%). The high rates of injecting drug use found in this group may, in part, explain why this group has, on average, more sex partners than all other ASEP risk "groups". Reported condom use among registered FCSWs in Quezon City and Metro Cebu increased significantly, but was much lower in registered FCSWs in Metro Davao, and in freelance FCSWs in all geographic sites. Reported

condom use in most of the high risk male "groups" remained very low.

The third HSS round, carried out from September to November, 1994, was expanded to include Pasay City, Angeles City and Iloilo, bringing the total number of sentinel sites to six. Serologic testing for syphilis was carried out on all blood specimens to provide a proxy measure of risky sexual behavior. Two HIV seropositives were detected, one in a registered FCSW in Quezon City and the other in a registered FCSW in Pasay City. Thus, in all three HSS rounds, HIV was found only among registered FCSWs in the National Capital Region (NCR).

\* Dissemination of the HSS Findings. The FETP has, within two to three months after completion of an HSS round, prepared and distributed a clear and concise report of the findings to policy makers, and all persons and agencies who participate in the collection of the data. The format of reports has been evolving, since each HSS round has included additional geographic sites and data.

### Key Findings

\* STD rates. Relatively high seropositive rates for syphilis (5 to 12%) were found in many of the risk "groups". The highest rates were generally found among the freelance FCSWs, but a very high rate (close to 10%) was found among registered FCSWs in Angeles City where routine syphilis serological testing has apparently not been carried out for several years.

\* Condom Use. The percent of FCSWs and male HIV risk "groups" in Quezon City and Metro Cebu who reported that they "always" use condoms are presented for each of the three HSS rounds in Figures One and Two. Among the FCSWs an increasing trend of reported condom use is seen with the highest reported rates in the registered sex workers and much lower, but rising rates in the freelance "groups". In contrast, reported condom use in male risk "groups" remains very low. The reliability of these data needs to be evaluated. It is possible that the registered FCSWs are increasingly reporting that they "always" use condoms because they believe that this is the "appropriate" answer to give to the SHC staff. The very low reported rates of condom use in the male "groups" is probably more reliable. Additional and alternate surveys will need to be planned and carried out to validate the behavioral data collected.

\* HIV Prevalence in the Philippines. The HSS system that was designed for the Philippines was intended to serve as an early warning system to detect the general prevalence and pattern of HIV infections. Using the HSS system that had been developed in

Thailand as a model, Detels and Frerichs recommended that as HIV prevalence increased in high risk "groups", sentinel surveillance should be expanded to include groups at lower risk of HIV infection (such as antenatal women) and additional geographic sites throughout the Philippines. (In Thailand, HIV prevalence rates in FCSWs and male STD patients increased in many sentinel sites from less than 1% in 1988 to about 5% by mid-1991).

Although detected HIV prevalence levels in high risk "groups" in the Philippines (mostly from Metro Manila and areas near United States military bases) were well less than 1% in 1991 and 1992, the general expectation was that these rates would increase markedly in a few years and gradual expansion of HSS population "groups" and geographic sites would be needed. A marked increase of HIV prevalence has not been detected during 1993 and 1994, and HIV prevalence remains less than 1% in all of the high risk "groups" included in the three HSS rounds supported by ASEP.

\* Access to HIV Risk "Groups". Given the current low prevalence of HIV detected so far, the HIV risk "groups" that have been selected remain the most appropriate "groups" for public health surveillance in the Philippines. At the local level, staff of Social Hygiene Clinics (SHCs) have been trained by FETP staff to carry out the sampling and data collection needed for each HSS round. SHCs routinely provide mandatory STD screening, primarily for registered FCSWs. As a result, the requisite sample size of about 300 has been attained for registered FCSWs at almost all HSS sites. The sample sizes attained for most other high risk "groups", especially high risk male "groups", are well less than the requested 300. During the most recent HSS round, very small samples of male STD patients, MSMs, and IDUs were collected at several of the geographic sites.

\* STD and Behavioral Surveillance. When the surveillance component of ASEP was developed, little or no attention was given to STD or behavioral surveillance. Drs. Detels and Frerichs from UCLA adapted the Field Guidelines for HSS developed by GPA/WHO to the HIV/AIDS epidemiologic situation present in the Philippines during the early 1990s.

Since that time, the third HSS round discovered high rates of syphilis within target groups. The ASEP Education Strategy Logframe identified behavioral surveillance as a means of verifying reductions in risk behavior resulting from IEC activities. As a result, the midterm evaluation team was asked to recommend whether STD and behavioral surveillance should be included in ASEP.

In late 1993, WHO distributed a set of Prevention Indicators for HIV/AIDS programs. It was recognized that the ultimate indicator of the success of HIV/AIDS programs would be a .

measurable increase of HIV infections and AIDS cases, but that these data are very insensitive indicators for interventions to eliminate or reduce HIV risk behaviors. More sensitive and direct indicators for interventions to change risk behavior are: (a) levels of acute STDs such as syphilis and gonorrhea; and (b) levels of HIV risk behavior (measured as average numbers of sexual partners and rates of condom use) for all episodes of penetrative sexual intercourse. Routine and periodic quantitative measurement of these variables represent the main parameters of HIV/AIDS behavioral surveillance.

\* Administration and Budget. ASEP support for HSS staff and activities at the national and local level is allocated through the MOUA between the DOH and WHO. At the outset, major problems were encountered in channeling funds for project implementation through WHO. Some delays still exist for reimbursement of local costs for HSS field work, mostly due to the bureaucratic and administrative requirements of WHO, DOH, and LGUs. However, these agencies/units have gained experience in the last three years with the various administrative systems and requirements involved. They now plan ahead and expect that the official processing of requests and claims will occasionally involve unavoidable delays.

### Conclusions and Recommendations

\* Limitations of HIV Prevalence Data. HSS findings as of early 1995 indicate that the prevalence of HIV continues to be very low among all high HIV risk "groups". HSS cannot be relied upon to provide precise measurement of HIV prevalence in the selected risk "groups", but is useful in monitoring general levels and trends of HIV transmission. In addition, HIV prevalence data are not sensitive indicators of the effectiveness of specific program interventions to reduce HIV risk behavior (Annex Four).

\* Number of Sentinel Sites and Risk "Groups" for HSS. Given the current low levels of HIV prevalence in the Philippines, there is no pressing need to expand the number of sentinel risk "groups" or to increase the current number of geographic sites for HSS. The initial target of 30 geographic sites by EOP is not practical or needed at this stage of the epidemic. If HIV prevalence does begin to reach 2 to 3% in one or more of the high risk "groups" in 1995, then plans for increasing the number of geographic sites for HSS from the current six to a total of ten or twelve should be considered in 1996.

\* Access to Risk "Groups". The SHCs do not appear to be able to obtain adequate numbers of many of the targeted risk "groups" selected for HSS. With the current low prevalence levels detected (well less than 1%), a minimum sample size of 300 is

needed to have any statistical confidence that the true prevalence is not more than 1%.

FETP should develop alternative methods and time frames for collecting blood specimens for HIV surveillance from "groups" such as men who have sex with men (MSM), male STD patients, and injecting drug users (IDUs). NGOs who work with the above risk "groups" should be more actively involved in obtaining access to these groups for collection of surveillance data.

The continued emphasis directed to CSWs whose clients are mostly foreign males is unwarranted. HIV has already been introduced into the Philippines and is present, albeit at low levels, among FCSWs in the Metro Manila area. Any "explosion" of HIV infections, if and when it may occur, will be more likely in CSWs who have the highest average number of sexual partners and who have low condom use rates. HSS should focus priority on CSWs with these characteristics and assure that they are included in the HSS.

\* Behavioral Surveillance. In coordination with the AIDS/STD Unit, FETP, PATH, and major NGOs should collectively decide what behavioral data are needed to evaluate the overall effectiveness of ASEP educational activities. FETP should support the development of standard questions for the routine collection of behavioral data (Annex Four).

DOH should be permitted to contract with a private or academic agency for the development and implementation of behavioral surveillance, if needed. As of early 1995, less than 15% of the budget available to the DOH for support of the surveillance component has been expended by FETP. There should be sufficient funds to support the development, implementation, and evaluation of HIV behavioral surveillance.

NGOs implementing the ASEP education component should not be given the primary responsibility of collecting the data for the behavioral surveillance, but should be asked to assist data collectors in gaining access to the groups they work with. Each NGO should continue to gather additional behavioral data needed to implement, monitor and evaluate its sub-project.

The collection of the behavioral data should be coordinated with HSS but probably should be carried out at a different time and with different staff. For example, HSS can be scheduled at a site from January to February and from July to August and the behavioral surveillance survey (BSS) from April to May and October to November. Behavioral data can then be used to evaluate and validate the more limited behavioral data collected in HSS.

\* STD Surveillance. ASEP should not develop a comprehensive STD

surveillance system at this time. No clear cut guidelines as to what STDs should be included and what clinical and laboratory tests should be used in STD surveillance have been developed. However, blood samples collected for HSS should continue to be routinely tested for syphilis. Data on syphilis prevalence provide another general measurement of risk behavior.

When high syphilis rates (>10%) for a given risk "group" are identified, more aggressive control measures such as expanded syphilis testing and treatment should be carried out.

\* Dissemination of HSS Findings. The report of the third HSS round included a classification of geographic sites: hot spot, potential hot spot, and high risk sector. A "hot spot" is essentially defined as a site where HIV infection is found. A "potential hot spot" is a site where no HIV infection is found, but where a high syphilis rate is found, and a "high risk sector" is a site where only risk behavior is documented.

This classification system was developed to direct attention and public health interventions to specific areas and populations for HIV intervention activities, but it needs to be re-evaluated. Many problems can be anticipated. Should Quezon City be classified as a "former" hot spot if no HIV infection is detected in the next HSS round? Also, the public and the news media may be misled to believe that the risk of HIV only exists in areas declared "hot spots".

Instead of using detected HIV positive cases or reported AIDS cases to target areas or "groups" for increased public health intervention, behavioral data collected in HSS rounds should be used to step-up public health and NGO activities in those areas and "groups" with the highest levels of risk behavior.

Surveillance reports should de-emphasize HIV/AIDS data and begin to highlight data on risk behavior. For example, behavioral data collected so far indicate that freelance FCSWs in Cebu City have high numbers of sexual partners, high levels of injecting drug use, and relatively low condom usage rates. Based on this information, freelance FCSWs should be a high priority for appropriate public health interventions to modify risk behavior. It needs to be re-emphasized that surveillance data are not merely for monitoring the HIV/AIDS situation, but are data for action!

\* Continuation of HSS After ASEP. The ability of local government units (LGUs) to implement routine HSS activities when ASEP funding ends (September, 1997) is a major concern given the wide range of capabilities and support LGUs have from their local government. As significant increases in HIV prevalence may be occurring by 1997, DOH should develop resources to assure that

HSS will not be discontinued in some geographic sites because of inadequate LGU support.

### III. TECHNICAL EVALUATION OF THE ASEP EDUCATION COMPONENT

#### Background.

The ASEP PP designated the DOH/Public Information and Health Education Service (PIHES) as the unit with overall responsibility for implementing the education component of ASEP. Under this component, project funds will enable PIHES and the lead NGO Program for Appropriate Technology in Health (PATH) to (1) develop a National AIDS Prevention and Control Communication Strategy, (2) continue and expand on-going IEC activities of local NGOs, (3) identify and support new interventions targeted toward other audience segments, and (4) 'rollout' successful interventions to new geographic sites.

PATH and its local partner NGOs (Kabalikat and RAFI) are responsible for: administering funds for sub-grants to local NGOs; contracting for services needed; monitoring sub-grantee performance; providing technical assistance; and submitting required financial accounting reports to USAID and the DOH.

\$4.2 million in ASEP funds were allocated for the provision of grants, and for the technical assistance, training, local costs and research needed to implement the education component. No commodities will be procured for this project component.

