

# STD Management for HIV and AIDS Prevention



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



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

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August 2003



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# table of contents

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<b>Acknowledgements</b>	iii
<b>List of Acronyms</b>	v
<b>Introduction</b>	1
<b>ASEP Education Component</b>	4
STDs in the Philippines	5
ASEP's STD Component	6
STD Syndromic Case Management Training	9
Triple S: Social Marketing of STD Treatment	12
Key Findings	24
Constraints	27
<b>Bibliography</b>	31



# acknowledgements

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This report synthesizes the experiences of the sexually transmitted disease (STD) prevention education and case management efforts of the AIDS Surveillance and Education Project (ASEP) in the Philippines. It draws on numerous project reports and documents written by key ASEP personnel, namely: Carmina Aquino, the ASEP Program Manager, Leona D'Agnes, the Technical Director, Joan Regina Castro, the STD Medical Specialist, and Ma. Elena Borromeo, the information, education, and communication (IEC) Specialist. External authors that assisted with the synthesis and preparation of this report include Program for Appropriate Technology in Health (PATH) Consultant Karen Schmidt and PATH Program Officer Kirrin Gill.

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

Eight city health offices and ten private organizations collaborated with PATH on STD capacity building and social marketing efforts in ASEP sites. The private-sector collaborators comprised six pharmaceutical

associations and four local NGOs. The partners and collaborators are listed below by sector.

#### Public Sector Partners

- Angeles City Health Office, Luzon
- Cebu City Health Office, Luzon
- Davao City Health Office, Mindanao
- General Santos City Health Office, Mindanao
- Iloilo City Health Office, Central Visayas
- Pasay City Health Office, National Capital Region
- Quezon City Health Office, National Capital Region
- Zamboanga City Health Office, Mindanao

#### Private Sector Partners

- Bidlisiw Health Resource Center, Cebu City
- Cebu City Pharmaceutical Association
- DKT Philippines Inc., Angeles City
- General Santos City Pharmaceutical Association
- Iloilo Pharmaceutical Association, Iloilo City
- Kabalaka Reproductive Health Center, Central Philippines University, Iloilo City
- Mindanao Federation Pharmacists Association, Davao City
- Pampanga Pharmaceutical Association, Angeles City
- ReachOut Reproductive Health Clinics, Pasay City and Angeles City
- Zamboanga Pharmaceutical Association



# list of acronyms

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AIDS	Acquired Immune Deficiency Syndrome
ASEP	AIDS Surveillance and Education Project
BCC	Behavior Change Communication
BFAD	Bureau of Food and Drugs
BCPC	Barangay Councils for the Protection of Children
BLAaCP	Barangay Legal Action Against Child Prostitution
CHO	City Health Offices
CHOW	Community Health Outreach Worker
COPE	Community Outreach and Peer Education
DOH	Department of Health
RFSW	Registered Female Sex Worker
FFSW	Freelance Female Sex Worker
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information, Education, and Communication
LGU	Local Government Unit
MSM	Men who have Sex with Men
NGO	Nongovernmental Organization
PATH	Program for Appropriate Technology in Health
PoCoMon	Policy Compliance Monitoring
SHC	Social Hygiene Clinic
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

USAID	United States Agency for International
Development	
USPF	University of Southern Philippines Foundation
WHO	World Health Organization

# introduction

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In 1992, the United States Agency for International Development (USAID) authorized the AIDS Surveillance and Education Project (ASEP), designed to prevent the rapid increase of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) in the Philippines by reducing HIV and STD risk behaviors and by promoting collaboration between nongovernmental organizations (NGOs) and city health departments. ASEP was faced with one primary challenge: mobilizing Filipinos, from the highest levels of politics to the most vulnerable people, to recognize that despite apparently low levels of HIV, Philippines was, and remains, at risk of a rapid spread of HIV. As a low-prevalence country, the Philippines' challenge is to keep risk perception elevated despite low prevalence.

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



education activities were underway in eight of those sites. Both components focused on those most at risk of contracting and transmitting HIV, especially sex workers, their customers, men who have sex with men (MSM), and injecting drug users (IDUs).

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

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

sex and 27 percent of males in the same age group reporting casual sex in the previous year. [28]

- Though awareness of HIV/AIDS was high (85 percent had heard of AIDS in a 1993 survey), misperceptions were common. Many people believed HIV could be transmitted through casual contact, and even health workers were ill informed.

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

The evaluation cited three major accomplishments:

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

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



# ASEP education component

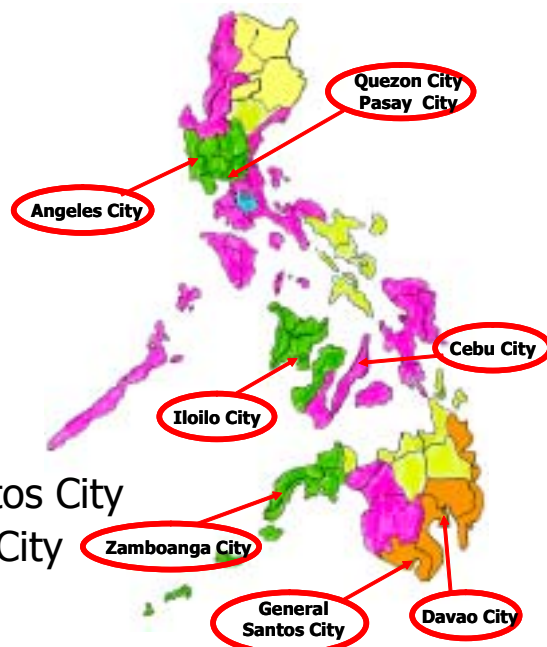
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The education component focused on three main areas: Community Outreach and Peer Education (COPE), STD case management, and policy and advocacy. This document describes the activities of the STD management component and is part of a series designed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

- Best Practices in HIV and AIDS Prevention
- Community Outreach and Peer Education for HIV and AIDS Prevention
- Policy and Advocacy efforts for HIV and AIDS Prevention

## Philippines

- 🚫 Angeles City
- 🚫 Quezon City
- 🚫 Pasay City
- 🚫 Cebu City
- 🚫 Iloilo City
- 🚫 Davao City
- 🚫 General Santos City
- 🚫 Zamboanga City



## STDs in the Philippines

Limited surveillance data available in the early 1990s from government Social Hygiene Clinics (SHCs)<sup>1</sup> suggested high rates of STDs in women employed in “entertainment” establishments registered with the local government. The data shows the total number of reported STD cases in the country rose from about 47,000 in 1989 to 72,000 in 1991, [2] a change attributed to better detection and reporting following a training program for SHC workers. A few other data sources on STDs were available:

- A 1990 study of 1,357 registered sex workers in Manila SHCs showed relatively high levels of inflammatory STDs with 14.5 percent testing positive for gonorrhea, 13 percent for chlamydia infection, 5 percent for candidiasis, and 3.8 percent for trichomoniasis.
- A cross-sectional study of 203 antenatal women at the Philippines General Hospital in 1994 showed 1.2 percent positive for gonorrhea, 5.6 percent for chlamydia infection and 1 percent for syphilis. [2]

In 1993, government STD services were provided by SHCs, of which there were