The major outputs identified under the MOUA between PATH and USAID/Manila are: (1) strengthened capacity of the DOH to develop and implement an IEC strategy, (2) strengthened capacity of local NGOs to serve as partners to the NAPCP, and (3) improved understanding of HIV risk factors and situations in the Philippines.

Initial target audiences identified include sex workers, clients of sex workers, and men who have sex with men. In Metro-Cebu, injecting drug users and their partners were also selected as a priority target group. Secondary risk groups include regular, non-paying partners of sex workers and clients of sex workers. In addition, frequent visits by foreign tourists was used as one of several criteria for ASEP site selection.

The Cooperative Agreement between Johns Hopkins University/Population Communication Services (JHU/PCS) and USAID/Manila was amended in April 1994 to provide additional assistance to the DOH in implementing HIV/AIDS mass media and public relations activities. The responsibilities of JHU/PCS under this amendment are to develop a mass media communications strategy, oversee the implementation and evaluation of mass media campaigns, and develop the public relations capacity of the DOH.

Approximately \$750,000 in ASEP funds were allocated to JHU/PCS for this activity.

### Accomplishments since the beginning of ASEP.

\* Strengthening local partner NGOs. There is no baseline for comparing NGO strength before and after ASEP. However, based on discussions with partner and implementing NGOs, it is clear that they understand the goals and purposes of the project, and are following guidelines for message development and outreach. Implementing NGOs have received PATH/partner NGO technical assistance (TA) in grant management, message development and outreach.

\* Strengthening DOH capacity. Delayed project start-up and DOH staff turnover have hindered progress toward this goal. Strong DOH oversight of a national AIDS IEC strategy has not yet occurred. Nevertheless, the sense of (ASEP) project ownership within the DOH is currently high and positive.

\* Implementation of IEC activities. ASEP has active projects through local NGOs in Pasay City, Quezon City, Metro Cebu, Angeles City and Davao. Project expansion to Iloilo is under development. A complete package of interpersonal, mass media and public relations interventions will be in place in at least three of the sites in 1995. The sites for education match the sites for the surveillance component, and this will facilitate strategy modification and evaluation.

A satisfactorily complete inventory of vulnerable populations and access points has been conducted in at least three of the sites. Based on this information, sub-projects are being tailored to "groups" most at risk.

\* Mass media campaigns. Two mass media campaigns are scheduled for 1995. One will be launched by ReachOut and McCann-Erikson (under contract with PATH) in April, 1995, and the other, by the Campaigns ad agency (under contract with JHU/PCS) in May, 1995. Although not funded under ASEP, DKT also conducts mass media campaigns to promote condoms directed to ASEP target populations.

### Key Findings

\* Process of Implementation. The ASEP education component is divided among two cooperative agreements which are not well-coordinated.

The HIV/AIDS Education Subcommittee, created in

collaboration with the DOH to formulate a communication strategy for ASEP, has not met as often as planned and currently is inactive.

Implementation through PATH uses a three-tier approach that involves extensive coordination among PATH, its Partner NGOs, and implementing NGOs. While this approach may improve capacity building and sustainability in the long-run, it can cause confusion if roles and responsibilities are not clearly defined and mutually agreed upon.

The flow of funds and reporting among the three tiers has been kept on schedule. Implementation of the ASEP education component is well-monitored and documented at all levels. However, only two of six scheduled quarterly project review meetings have been held. Coordination of implementing partners mostly takes place through informal channels.

Morale and dedication among the partner and implementing NGOs is high. Mutual trust and respect between PATH and the partner NGOs is evident, and sincere efforts are made to maintain the constructive relationships. However, some implementing NGOs want a greater say in the development of ASEP IEC materials and the format of progress reports.

Some implementing NGOs are sharing community maps, IEC materials and data from focus groups discussions. However, there is evidence of competition among ASEP NGOs, which could eventually impede project implementation unless team-building measures are taken now.

According to its SOW, JHU/PCS is required to develop a one-year strategy and a five-year plan. The team saw no evidence that these deliverables were being developed. They should be in place, for mass media activities are scheduled to begin in May, 1995.

PIHES seems minimally informed of ASEP education activities, although it is willing to cooperate and share as needed. PIHES defers to the AIDS/STD Unit to provide guidance on HIV/AIDS education.

\* Target Populations. HIV is not in the general population, nor is it an immediate threat to the general population. Populations vulnerable to HIV/STD in the Philippines are diverse, fluid, and at unequal risk. Multiple sources of data indicate that freelance CSWs are at higher risk of HIV/STD than registered CSWs. There is also evidence of overlap among IDUs and CSW populations. There is no evidence that foreign tourists are a major source of HIV/STD transmission.

While overseas contract workers (OCW) were identified as a

primary risk "group" in the ASEP PP, this group has effectively been dropped in the implementation of the ASEP education component. There is no evidence to suggest that OCWs are at greater risk of HIV/STD than other groups in the general population. Therefore, the team did not look at what efforts are being made to provide HIV education to this group.

ASEP mass media campaigns have emphasized that only those who engage in risk behavior are vulnerable to contracting HIV. However, other media campaigns which have emphasized that AIDS does not discriminate against anyone may have inadvertently encouraged the belief that all Filipinos are at equal risk of contracting AIDS.

PATH and its partners are aggressively targeting registered and unregistered CSWs, MSMs, and (where indicated) IDUs. The JHU/PCS mass media campaign will reportedly target adolescent men and women who are single, and young married men. The ReachOut media campaign will target clients and partners of CSWs.

\* IEC Strategy. Target audiences are involved in the design of IEC strategies, primarily through participation in focus groups. IEC and mass media messages and themes are adequately pre-tested among the target audiences.

ASEP Cooperating Agencies (CAs) are using two different communication strategy documents (the ASEP Education Strategy of March, 1994 and the Philippines National AIDS/STD Communication Strategy of September 1994). There is potential for duplication of efforts unless activities being implemented under the two strategies are more closely coordinated by the DOH.

The ASEP Education Strategy of March, 1994 explicitly describes distinct IEC strategies for defined target audiences. The PATH implementation plan clearly specifies how the strategy will be carried out.

The full range of IEC strategies are being implemented: full-time outreach workers, peer educators, PWA educators, print media, visual media, sound media, broadcast and narrowcast media channels, hotlines, individual counseling, small group and large group interactions, drop-in sites and street theater.

Implementing NGOs and mass media agencies clearly understand the full range of behavior change options, although sub-projects have different emphases depending on the target audience. Communication materials being used offer a range of behavior change choices and do not prescribe any single action.

It is premature to conclude which outreach strategies are most cost-effective for a given target audience. However, a wide variety of outreach strategies are being implemented. The

relative effectiveness of different strategies can be assessed over time.

Although the ASEP education strategy mentions the inclusion of additional target groups. Audience research has begun for transport workers, but there are no current plans to develop activities for new target groups.

\* Mass Media Campaigns. The PATH/ReachOut campaign is targeted to Metro Manila while the JHU/PCS campaign is presumably national in scope. Initial efforts were made to coordinate the two campaigns, but no coordination meetings have been held recently.

Evaluation of these two campaigns must await implementation. However, they have similar target audiences and message content. There is a potential for duplication of effort. It also may be quite difficult to evaluate the separate effects of these two campaigns.

\* Public relations campaigns. Both ASEP mass media strategies include public relations activities. Evaluation of these activities must also await implementation. However, as with the mass media campaigns, there may be a potential for duplication of effort.

\* Condom Programming. ASEP does not provide condoms for HIV/STD in the Philippines, and condom programming is technically not part of the education component. However, many ASEP IEC activities are clearly intended to increase the demand for condoms. PATH has contracted with DKT to increase access to and proper use of condoms.

Condoms are being directly marketed to commercial sex access points at low price. Over eight million pieces of the Trust condom marketed by DKT were sold in 1994. In addition, the SOMARC project is reportedly providing condoms for STD/HIV prevention through its service channels in ASEP project sites. One implementing NGO views direct condom marketing to commercial sex access points in their target area as an indirect criticism of NGO performance.

A variety of brands of condoms are widely available, accessible, affordable and of good quality. However, the amount of lubrication on local condoms may be inadequate for sex workers with more than three partners per night. Condom advertising and placement of the product is open and can be considered advanced for countries in Asia. At least one social hygiene clinic provides 12 pieces of 49mm condoms free to each CSW who appears for weekly check-ups. There was no evidence of outreach NGOs obtaining free government condom supplies for distribution to high risk groups.

Although impressive increases in condom use have been observed for some sentinel populations, consistent condom use remains dangerously low for free-lance CSWs, men who have casual sex with other men and male and female IDUs. Greater use of condoms in risk situations is demand constrained rather than supply constrained at the present. The use of condoms for disease prevention still suffers from perceptions that condoms interfere with sex and reduce sensation. These perceptions may explain, in part, low levels of condom use in some ASEP risk "groups".

\* STD Infrastructure. ASEP does not include an STD component. The education component was not designed to be implemented through SHCs located in project sites. Nevertheless, SHCs are one point of referral for ASEP risk "groups", especially registered commercial sex workers. SHCs also play an important role in coordinating efforts of non-government and government organizations at the local level.

While there is significant variation in the range and quality of services offered at SHCs in ASEP sites, support for indigenous networks of CSWs through the SHCs is taking place. At least one SHC provides clinic-based education for CSWs (especially for new clients); conducts community outreach to CSWs who miss their weekly examination; and provides quality care. In general, SHCs, have adequate space for private, individual counseling. However, they lack a variety of up-to-date education materials.

Research recently conducted by AIDSCAP on STD health seeking behavior, STD drug resistance, and STD treatment in the Philippines has further confirmed the need to strengthen both public and private sector STD service delivery. AIDAB/WHO will soon implement pilot projects to train health care providers in STD syndromic diagnosis, and to establish public sector 'community health clinics' (which may serve as an alternative to SHCs). However, much more needs to be done in this area.

\* Evaluation. No detailed survey was conducted at the beginning of ASEP to measure baseline risk behaviors by project site. However, some useful behavioral data on risk "groups" in two ASEP sites were gathered by FETP prior to the initiation of project IEC activities. Data on risk behavior in three additional cities became available in mid-1994. Behavioral data on risk "groups" in all six proposed ASEP sites was made available by the end of 1994.

PATH and its partner NGOs assisted implementing NGOs in conducting audience research on different target groups. These results were shared among NGOs and with JHU/PCS. JHU/PCS also conducted focus groups on target audiences for its mass media campaign and shared the results with other ASEP implementing

partners.

Implementing NGOs are providing regular and extensive output data (including establishments contacted, persons reached, materials produced and distributed) in their quarterly progress reports to the partner NGOs. One NGO, TriDEV, is conducting a behavioral baseline survey on its target populations in order to gain a more complete understanding of their risk. TriDEV is using these data to orient peer educators. Surveying will be followed by in-depth data collection to probe factors affecting high and low risk behaviors.

The above sources of quantitative and qualitative data, combined with an expanded behavioral surveillance tool, should provide adequate process, outcome and impact data to evaluate the ASEP education component over time.

It is more difficult to assess the prospect of successfully evaluating mass media efforts, as no evaluation plans were presented to the team. Both campaigns will refer the audience to telephone hot lines. Monitoring time trends in the number and content of calls will provide a short-term assessment of response but will not help track behavior change.

\* Miscellaneous Findings. Numerous issues relevant to the ASEP education component were discussed during team field visits. Some of these issues are presented here.

Some ASEP IEC materials distinguish the term "AIDS" from asymptomatic HIV infection. Because the general public refers to HIV disease as "AIDS" in the local vernacular, these materials may confuse target audiences.

The widely advertized "ABC's" of prevention (Abstinence, Be faithful and Condoms) implies a natural priority which may not reflect ASEP's education strategy or the priorities of its primary target populations.

Considerable emphasis is being placed on telephone counseling as a strategy for behavior change.

Some of the pre/post-test evaluation questions used in ASEP training activities are ambiguous and inaccurate.

ASEP project staff are being trained to help with pre/post-test counseling for subjects in the sentinel surveillance. This may compromise the anonymity of the surveillance process.

Portions of the self-risk assessment tool Risk Advisor are being included in training materials, despite some flaws in the content and in weighting of risk.

## Recommendations.

The Philippines AIDS prevention program has the potential to become the model for a low-prevalence country. The following recommendations are offered mostly to help refine an otherwise well-conceived, timely and solid project.

\* Process of Implementation. Two project coordinating mechanisms, the quarterly progress review meetings chaired by the DOH and the Education Subcommittee, urgently need to be revitalized. In addition, all ASEP implementing partners must come to view the DOH, and especially the AIDS/STD Unit, as the focus of coordination and strategy development.

PATH needs to ensure that roles and responsibilities inherent in each of the three tiers of project management are more clearly understood, and acceptable to all partners. PATH and its partner NGOs need to be more sensitive to implementing NGO concerns regarding the comparison of output performance and IEC materials for different target audiences.

JHU/PCS needs to adhere more closely to its scope of work and produce a 12-month plan and evaluation strategy that can be shared with other ASEP implementing agencies.

\* Target Populations. Where it exists, the notion that all Filipinos are at risk of STD/HIV should be discouraged and discontinued.

The ASEP education component should continue and refine its focus on high risk "groups" by prioritizing target populations and allocating resources accordingly. By EOP, all (100%) of the highest risk populations in the ASEP project sites should be targeted for coverage with interpersonal outreach, multimedia exposure, condom access, and referral for STD diagnosis and treatment.

\* IEC Strategy. The ASEP Education Strategy and the Philippine National AIDS/STD Communication Strategy should gradually be merged into a single strategy document in coordination with the development of national strategy guidelines.

As soon as possible, ASEP implementing agencies should determine which IEC approaches are most cost-effective, and replicate them in all project sites.

Educational efforts should be gradually reoriented to reflect changes in risk levels, as indicated by behavioral surveillance. Mass media should not be used to further HIV/AIDS awareness in the general population, but rather to target clients of CSWs and modify social norms. ASEP technical managers should ensure that a range of behavioral options are included in all IEC

materials.

\* Condom Programming. PATH and Partner NGOs can help implementing NGOs to view the direct marketing of condoms to their target populations as a complementary activity rather than a short-cut means of achieving behavior change.

SHCs should make free condoms available to NGO outreach teams for use by high risk individuals who cannot afford socially marketed condoms.

USAID should consider whether there is a need for closer coordination between SOMARC and DKT condom social marketing activities in ASEP cities.

\* STD Infrastructure. ASEP IEC materials should be shared with SHCs to increase coverage. As public sector services are upgraded through projects funded by WHO, AIDAB, and others, ASEP communication activities should increasingly refer individuals to these outlets for STD diagnosis and treatment. As appropriate models and strategies for improving public and private sector STD treatment and management in the Philippines are developed, USAID/Manila should consider providing assistance in this area, in coordination with other donors.

\* Evaluation. The method of sub-project evaluation being used by TriDEV could serve as a model for other grantees. Evaluation plans for both mass media campaigns need to be developed and pre-tested before the April/May launch. Consideration should be given to developing a method for determining the differential impact of the two campaigns.

If behavioral surveillance is undertaken, the resulting data should be used to look at aggregate trends in behavior among risk groups in ASEP sites. Surveillance data should not be used to evaluate the performance of sub-grantees, as they use a variety of means to reach diverse target groups in diverse situations. Behavioral surveillance data should only be used for an overall assessment of project impact.

\* Miscellaneous. The term "AIDS" should be used to refer to all stages of HIV disease, asymptomatic and symptomatic. The ABC's of prevention might be amended to include a "D" for "Diagnosis and treatment of STDs." The content of training materials needs to be screened more carefully by local PATH technical staff. Questionable items should be verified by full-time AIDS professionals such as staff of GPA or AIDSCAP.

ASEP should continue to support telephone counseling. While some NGOs are already tracking which ASEP target groups are using the service, more data on utilization of this service need to be collected.

#### IV. Organizational Evaluation of the ASEP Project

##### Key findings.

\* The Two Components of ASEP. In the initial phase of ASEP, the education and surveillance components were being implemented separately. A Steering Committee has since been established to provide a mechanism for coordinating the two components. In addition, PATH and FETP staff have begun to work together to facilitate more effective implementation of activities at the local level. FETP has recognized the value of using NGOs to gain access to sentinel groups. Some NGOs have also found surveillance data to be useful in informing LGUs about HIV/AIDS.

\* The Subcommittees for Surveillance and Education. It was originally envisioned that Surveillance and Education Technical Working Groups would help guide the implementation of ASEP activities. The Education Subcommittee met in October 1993, but, in general, it has not met as often as mandated. The Surveillance Subcommittee is currently being organized. Periodic evaluation of project progress has been limited by a lack of guidance from these Subcommittees.

\* The AIDS/STD Unit. Responsibility for the NAPCP, of which ASEP is a major component, has been delegated to the DOH AIDS/STD Unit. Relative to other bodies in charge of national programs, the AIDS/STD Unit does not have a prominent position in the DOH structure.

Organizational changes intended to increase the ability of the AIDS/STD Unit to implement the NAPCP are in progress. The STD Control and Prevention Program was recently merged with the NAPCP. Plans are also under way to increase the number of permanent employees in the AIDS/STD Unit. The majority of Unit employees are contractors.

\* Program Management. Management of the NAPCP has changed hands three times in as many years. Expectations are high that the newly appointed program manager will be able to work better with ASEP implementing agencies.

It was reported to the team that the previous program manager did not include all NAFCP partner agencies in important decision-making processes. The absence of an administrative map clearly defining the roles and responsibilities of the program manager was probably a contributing factor in this.

\* Local Government - NGO Collaboration. Local level AIDS Task

Forces and similar multi-sectoral coordinating bodies have helped to implement desired policies in a more coordinated way. However, in certain cases, LGU action agendas have contradicted local Task Force priorities, making some member NGOs reluctant to share information about risk "groups" and planned IEC activities with LGUs. However, through the active encouragement of the City Health Office, NGO representatives have remained in the Task Force. Efforts are now underway to make the Kabalikat drop-in center the central base for Quezon City's response to HIV/AIDS.

Cebu City offers another model of coordination. Instead of forming an AIDS Task Force, the Cebu City Health Office has used the existing Basic Urban Health Services Task Force, a multisectoral body started under a UNICEF sanitation and health program, to develop a joint LGU-NGO action plan for implementing HIV prevention programming.

In Angeles City, PATH was instrumental in organizing establishment-based sex workers and floor managers. The group they formed, Angeles City Entertainers (ACE), has been active in bringing to joint GO-NGO sponsored education and counselling services to its members. One of ACE's more outstanding accomplishments, made possible by the support of the Angeles City government, is the creation of a room in the SHC which sex workers and managers can use as a base for providing HIV education and support services.

The capacity of LGUs to implement HIV prevention programs, and the most appropriate mechanisms for doing this, vary in each locality. Much depends on the degree to which City Health Officers actively encourage cooperation among the government, NGOs and individuals at risk. The experience gained through ASEP in LGU-NGO collaboration in HIV prevention is informative. Several models for joint public-private sector response to HIV/AIDS have arisen.

\* The Philippine National AIDS Council (PNAC). At the national level, high-ranking officials of thirteen government agencies and representatives of six NGOs have been tapped to serve on the PNAC. The Council was tasked to advise the President of the Philippines on matters pertaining to HIV/AIDS. The efficacy of the PNAC is therefore dependent on actions taken by the President to implement its recommendations.

Due to several interacting factors, the PNAC has not been effective. Representatives of other government agencies do not perceive HIV/AIDS as an imminent threat in the Philippines, and

assume that the DOH can address it. PNAC members also have widely divergent views as to what approaches to HIV prevention and control are effective and appropriate.

It was envisioned that the PNAC would have high-level members with the authority to make decisions for their Departments. In reality, items proposed at meetings are not immediately acted upon because meetings are often attended by subordinates who must seek prior clearance from their principals. Momentum is then lost in acting on proposals.

\* Specific Roles and Responsibilities. From certain members of PNAC to implementing NGOs to LGUs, there are uncertainties regarding their roles and responsibilities in implementing the NAPCP. With the devolution of funds to local government, DOH Units, including the AIDS/STD Unit and FETP, have had to reorient themselves to carry out the DOH's new role of "servicer of servicers". While the DOH has recently developed a strategy for clarifying roles and responsibilities, the transition from "rowing" to "steering" is ongoing.

The ASEP education component has received minimal supervision from the DOH. In contrast, one partner NGO reported that PATH supervises its management of subgrants too closely. In this respect, it should be noted that PATH must meet USAID financial and technical accountability requirements for bilateral projects. The reporting requirements of USAID bilateral projects are more comprehensive than those of the AIDAB regional HIV/AIDS initiative, which is also providing grants to many of the same NGOs. Due to differences in donor funding mechanisms being used to support local NGOs, it may appear to them that USAID/PATH is micro-managing unnecessarily.

\* Financing Mechanisms. The formal organizations established at various levels to carry out the NAPCP have been, to a large extent, dependent on foreign funding. ASEP comprises a substantial portion of the NAPCP.

The DOH, having devolved functions to LGUs, has had to relinquish control over the allocation of health funds. Because of budget constraints and more immediate priorities, LGUs generally have limited funds available for health spending.

\* Implementing NGOs. USAID, as well as other donors, have relied heavily on a small number of NGOs which have solid track records in HIV prevention programming. Concerns have been raised that the capabilities of these NGOs are being overstretched.

\* Donor Coordination. There is a reported lack of donor coordination to the NAPCP. Apart from the organizational and follow-on meetings held in 1991, there have been no formal donor meetings in the last three years. However, donor representatives

talk frequently among themselves to develop strategies for implementing the NAPCP, and to discuss common concerns.

### Recommendations.

\* Project Oversight. The Steering Committee of ASEP must be reactivated. It could formulate recommendations for making ASEP more responsive to the prevailing HIV/AIDS situation. It could facilitate the implementation of initiatives, such as the revision of the Sanitation code, that are beyond the scope of ASEP but affect project success. The DOH must also consider the need to exercise its ASEP oversight function more forcefully.

\* Mechanisms for Coordination. The ASEP Education Subcommittee must meet more regularly to assess the efficiency and impact of IEC activities and to enable implementing agencies to act in a more coordinated manner.

Consideration should be given to the establishment of a "grievance system" whereby unresolved disagreements between ASEP NGOs, or between NGOs and LGUs, could be addressed expeditiously.

\* The AIDS/STD Unit. The AIDS/STD Unit must be institutionalized as a permanent "service" in the DOH. Its continued attachment to the Office of Special Concerns (OSC) may be recommended, as there is a potential for synergism among OSC programs which have overlapping concerns.

The technical and financial capability of the AIDS/STD Unit to develop and manage a strategic plan for STD prevention and control must be strengthened.

\* Program Management. The success of the AIDS/STD Unit should be made to depend less on the person in charge of it. Expectations of the program manager must be based on the resources and powers at his/her disposal. To this end, his/her authority, functions and liabilities must be spelled out more clearly.

\* Local Government/NGO Collaboration. Local level public/private sector partnership must be further strengthened. The relevant experience gained in cities such as Angeles and Cebu could serve as a model for other cities. (The search for learning "models" may be directed away from Thailand towards local achievements in mobilizing joint GO-NGO responses to HIV/AIDS.)

\* The PNAC. The PNAC could serve as a venue for policy dialogue and a vehicle for instituting policy reforms, but its potential has not yet been realized. Policy dialogue which can properly orient and enlighten members of PNAC must be considered as a potential area for expanded USAID/Manila assistance.

\* Roles and Responsibilities. The specific roles and responsibilities of NAPCP implementing agencies must be redefined and clearly communicated. Important factors such as the devolution of health services and the administrative responsibilities of NGOs should be taken into account. In this respect, USAID/Manila should re-assess the three-tier management of the ASEP education component.

\* Financing. Mechanisms need to be devised to increase public and private sector investments in health. As ASEP represents a major proportion of the NAPCP, there may be a need to reassess the balance between short-term funding of direct services and longer-term investments in building local capabilities. For example, it was originally envisioned that the Public Information and Health Education Service would oversee the implementation of the ASEP education component. In reality, PIHES has not been involved in the implementation of ASEP IEC activities, deferring instead to the AIDS/STD Unit to provide guidance. USAID/Manila may want to consider whether the involvement of PIHES in ASEP should be strengthened, in order build the capability of this unit of the DOH.

Government agencies responsible for implementing the NAPCP must be more proactive in determining which donor agencies will support various components of the programs.

\* Donor Coordination. Future donor assistance must be coordinated more systematically as activities in other NAPCP program areas are implemented, and as the number of donors and levels of funding increase. The DOH should consider taking the lead role in convening donor meetings.

\* National Strategy Development. Plans are underway to use the 'Australian method' to develop a national AIDS strategy for the Philippines by December 1, 1995 (World AIDS Day). This process will involve all national and local level agencies involved in implementing the NAPCP, in an effort to achieve consensus on key issues that are still unresolved. The development of a national AIDS strategy represents an important opportunity to put a much needed legal/regulatory framework in place, and galvanize political commitment to addressing HIV/AIDS issues at all levels of government.

ANNEX ONE: LIST OF PERSONS VISITED BY THE EVALUATION TEAM

NAME	TITLE	AGENCY
Cortado, Flora	President	(ACE)Angeles City Entertainers
Thomas, Margaret	Second Secretary (Development Assistance)	AIDAB
Esguerra, Teresita (MD)	Chief, Social Hygiene Clinic	Angeles City Health Department
Manoling	Social Worker	Angeles City Health Department
Mejia, Proceso A. (MD, MPH)	City Health officer	Angeles City Health Department
Sigua, Teresita L.	Health Educator	Angeles City Health Department
Jereza, Lourdes "Odette" D.	President	Association of Non-Traditional Educators in the Philippines
Itaas, Julie V.	Project Development Officer	Bidlisiw Foundation, Inc.
Abellanos, Ilya P. (MD)	Head, STD/AIDS Detection Unit	Cebu City Health Department
Fernandez, Thomas L. (MD, MPH)	City Health Officer	Cebu City Health Department
Aballe, Ervyl (RN)	Public Health Nurse	Cebu Social Hygiene Clinic
Perales, Carmelita	Nurse Attendant	Cebu Social Hygiene Clinic
Tomines, Daylinda	Sanitation Inspector	Cebu Social Hygiene Clinic
San Miguel, Maribeth R.	Program Manager	Children's Lab
Gabor, Marina	Under Secretary	Department of Tourism
Avendano, Eduardo L.	National Sales Manager	DKT International, Inc.
Calica, Carlos L. (MD)	Marketing Director - Rx Div	DKT International, Inc.
Darden, Craig M.	Country Director	DKT International, Inc.
Llapitan, Benny L., Jr.		DKT International, Inc.
Capul, Rosendo R. (MD, MPH)	Senior Advisor	DOH
Reodica, Carmencita N. (MD, MPH)	Under Secretary for Public Health	DOH
Abesamis, Criselda G. (MD)	Division Chief	DOH/BRL
Ramos, Grace F.A. Mina (MD)	Chief, Hematology & Immunology Section	DOH/BRL

Paraan, Asuncion A. (MD)	Program Manager, National Voluntary Blood Program	DOH/BRL
Dayrit, Manuel M. (MD, MSc)	Assistant Secretary of Health	DOH/BRL/FETP
Badoy, Timoteo J., Jr. (MD)	Project Coordinator, National HIV Sentinel Surveillance	DOH/FETP
Maningas, Christina C.	Program Administrator	DOH/FETP
Uysingco, Perfecto	Social Scientist	DOH/FETP
Gacad, Evelyn Grace B. (MD)	Program Manager/AIDS-STD	DOH/NAPCP
Wi, Teodora (MD)	AIDSCAP Resident Advisor	DOH/NAPCP
Bernaje, Marietta	Officer-in-Charge	DOH/PIHES
Kamigatakuchi, Tokujiro	AIDS Program Coordinator	Embassy of Japan
Yoda, Norihiko (MD)	First Secretary	Embassy of Japan
Alvarez, Rowena	Executive Director	ISSA
Daliraz, Rita	Project Coordinator	ISSA
Diaz, Mariel O.	Program Officer	ISSA
Coleman, Patrick L.	Senior Resident Advisor	Johns Hopkins University
Victoriano, Melanie M.	Program Officer	Johns Hopkins University
Bagasao, Teresita "Bai"	Executive Officer	Kabalikat
Dendiego, Arnold	Project Assistant	Kabalikat
Aquino, Carmina N.A. (MD)	Consultant/ASEP	PATH
D'Agnes, Leona A.	Country Director	PATH
Rahardjo, Virginia Sonya (PhD)	Project Manager/ASEP	PATH
Inumerable, Annie V. (MD)	Medical Officer V	Quezon City Health Department
Aboitiz, Ma. Christina C.	Executive Vice President	RAFI
Caseros, Mary Grace D.	Program Officer	RAFI
Chiu, Leonardo V.	Director, Program Dev & Eval	RAFI
Llenos, MA. Dolores V.	IEC Specialist/Res Officer	RAFI
Razalo, Francisco (MD, MPH)	Resident Advisor	RAFI/PATH
Sabucido, Christina R.	Accountant	RAFI
Sita, Ireneo B.	Program Manager	RAFI

Castro, Joan Regina (MD)	Director/Counseling Program	ReachOut
Fleras, Jomar	Executive Director	ReachOut
Jardenil, John	Program Officer	ReachOut
Aplasca, Marie Rose (MD)	OIC, AIDS Research Group	RITM
Monzon, Ofelia T. (MD)	Consultant on AIDS	RITM
Paladin, Fem Julia E. (MSc)	Head, Virology Section	RITM
Del Gallego, Nanette	Project Manager	TriDEV
Montes, Necta	Project Coordinator	TriDEV
Parawan, Amado (MD)	Executive Director	TriDEV
Tiglao, Teodora V. (MD)	Professor Emeritus	U.P. College of Public Health
Tempongko, Ma. Sandra B. (BSMT, MPH, DrPH)	Associate Professor	U.P. College of Public Health
Barash, Mahlon A.	Deputy Chief, Office of Portfolio Dev & Impl Supp	USAID/Philippines
Manaloto, Corazon R. (MD,DTMH)	Public Health Advisor	USAID/Philippines
Palmer, Douglas (MSPH)	Health Development Officer	USAID/Philippines
Voulgaropoulos, Emmanuel (MD, MPH)	Chief, Office of PHN	USAID/Philippines
Manthey, Geoff	Technical Officer	WHO/GPA/Philippines
Sarda, Rabin M. (MD)	Medical Officer	WHO/GPA/WPRO

ANNEX TWO: LIST OF PROJECT DOCUMENTS AND OTHER RELEVANT REPORTS

List of Reference Documents

1. ASEP Project Paper  
USAID/Philippines  
May 1992
2. Briefing Kit for ASEP Evaluation Team  
PATH  
January 1995
3. ASEP Education Strategy  
HIV/AIDS Subcommittee and PATH  
March 1994
4. Communication Strategy: National AIDS/STD Prevention and Control Program: 1994-1999  
DOH  
September 1994
5. Scope of Work: JHU/PCS Cooperative Agreement  
USAID/Philippines  
April 1994
6. First Annual Report - ASEP Education Component  
PATH  
January 1995
7. Minutes of the ASEP Organizational Meeting  
Office of Special Concerns, DOH  
November 1993
8. Country Report: Philippines 1987-92  
AIDSTECH  
circa 1993
9. The Continuing Lives of Women in the Entertainment Industry  
WEDPRO  
1994

10. An Ethnography of Male Sex Workers in the Philippines  
Laufred Hernandez  
January 1994
11. Philippines Health Education Intervention Program on AIDS  
for High Risk Individuals in Olongapo and Angeles City  
Nancy Williams  
circa 1993
12. A Review of Social and Behavioral Studies Related to  
HIV/AIDS in the Philippines  
Michael Tan  
October 1994
13. Essentials: Vol 1, No. 10. Women, Sex, AIDS, Condoms,  
EMPOWERMENT  
Population Services Pilipinas  
September 1992
14. Sexual Behavior of Filipino Female Prostitutes after  
Diagnosis of HIV Infection (in Southeast Asian J Trop Med  
Public Health: vol 21, no. 2.)  
Cora Manaloto et. al.  
June 1990
15. Final Report on Health Education Intervention: Kabilikat  
Component  
(no author)  
1991
16. Am I Taking Too Many Chances? Risk Advisor  
PATH  
(no date)
17. Sex work related HIV/AIDS and STD prevention interventions:  
Suggested plan of action for Cebu  
(no author)  
January 1995
18. Considerations for a National AIDS Strategy: Financing and  
Local Government Issues  
Mario Taguiwalo  
November 1993

19. Travel Report Summary  
Carmina Aquino  
February 1995
20. Qualitative data relevant to AIDS prevention gathered from sex workers, injecting drug users, and at-risk youth in Cebu  
Ramon Aboitiz Foundation, Inc. (RAFI)  
August 1994
21. Assorted proposals, financial and activity reports of sub-grantees.
22. Country Report: Sexually Transmitted Disease (STD) Prevention and Control Program - Philippines  
Eumelia Salva  
circa 1993
23. Preliminary Results: Rapid anonymous survey of STD services in the Philippines  
AIDSCAP  
September 1994
24. STD Statistics per region: January 1993 - September 1994  
DOH  
late 1994
25. Report on Project Activities in the Philippines  
AIDSCAP  
September 1994
26. Assessment report of STDs in the Philippines  
John Gallwey  
early 1993
27. Trip Report: Philippines  
Peter Perine  
July 1994
28. Strategic Plan for the Philippines  
AIDSCAP  
October 1993
29. Trip Report: Philippines

Doris Mugrditchian  
October 1994

30. HIV/AIDS in the Philippines (in AIDS 1994, 8 - suppl 2)

Michael Tan and Manuel Dayrit  
August 1994

31. Consultant Report on HIV/AIDS Surveillance Strategies and Estimation and Project of HIV/AIDS in the Philippines

James Chin  
December 1993

32. Provisional Operational Plan: 1992. National AIDS Prevention and Control Program

DOH  
March 1992

33. The Epidemiology of HIV Infection in Metro Manila and Two Former Military Base Areas

U.S. Naval Medical Research Unit No. 2 (NAMRU)  
circa mid-1994

34. Implementation of an HIV/AIDS Control Program for the Philippines: A Proposal for Action

Roger Detels and Ralph Frerichs  
circa 1991/1992?

35. The National HIV Surveillance System: Strategy 1992-1997

DOH  
July 21, 1992

36. Memorandum of Understanding and Agreement for Implementation of USAID Grant No. IA93002

DOH and WHO  
August, 1993

37. National HIV Surveillance Operations Manual

DOH  
March 1994

38. Results of the First Round of HIV Sentinel Serologic Surveillance in the National Capital Region - Quezon City Sentinel Site and Metro Cebu, June-September 1993

- TJ Badoy, ME White, and MM Dayrit - (FETP)  
circa late 1993?
39. Results of the Second Round of Surveillance Activities, NCR-  
Quezon City, Metro Cebu, and Metro Davao, April-June, 1994
- Manuel M. Dayrit and Timoteo J. Badoy, Jr. - (FETP)  
October, 14, 1994
40. Results of the Third Round of Surveillance Activities, NCR-  
Quezon City and Pasay City sentinel sites, Metro Cebu, and  
Metro Davao, Angeles City, and Iloilo City, Sept.-Nov. 1994
- Manuel M. Dayrit and Timoteo J. Badoy, Jr. - (FETP)  
January 19, 1995
41. (Abstract) Survey of HIV Risk Behavior Among Female Sex  
Workers in Pasay City, Metro Manila, Philippines, April-May  
1994
- Judith S Iturralde-Tapiador, Florante P Magboo, Mark E White  
and Manuel M Dayrit - (FETP)  
circa late 1994?
42. The National HIV Surveillance System: Operational Plan Sept  
1993 - Sept 1994
- DOH  
circa 1993?
43. Mid-Year AIDS/HIV Registry Report - June, 1993
- FETP  
August, 1993
44. HIV/AIDS Registry: Annual Report January-December 1994
- FETP  
February 2, 1995
45. National AIDS Prevention and Control Program 1990-1992:  
Final Report of the External Review Team - June-July 1993
- External Review Team (?)  
circa late 1994?
46. Recommendations for the First HIV Surveillance Round Based  
on a Review of HIV Sentinel Surveillance Studies, 1992
- DOH HIV Surveillance Group of 1992  
June 7, 1993

47. Organizational Chart, per E.O. 119

Department of Health  
1987

48. Creation of a Subcommittee for the Education Component of the AIDS Surveillance and Education Project (ASEP), Transcript of Signed Department Order No. 326-H, s. 1993

Department of Health  
October 7, 1993

49. Creation of Steering Committee for the AIDS Surveillance and Education Project, Department Order No. 3298, s. 1993

Department of Health  
October 8, 1993

50. Creating the Philippines National AIDS Council (PNAC as a National Policy and Advisory Body in the Prevention and Control of HIV (Human Immunodeficiency Virus) Infection and AIDS in the Philippines, Executive Order No. 39

Office of the President  
December 3, 1992

ANNEX THREE: ASEP MIDTERM EVALUATION SCOPE OF WORK

.. The AIDS Surveillance and Education Project  
Mid-Term Evaluation

Scope of Work

A. Project Background

Prior to the commencement of the AIDS Surveillance and Education Project (ASEP), USAID provided over \$3.5 million to the National AIDS Philippine Control Program (NAPCP). This assistance was used to fund activities in Metro Manila, Cebu, Olongapo and Angeles which included training in AIDS counseling, support for an AIDS hotline, general AIDS education, upgrading social hygiene clinics, upgrading regional blood centers, and the completion of a market feasibility study for condoms.

Recognizing the need to do more in HIV/AIDS control and the requirement to support more focused efforts, USAID authorized the ASEP in late 1992. The project is scheduled to continue until 1997 with a present funding level of \$7.5 million.

The project's overall objective is, "To establish institutional mechanisms in the public and private sectors which can:

1. Monitor the prevalence and transmission of HIV infection; and
2. Encourage behaviors which reduce HIV transmission."

The two components of the project are:

1. Surveillance. Project funds are targeted at establishing an HIV sentinel surveillance system at strategically located geographic sites and population
2. Education. Local NGOs are supported to provide community-based education targeting groups that practice high risk behaviors, in locations where the sentinel surveillance system have been established. Education and some mass media are based on behavioral research and surveys supported by the ASEP and other projects. The educational component of the project aims to reduce high risk behaviors, thus the transmission of HIV. (Funds are provided via a cooperative agreement with PATH for this component.) groups. Presently the Department of Health's (DOH) Field Epidemiology Training Program (FETP) Unit has established sentinel sites in Pasay City and Quezon City -- in the greater Manila area; in Cebu City; Davao City, Iloilo City and Angeles City.

The surveillance system has initially monitored both male and female commercial sex workers (CSWs), men who have sex with men (MSMs), IV drug users (IVDUs), and patients of STD clinics ("clients"). Other groups assumed to practice high risk behaviors are planned to be included in the surveillance, such groups include truck drivers, the military, and the police. (Equipment and support for surveillance are provided through a grant to the WHO for surveillance.)

Other activities supported through the project include: (a) a nation-wide mass media AIDS education effort directed at the general population. This media blitz will run during late 1994 through mid-1995 with the exceptions of the Christmas season, the visit of the Pope in January, and during the May elections. (Mass media efforts are funded through John Hopkins University.) And, (b), assistance to establish an all-voluntary blood banking system(s) in the Philippines. (This activity has yet to be designed.)

USAID, by significant margin, is presently the major donor in the Philippines' National AIDS Control Program. Other donors include AIDAB, UNFPA, the Japanese through the "Common Agenda," and WHO.

#### B. Evaluation Purpose:

This is a mid-term evaluation. Most activities have been running less than two years; however, given the length of time since the project was designed, it is time to take a look at overall project planned activities and assumptions. The evaluation will focus on USAID's assistance to STD/HIV/AIDS control through the ASEP and, via other means, such as AIDSCAP. It will also assess the overall national program and other donor efforts, as all activities are focused on STD/HIV/AIDS control. The evaluators then will look at the entire NAPCP Program and make recommendations to the GOP, particularly the DOH, and to donors on how the national program can enhance its achievements and resolve any problem areas in order to make the program more effective and efficient in the control or the spread of HIV and other STDs in the Philippines.

#### C. Evaluation Scope of Work:

1. Evaluation members will work as a team. The evaluation team leader will be responsible for assuring that the entire scope of work is completed and the evaluation report is put in final form before departure.
2. Detailed Evaluation SOW is given below; however, the evaluation team will be given questions submitted by

the DOH, WHO, AIDAB, DKT and PATH for consideration and expansion. The great majority of their inputs have been utilized in the following SOW:

(a) Surveillance:

- (1) Should the ASEP aim to establish 30 geographic sentinel surveillance sites by 1997, as in the project design, or should the number of sites be restricted in number?
- (2) What groups should the seroprevalence surveillance target at this stage? Has a system been developed for behavioral surveillance? Are representative groups included in the surveillance?
- (3) Should the 6-monthly seroprevalence and behavioral surveillance studies at the DOH/FETP be conducted at the same time? Does this bias results of the behavioral survey?
- (4) Are surveillance results being routinely and clearly communicated to all entities involved in HIV/AIDS control efforts? i.e. within the DOH, to NGOs, and to the donors? Is the data being integrated and are the implications and recommendations being formulated and communicated with end users in mind?
- (5) How will the behavioral change planned: "increase in safe sex practices" be measured? Does the FETP-generated survey provide sufficient and usable data?
- (6) Has the AIDSCAP STD behavioral survey provided an adequate behavioral baseline with the CSW target group?
- (7) What role do local government officials play in seroprevalence and behavioral surveillance? What role do the NGOs play? Should they be modified?
- (8) Is behavioral surveillance being conducted for tracking purposes only or is the data being utilized in control efforts?
- (9) Are the surveillance data presented in a useable format? Can it be improved?
- (10) How timely are the delivery of surveillance results?

b) Education

- (1) Should the project limit its IEC focus on selected high risk groups, given the present stage of the epidemic?
- (2) Quezon City has a seroprevalence rate of over 1%. What is the DOH and the donor and NGO community doing to address the situation in this area? What should what can they be doing?
- (3) Is the ASEP strategy of utilizing NGOs to provide IEC effective? Should the private sector and/or the GOs be brought in more to assure coverage? If so, how should they be brought into the effort?

What roles should they play?

- (4) Is peer education the culturally appropriate model for AIDS education and intervention programs in the Philippines?
- (5) Should the project rely more on social marketing in the delivery of IEC?
- (6) A 1994 draft audit report noted that "target numbers for the ASEP education activities are lacking." What should the target numbers be?
- (7) Does mass media, aimed at the general population make sense at this stage? (See the DKT questions for a complete response.)
- (8) What has been the IEC process of project development and start-up? How has coordination with USAID and the DOH affected project organization and implementation of activities?
- (9) Has a system been developed for monitoring and evaluation the quality and impact of strategy activities?
- (10) What are the gaps in other support services for STD/AIDS intervention that need to be addressed for overall project impact?

(c) Mass Media:

- (1) What are the channels of coordination between the mass media component and the surveillance and education components?
- (2) What is the strategy for the mass media component? Is it epidemiologically sound?
- (3) What impact has past media efforts have on target groups? The general public? Have this be assessed?
- (4) Should mass media target building awareness when there are indications that awareness is extremely high?

(d) Organizational Policy and Other:

- (1) Are donors effectively coordinating assistance to the NAPCP? Is there duplication of efforts and/or areas where too much assistance is being delivered, thus stretching the abilities of the implementing units? Are there important areas where little assistance is being provided?.
- (2) Should USAID assistance keep its focus on "high risk" groups in assumed "hot spot" areas? Should the focus be narrowed? Broadened? What are the DOH plans?
- (3) Should ASEP address the apparent need to improve STD diagnosis and treatment to groups practicing high risk behaviors, given the important of classic STDs in HIV transmission? If so, how/what assistance should be provided?

- (4) Are condoms available to groups practicing high risk behaviors?
- .. (5) Is the PNAC functioning? What are the constraints?
- (6) Has the DOH issued a Departmental Order to establish clear lines of responsibility for implementation of the NAPCP?
- (7) Are other national governmental departments involved in the NAPCP? How can they be involved? What governmental action(s) are needed to get their involvement?
- (8) What are the other donors planning re. support for HIV/AIDS control? Are the donors coordinating adequately? Are there overlaps: are there gaps?

## ANNEX FOUR: USES AND LIMITATIONS OF HIV/AIDS SURVEILLANCE, INCLUDING BEHAVIORAL SURVEILLANCE

### Introduction.

Public health surveillance can be defined as "the collection, analysis, and dissemination of all data relevant to the prevention and control of a public health problem". Methods and systems for public health surveillance of HIV infections and AIDS cases (HIV/AIDS) have been evolving since the initial development of HIV sentinel surveillance (HSS) in the late 1980s by the Global Programme on AIDS (GPA) of the World Health Organization (WHO). As of 1995, routine surveillance of sexually transmitted diseases (STDs) and surveillance of behaviors that place a person at increased risk of acquiring or transmitting an HIV infection have not been carried out by any national HIV/AIDS Prevention and Control Program.

Basic questions that need to be answered before the development of any surveillance system include: what data are needed, with what frequency, and with what accuracy? However, before these basic questions can be answered in detail, the more basic question - what specific action or actions, if any, will be taken as a result of surveillance findings? - needs to be answered first. Surveillance data are supposed to be data for public health action. Up to now, it seems that very little, if any, specific actions have resulted from most of the public health HIV/AIDS surveillance data that have been collected to date.

For surveillance data to be relevant and useful, the basic objectives of the program should be reviewed to determine if the surveillance findings are useful for the achievement of program objectives. The basic and primary objective of any AIDS prevention and control program is to prevent the transmission of HIV infections; a secondary objective is to be able to estimate the current and future number of AIDS cases so that adequate health and social services can be mobilized.

### Surveillance of AIDS and HIV Infection.

Reported numbers of AIDS cases are of limited value for public health planning. In addition to reflecting HIV infections which were acquired many years previously, significant "adjustments" usually have to be made to the reported data to account for delays and incompleteness of reporting. Estimates of the prevalence of HIV infection are essential for monitoring the epidemiological patterns and scope of individual epidemics. In addition, future cases of HIV-related diseases, including AIDS, will depend on the number of persons infected with this virus.

Since it is difficult and generally not feasible to monitor the trends of HIV infection in the total or "general" population, many public health surveillance systems have relied on the routine and consistent collection of data from sentinel groups. Such surveillance has focused on easily defined and accessible population groups. The basic purpose of sentinel HIV surveillance is to detect changes in the prevalence of HIV infection in the groups selected. If different sentinel groups are monitored uniformly over a period of time at selected sites, the data collected will provide information on HIV trends in these groups which should be sufficient for the design and direction of HIV/AIDS prevention and control programs. The sentinel populations selected should allow for the monitoring of all the major HIV risk behaviors or factors known to be prevalent in any given area.

What information is needed regarding the prevalence of HIV in different population groups for HIV/AIDS prevention and control programs? If HIV prevalence is estimated from the available surveillance data to be low (i.e., less than 1 percent), is there a need to attempt to determine precisely how low the actual prevalence might be? It may be quite sufficient for HIV/AIDS prevention and control programs to be aware of the following general levels of HIV prevalence for different population "groups":

- A. HIV not detected
- B. HIV present and prevalence probably very low (less than 0.5 percent?)
- C. HIV prevalence close to 1 percent
- D. HIV prevalence more than 5 percent

These arbitrary HIV prevalence levels are within the capability of most public health HIV/AIDS surveillance systems to measure and monitor with reasonable sample sizes. To be able to measure any specific prevalence level below 1 percent with any degree of statistical confidence would require very large sample sizes, and the additional problems of biases in sample selection and participation also contributes to the general lack of precision in public health surveillance data.

In many developed countries, HIV seroprevalence levels in men who have sex with many men (MSM) and injecting drug users (IDUs) reached level D within a few years of the start of HIV epidemics in these risk "groups", whereas many heterosexuals who have multiple sexual partners (HMSPs) in many areas are still at level B. These arbitrary "threshold" levels can be changed by HIV/AIDS programs to fit their own priorities or anxieties. It also has to be emphasized that public health HIV surveillance systems cannot provide complete surveillance coverage of all areas and populations, nor is there any overriding need for such a comprehensive surveillance system.

A frequent criticism of starting sentinel HIV surveillance in only a few of the highest HIV risk "groups" in the highest risk areas (usually the largest cities) is that possible epidemics in other areas and populations will go undetected. While this is always a possibility, more than a decade of experience in public health surveillance of HIV/AIDS indicate that concern about HIV epidemics occurring outside of the largest urban areas before high HIV seroprevalence levels are reached in the large cities are unfounded. Experience in many countries, where HIV epidemics have reached level D among several heterosexual high HIV risk groups such as female commercial sex workers (FCSWs) and/or heterosexual STD patients, also indicate that spread to the "general" population of heterosexuals as reflected by HIV seroprevalence levels among antenatal women may take up to 5 years or more to reach level C.

There has been a general uneasiness of public health programs to accept the fact that the incidence and prevalence of HIV infection are difficult to measure with any great degree of precision and/or confidence. In addition, there has been an even greater reluctance on the part of HIV/AIDS program managers and policy makers (including many public health epidemiologists) to accept the fact that even the most accurate and timely data on the incidence and prevalence of HIV infections and AIDS cases will not provide adequate or sensitive indicators of the effectiveness of HIV/AIDS prevention and control programs.

#### Behavioral Surveillance.

During the early 1990s, at the behest of international donors, increasing attention was given by GPA/WHO to the development of evaluation indices for HIV/AIDS program. Although the importance of data on the prevalence and pattern AIDS cases and HIV infections is accepted, these data are also acknowledged to be of limited use for the evaluation of the effectiveness of education and other intervention measures in changing HIV risk behaviors.

Methods for routine STD and behavioral surveillance that should be implemented by HIV/AIDS programs, including the specific data that need to be collected, have not been fully developed by GPA/WHO or by any major public health agency. The concept of behavioral surveillance was not formulated until 1993 and behavioral surveillance targeting high risk "groups" has not yet been systematically and routinely implemented in any national HIV/AIDS program. In addition, programmatic uncertainty exists as to whether the routine collection of behavioral data should be the responsibility of traditional public health epidemiology and surveillance units or whether behavioral surveillance should be developed and implemented by those responsible for education and outreach activities.

**Best Available Copy**

GPA/WHO continues to give high priority to periodic (every 3 to 4 years) and relatively large scale Knowledge, Attitudes, Beliefs, and Practices (KABP) surveys of a large (3,000 or more) random survey of young and middle-aged adults. Such KABP surveys are important to accurately measure and to better understand prevalent beliefs and behaviors in the "general" adult population, but are of limited or no use for the timely evaluation of intervention measures directed to specific population "groups" or specific behaviors such as condom usage in CSWs. These surveys have been developed and supported by social/behavioral research personnel at GPA/WHO and have not involved the HIV/AIDS surveillance unit. AIDSCAP has been developing detailed protocols for periodic (every 6 months or year) cross sectional behavioral surveys in specific population groups in Bangkok and a draft manual and questionnaire should be available for distribution by mid-1995.

It needs to be critically asked - would the most accurate and timely data on the patterns and prevalence of HIV infections and AIDS cases significantly change any of the programs and policies currently in place? From what has been learned about the epidemiology of HIV infections over the past decade, it is clear that multiple and to some extent separate epidemics of HIV infections can occur in any country or region depending on the distribution and prevalence of specific HIV risk behaviors - MSM, IDUs who routinely share injecting equipment, and HMSPs. HIV surveillance systems need to be designed to appropriately monitor each of these relatively separate HIV epidemics.

The more appropriate and essential surveillance data needed by AIDS prevention and control programs are the patterns and prevalence of sexual behaviors related to multiple sexual partners and the patterns and prevalence of sharing injecting equipment among injecting drug users. There is a critical need to develop routine surveillance of these HIV risk behaviors. If public health programs are to be effective in reducing or at least modifying these HIV risk behaviors, they must first obtain reliable baseline data on sexual and injecting drug behaviors in population "groups" who are known to practice these risk behaviors. The essential data needed for all risk "groups" are:

1. On average, how many different sexual partners did persons in this "group" have over the past month and/or week?
2. For each of these sexual encounters, was a condom used?

Tabulation and analysis of the answers to these questions yields two basic numbers which can provide programs with:

- A. Specific and reasonable targets to achieve over a specified period of time; and
- B. A specific means of evaluating the effectiveness of program interventions with regards to achieving the stated targets.

For example, if the targeted population were truck drivers, and the baseline behavioral surveillance survey indicated that this "group" had an average of 3.5 different sexual partners per month and the condom usage or coverage rate for these sexual contacts was 20%, then the program can initially set objectives or program targets to reduce the average number of sexual contacts in this "group" to 2 or less per month, and to increase the condom usage rate to 50% over the next 6 months or year. Such program objectives should be pursued regardless of whether the HIV seroprevalence in the community is very low, moderate or high. A second behavioral survey 6 months or a year later can be used to measure if program targets were achieved, or at least to determine if any statistically significant changes occurred or not.

All identified high HIV risk "groups" need to have routine sexual behavioral surveillance surveys (not research studies) carried out on a regular basis. For those "groups" who may engage in injecting drug use, the essential behavioral questions they need to be asked in addition to the two basic sexual behavioral questions are:

1. How many persons, and/or times did they share drug injecting equipment during the past month and/or week; and
2. Did they use separate and/or clean injecting equipment, when they shared injection equipment.

The answers to these behavioral questions will provide public health programs with data to develop targets for changing these behaviors and with data to evaluate the effectiveness of education and other interventions in achieving these targets. Public health epidemiologists, in collaboration with behavioral scientists and experts need to develop and evaluate instruments (questionnaires, etc.) and methods for the routine collection of behavioral surveillance data for specific populations.

#### Summary and Conclusions.

As described above, surveillance data on HIV infections and AIDS cases are needed to estimate the current patterns, prevalence, and trends of the epidemic. However, routine HIV/AIDS surveillance data are not sufficiently sensitive or timely for the direction of prevention programs. By the time that HIV surveillance data indicate that HIV infections are increasing at a very rapid rate in any specific population, it is generally too late and/or too difficult to prevent further extensive spread. In addition, without extensive qualitative and quantitative data on behavioral patterns, public health programs will not be able to adequately design and direct appropriate intervention measures to specific target populations to change or modify their documented risky behaviors.

**Best Available Copy**

## ANNEX FIVE: AIDS CASE REPORTING AND HIV SEROSURVEYS IN THE PHILIPPINES

AIDS case reports are received by the AIDS Registrar in the FETP Office/DOH/Manila via a passive reporting system. The first case of AIDS was diagnosed in the Philippines in 1984. As of early 1995, close to 190 AIDS cases have been reported to the National AIDS Registry. The majority (close to 90%) of the reported AIDS cases probably acquired their HIV infection via the sexual route - over half of the total reported cases are in heterosexuals and over a third are in homosexual males. More male cases have been reported compared to female cases and the male:female ratio has been about 1.3:1. In general, male cases are older than female cases and the median age for male AIDS cases in 1994 was 36, whereas the median age for female AIDS cases was 30.

Up to 1992, less than 20 AIDS cases were reported annually but a marked increase has been noted over the last couple of years - 32 cases were reported in 1993 and 56 in 1994. No specific studies are available to estimate how incomplete, inaccurate, and delayed AIDS case-reporting may be in the Philippines, but informal discussions with senior staff of FETP suggests that the actual number of AIDS cases, as of early 1995, may be conservatively estimated to be at least 300.

AIDS surveillance data, collected in the Philippines via a passive reporting system, continues to provide an incomplete and delayed description of the HIV situation. As of early 1995, about 190 AIDS cases have been reported but it is conservatively estimated that at least 300 AIDS cases may have occurred. Although general education, to medical providers and hospital workers to better recognize and report AIDS cases, should be increased and improved, the general passive reporting system of AIDS cases in the Philippines can be expected to remain incomplete and unreliable.

As of early 1995, in addition to the reported AIDS cases, a cumulative total of about 400 HIV-infected persons have been detected in the Philippines. Almost all of these HIV-infected persons were found through HIV serosurveys carried out from 1985 up to 1993, before the start of ASEP. By 1993, over 1 million HIV tests had been done. Over 500,000 of these tests were in OCWs (mainly because of requirements by middle-east countries), over 300,000 tests were for screening of blood for transfusion, and over 175,000 were in female commercial sex workers primarily in Olongapo, Angeles City and Manila. These relatively large scale HIV sero-surveys documented the presence of HIV infection in the Philippines, but at very low levels--about 2 to 3 per 1,000 among MSM and, on average, less than 1 per 1,000 among FCSWs.

ANNEX SIX: SUMMARY OF THE MOST RELEVANT SURVEY DATA FOR ASEP

1. HIV Infection Percent HIV+

<u>Population</u>	<u>Quezon City</u>	<u>Pasay City</u>	<u>Metro Cebu</u>	<u>Davao</u>	<u>Angeles</u>	<u>Iloilo</u>	<u>Total</u>
<u>FETP-HSS</u>							
Female CSWs: Registered							
Jun-Aug '93	0.3	-	0.0	-	-	-	0.2
Apr-Jun '94	0.3	-	0.0	0.0	-	-	0.1
Sep-Nov '94	0.3	0.3	0.0	0.0	0.0	0.0	0.1
Female CSWs: Free lance							
Jun-Aug '93	0.0	-	0.0	-	-	-	0.0
Apr-Jun '94	0.0	-	0.0	0.0	-	-	0.0
Sep-Nov '94	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Male CSWs							
Jun-Aug '93	0.0	-	0.0	-	-	-	0.0
Apr-Jun '94	0.0	-	0.0	0.0	-	-	0.0
Sep-Nov '94	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Males with an STD							
Jun-Aug '93	0.0	-	0.0	-	-	-	0.0
Apr-Jun '94	0.0	-	0.0	0.0	-	-	0.0
Sep-Nov '94	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Men who have sex with men							
Jun-Aug '93	0.0	-	0.0	-	-	-	0.0
Apr-Jun '94	0.0	-	0.0	0.0	-	-	0.0
Sep-Nov '94	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Injecting drug users							
Jun-Aug '93	0.0	-	0.0	-	-	-	0.0

Apr-Jun '94	0.0	-	0.0	0.0	-	-	0.0
Sep-Nov '94	0.0	0.0	0.0	0.0	0.0	0.0	0.0

1. HIV Infection (cont.) Percent HIV+

<u>Population</u>	<u>Quezon City</u>	<u>Pasay City</u>	<u>Metro Cebu</u>	<u>Davao</u>	<u>Angeles</u>	<u>Iloilo</u>	<u>Total</u>
-------------------	--------------------	-------------------	-------------------	--------------	----------------	---------------	--------------

NAMRU

Female CSWs

Jul93/Apr94	0.0	0.5	-	-	0.4	-	0.1
-------------	-----	-----	---	---	-----	---	-----

Male CSWs

Jul93/Apr94	0.0	-	-	-	0.0	-	0.0
-------------	-----	---	---	---	-----	---	-----

3. Reported Risk Behaviors Percent Reporting "Always Use Condoms"

Population	Quezon City	Pasay City	Metro Cebu	Davao	Angeles	Iloilo	Total
<u>FETP-HSS</u>							
Female CSWs: Registered							
Jun-Aug '93	22	-	42	-	-	-	-
Apr-Jun '94	62	-	69	27	-	-	-
Sep-Nov '94	60	33	81	21	25	40	43
Female CSWs: Free lance							
Jun-Aug '93	30	-	1	-	-	-	-
Apr-Jun '94	29	-	11	19	-	-	-
Sep-Nov '94	43	69	13	35	11	17	36
Male CSWs							
Jun-Aug '93	18	-	1	-	-	-	-
Apr-Jun '94	4	-	1	12	-	-	-
Sep-Nov '94	34	8	2	3	10	-	13
Males with an STD							
Jun-Aug '93	-	-	-	-	-	-	-
Apr-Jun '94	-	-	-	0	-	-	-
Sep-Nov '94	-	8	-	1	-	-	2
Men who have sex with men							
Jun-Aug '93	1	-	1	-	-	-	-
Apr-Jun '94	0	-	2	3	-	-	-
Sep-Nov '94	3	1	2	10	3	8	3

3. Reported Risk Behaviors (cont.) Median Number of Sex Partners Per Week

Population	Quezon City	Pasay City	Metro Cebu	Davao	Angeles	Iloilo	Total
<u>FETP-HSS</u>							
Female CSWs: Registered							
Jun-Aug '93	2	-	3	-	-	-	-
Apr-Jun '94	5	-	3	3	-	-	-
Sep-Nov '94	5	7	3	3	4	3	4
Female CSWs: Free lance							
Jun-Aug '93	3	-	14	-	-	-	-
Apr-Jun '94	4	-	14	3	-	-	-
Sep-Nov '94	3	2	5	3	4	3	3
Male CSWs (male and female partners)							
Jun-Aug '93	3	-	2	-	-	-	-
Apr-Jun '94	3	-	1	2	-	-	-
Sep-Nov '94	3	2	1	3	2	-	2
Males with an STD							
Jun-Aug '93	-	-	-	-	-	-	-
Apr-Jun '94	-	-	-	2	-	-	-
Sep-Nov '94	-	1	-	2	-	-	2
Men who have sex with men (male and female partners)							
Jun-Aug '93	1	-	2	-	-	-	-
Apr-Jun '94	1	-	1	2	-	-	-
Sep-Nov '94	1	1	1	2	2	1	1

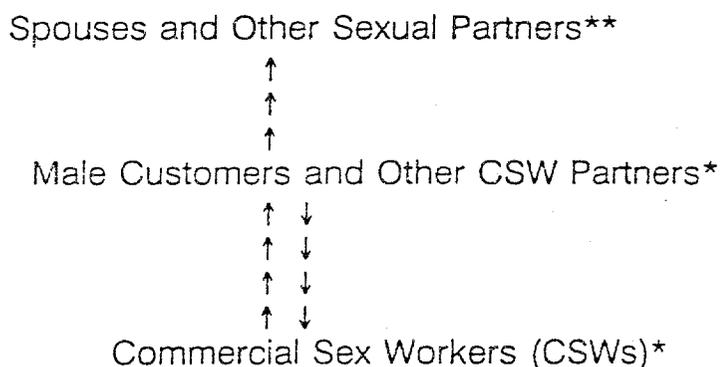
3. Reported Risk Behaviors (cont.) Percent Reporting Drug Use

<u>Population</u>	<u>Quezon City</u>	<u>Pasay City</u>	<u>Metro Cebu</u>	<u>Davao</u>	<u>Angeles</u>	<u>Iloilo</u>	<u>Total</u>
<u>FETP-HSS</u>							
Female CSWs: Registered Sep-Nov '94	2	1	2	1	1	2	1-2
Female CSWs: Free lance Sep-Nov '94	-	5	3	1	-	-	3
Male CSWs Sep-Nov '94	-	-	12	6	1	-	7
Males with an STD Sep-Nov '94	-	7	-	1	-	-	2
Men who have sex with men Sep-Nov '94	-	3	5	5	-	2	4
(% who share needles)							
Male injecting drug users Sep-Nov '94	16	66	61	33	40	-	59
Female injecting drug users Sep-Nov '94	57	-	17	-	-	-	38

## ANNEX SEVEN: DEVELOPING PRIORITIES AMONG PRIMARY RISK POPULATIONS FOR SEXUAL TRANSMISSION OF HIV

Interpersonal communication for behavior change is the centerpiece of most serious prevention programs around the world. However, experience has shown that it is rarely possible to reach all vulnerable individuals before an epidemic eventually breaks out. Therefore programs must make painful decisions concerning which subgroups are to receive higher priority and first access to services.

There is little in the scientific literature to guide program managers in the development of priorities for risk populations. Lamptey (1991) has summarized the relationships and transmission paths between primary and secondary "risk groups" for sexual transmission of HIV and a modified version of that schema follows:



---

Source: Peter Lamptey. "An Overview of AIDS Interventions in High-risk Groups" in AIDS and Women's Reproductive Health. L.C. Chen et al eds. New York. 1991.

Individuals in the primary risk group (denoted by one \*) are those who by choice, occupation or circumstance have multiple, different sexual partners on a regular basis. The most common groups of individuals in this category are male customers of commercial sex workers (CSWs) and the CSWs themselves. The secondary risk group (denoted by two \*\*) are the sex partners of the primary risk groups. To the extent that condoms are not used and STDs are prevalent in these populations, HIV once introduced in sufficient quantity, can rapidly infect the individuals at primary risk and then spread to the much larger population at secondary risk. Thus, a community or a country's best defense against such an epidemic is to reduce the level of risk among the primary risk groups.

The Philippines is in a pre-epidemic phase and the AIDS Surveillance and Education Project (ASEP) has correctly targeted the individuals who have the highest risk behavior. These include CSWs, customers of CSWs, men who have casual sex with other men and injecting drug users (IDUs). These populations are of unequal size and

are quite diverse. Risk is unequal within each group as well. For example, among CSWs free-lance street-walkers may be at higher risk of STD and HIV than unregistered CSWs in a Casa (call-girl house). CSWs who charge lower fees are generally more vulnerable than those who charge higher fees (since price for sex generally correlates inversely with number of partners). Among men who have sex with other men, those with casual (anonymous) partners may be at higher risk than those with several regular partners.

When human and financial resources are limited (as they usually are) prevention programs must direct their efforts to the members of the high risk groups with highest risk first. The level of risk is determined by qualitative and quantitative behavioral surveys and confirmed by periodic STD prevalence data. However, for educational outreach programs, other factors than risk behaviors may influence the priority attached to different groups. For example:

Size of the Population: The larger the size of the population, the more chance there is that HIV will penetrate (other things being equal). The more densely populated a high risk community, the higher the probability that a critical mass of infected will be reached to spark an epidemic. Thus, through enumeration and mapping, program resources can be directed first to the more populous and dense areas. However, managers must also consider..

Accessibility: The program may be able to identify a population of street walkers, however if they are constantly on the move and difficult to locate, then they might drop in priority below more stable groups of similar number and equal level of risk behavior. But keep in mind..

Mutability: How probable is it that an individual is able to change his or her behavior. IDUs or brothel-based CSWs may have little ability to control or limit their exposure to risk. Unless a supportive environment for change is in place, it may be a waste of resources to devote too much effort on outreach to these individuals. At the same time, some of the individuals in these groups have a much greater potential for distributing the infection to many others such that another factor is taken into consideration:

Transmissibility: This factor is determined by a composite estimate of the number of unprotected risk contacts combined with the level of HIV (or STD in the absence of HIV).

No single factor should be paramount in developing the priorities. All are important. The goal is the most cost-effective result that may prevent the most infections. Clearly some basic data collection is needed to begin development of a priority list. But in the case of ASEP, much of the necessary data are already in hand. To aid in viewing these factors simultaneously, a grid format is proposed. By assigning values for each

of these factors to each of the risk groups an objective hierarchy is developed that can be used as a guide to intervention program managers.

*DEVELOPING A PRIORITY LIST OF SEXUAL RELATIONSHIPS FOR  
RISK OF HIV/STD TRANSMISSION*

Commercial Sex Relationships

	Lower-fee CSWs	Higher fee CSWs	Customers of CSWs
<b>Message Potential</b>			
1. Ease of access to written messages			
2. Ease of access to personal education			
3. Ease of changing behavior to lower risk			
<b>Transmitter Potential</b>			
1. Seroprevalence of HIV (or syphilis)			
2. Potential to spread HIV to many others			
3. Size of population			
<b>Total Score</b>			

*Suggested scoring key:*

Message Potential: (Very difficult = 1, Difficult = 2, Moderate = 3, Easy = 4)

Transmitter Potential: (Low = 2, medium = 4, high = 6)

DEVELOPING A PRIORITY LIST OF SEXUAL RELATIONSHIPS FOR  
RISK OF HIV/STD TRANSMISSION

Casual Sex Relationships

	Men who have sex with men	IDUs	Street Adolescents
<b>Message Potential</b>			
1. Ease of access to written messages			
2. Ease of access to personal education			
3. Ease of changing behavior to lower risk			
<b>Transmitter Potential</b>			
1. Seroprevalence of HIV (or syphilis)			
2. Potential to spread HIV to many others			
3. Size of population			
<b>Total Score</b>			

*Suggested scoring key:*

Message Potential: (Very difficult = 1, Difficult = 2, Moderate = 3, Easy = 4)

Transmitter Potential: (Low = 2, medium = 4, high = 6)

In the case of ASEP, all of the populations listed in the above tables are targeted for interventions. The prioritization process should not be used to eliminate any of these groups from outreach programs. Instead, the scoring can be used to assist program managers in the following ways:

- As a criteria in soliciting and screening proposals for more outreach activities;
- As a means for deciding which groups to begin working with first;
- As a means for allocating unprogrammed resources;
- As a means for discussing strategy modifications with implementing agencies.

The scoring weights (e.g., 2 for 'difficult', 4 for 'medium') are not arbitrary. They give somewhat higher priority to transmitter potential dimensions than message potential. This partly reflects the fact that more is known about the potential of individuals to spread HIV to others than is known about the relationship between education and sustained behavior change. Thus, the total score will be influenced slightly more by the transmission potential variables than the message potential variables. Deciding on the scores for the individual cells (i.e., ease of changing behavior among customers of CSWs) needs to be discussed among a small group of well-informed individuals who have worked with the population in question. If there is wide variation within a group (e.g., sauna workers, street walkers and beer house girls) then these sub-groups can be scored separately. However, too much subdividing of target populations may be unrealistic given the lack of clear distinctions between some groups and constantly changing formats of risk behavior.

It is important to emphasize that all the listed population sub-groups are vulnerable and are worthy of the ASEP outreach services. It is the timing and relative amount of resources that is uneven and can be adjusted by program managers to achieve optimal coverage. The above tool is an aid to managers to help them make more objective judgments in the difficult, but necessary, prioritization process in AIDS prevention education outreach.

## ANNEX EIGHT: RANGE OF SEXUAL BEHAVIOR CHANGE OPTIONS IN THE AIDS ERA

The "Just Say No" campaign used by the U.S. in the 1980s to combat drug abuse has been applied by some to HIV prevention. The implication of this message is two-fold: that there is only one behavioral option to avoid risk (i.e., abstinence) and that only will-power is needed to choose abstinence. In fact, many individuals would like to reduce their risk of drug addiction or HIV infection but are not able to do so for a variety of reasons that have little to do with will-power. Prevention programs that have worked with the most marginalized populations have learned that it is critically important to offer these individuals viable options for behavior change. For example, family planning programs do not offer a single contraceptive choice to couples; a cafeteria approach has been proved to increase contraceptive prevalence -- prevalence increases as the range of choices expands. In the same way, HIV prevention programs can expect to increase the prevalence of lower risk practices as more behavioral options are offered.

However, simply knowing about the options is clearly not enough. Programs must make sure that high risk individuals have access to prevention services and the skills to use them. The attached chart presents a form of hierarchy of prevention choices. Individuals may choose a combination of options or switch back and forth among options as the situation demands. Generally, in the case of HIV prevention, the more options used results in a reduction of risk. But there are exceptions of course. For example, merely reducing one's overall number of sex partners while retaining the most risky partners will do little to protect against HIV/STD. Substituting casual sex without condoms for commercial sex with condoms may actually increase one's risk.

The following list of behavioral options are organized into five categories:

1. Reduce sex with risky partners
2. Use condoms for disease prevention
3. Use spermicides for disease prevention
4. Have STD check-ups and treatment
5. Seek HIV counseling and testing

Although the relative safety of these behaviors varies with the level of HIV in a community, greater reduction in risk can generally be achieved by reducing one's sex partners (assuming all partners are equally risky themselves). If reducing sex partners is not a viable option, then using condoms is a viable alternative to reduce risk. Several scientific studies have confirmed the effectiveness of condoms in preventing HIV transmission. A situation might arise when condoms are not available and there is no alternative to having sex with someone who might be infected with an STD. Then,

commercially available spermicides may offer some protection against STDs and HIV. (Note: frequent applications of spermicides -- several times in one night for example -- have been found to cause vaginal irritation which could increase risk. Used infrequently however no such side effects have been observed and reduction of risk for STD and HIV has been scientifically documented in field trials.) If neither condoms or spermicides are available, and sex with a risky partner is unavoidable, then the next best course of action is to have an STD check-up with a qualified medical practitioner as soon as possible. While treating an STD won't necessarily protect against HIV, the risk of contracting HIV is much higher when a person has an active venereal infection. Finally, the most vulnerable, those who cannot reduce the number of risky partners and cannot increase the use of condoms, should seek HIV counseling and testing. Although the HIV test does not confer protection against future infection, some studies have shown that counseling plus HIV test results may motivate a person to adopt safer sex practices.

The lesson for prevention programs is that educational outreach, hotlines and mass communication must always try to communicate the message that there is a choice of multiple options -- and that people are available to help explain the choices and how to use any or all of them.

\*\*\*\*\*

Notes on terms used in the attached chart:

"Concurrent" sexual partners refers to having sexual relationships with more than one person during a certain time period. For example, a married man may have sex with his wife and also seek commercial sex on some occasions. "Serial" sexual relationships refer to individuals who are faithful to one partner during the relationship but terminate the relationship and then initiate a new, monogamous sexual relationship.

CSW refers to female and male commercial sex workers.

Condoms refer to both male and female, latex and plastic versions as prescribed for disease prevention.

Spermicides (containing, for example, memfegol, nonoxynol 9) refer to vaginal films, gels, foams or tablets which are inserted in the vagina shortly before sex.

PHC is an abbreviation for primary health care provider.

NGO: Non-governmental organization.

Self-test refers to products that may come on to the commercial market as (saliva or blood) collection devices and rapid tests which, when linked with testing centers could

provide test results directly to the consumer.

## Cafeteria of Options: Reducing Risk of HIV

### Reduce Sex With Risky Partners

↓

- Reduce the number of partners
  - abstinence

↓

- fewer concurrent partners
- fewer serial partners

↓

- Reduce the type of partners

↓

- less CSW partners
- less partners who have multiple partners

↓

- Reduce the number of episodes

↓

- delay first sex

↓

- substitute non-penetrative and oral sex for vaginal/anal sex

↓

### Use Condoms

↓

- Use for commercial sex
- Use for casual sex
- Use for pre-marital and extra-marital sex
- Use for marital sex

↓

↓

### Use Spermicides

↓

- Use for casual sex
- Use for premarital and extra-marital sex
- Use for marital sex

↓

↓

### Have an STD Check-up

↓

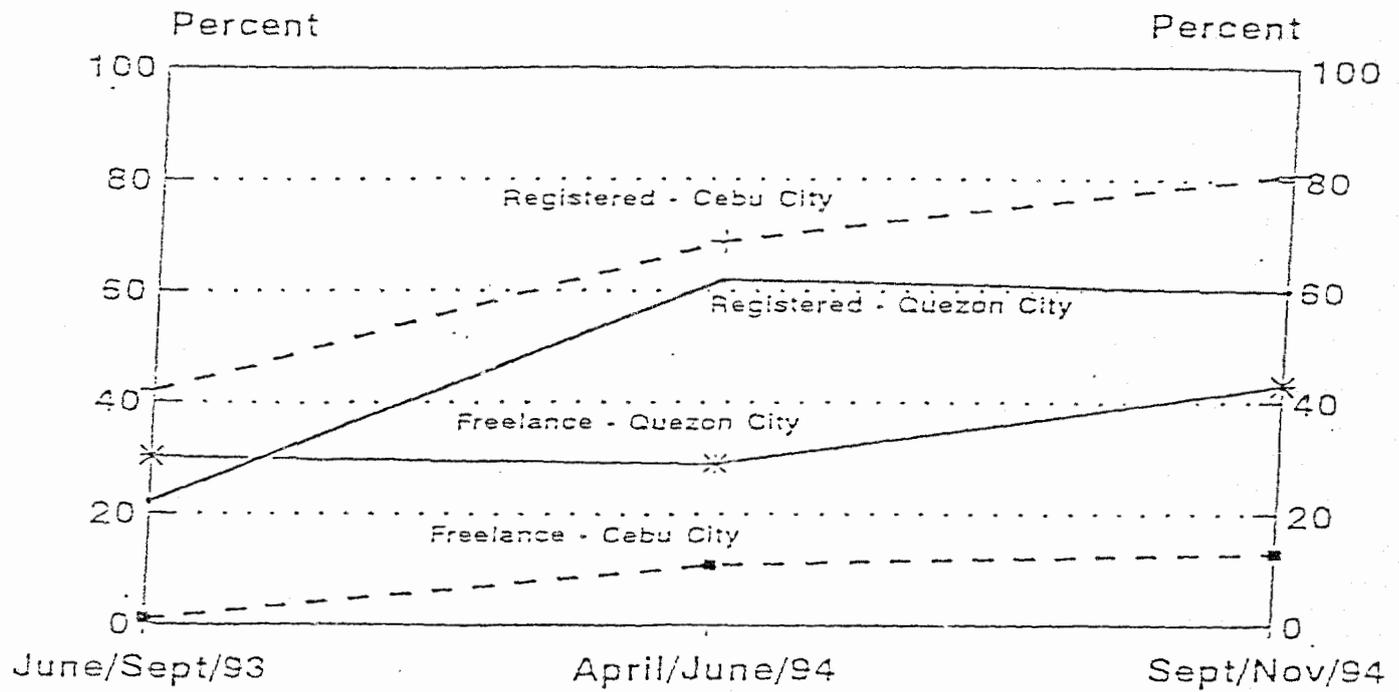
- Government clinic or hospital
- Private practitioner, clinic or hospital
- Gatekeeper (PHC provider or pharmacist)

↓

### Seek HIV Counseling/Testing

- Anonymous clinic
- NGO clinic/center
- Private, commercial
- Government clinic, hospital
- Self-test (pharmacy)

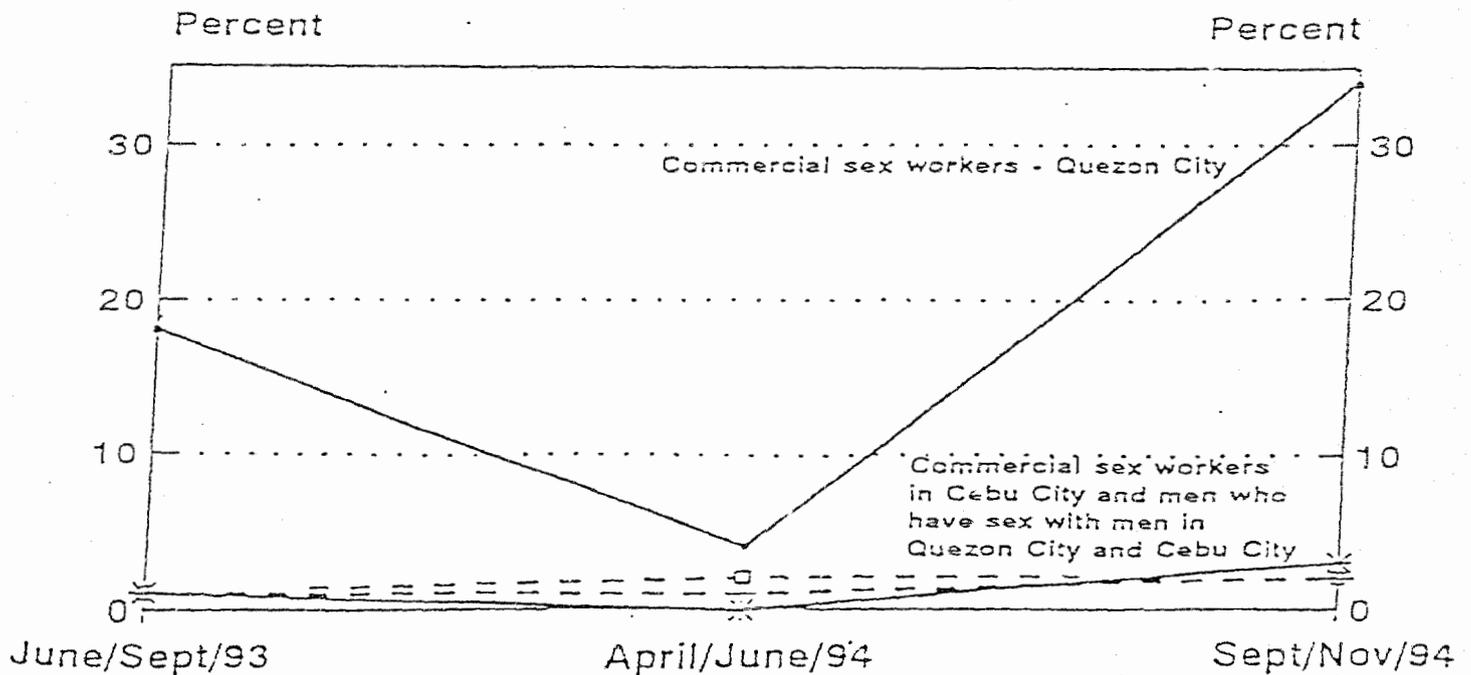
Figure 1  
 Female Commercial Sex Workers Who Report  
 "Always" Using Condoms



PSS1/95

USAID

Figure 2  
 Males With Multiple Sex Partners  
 Who Report "Always" Using Condoms



PSS2/95

USAID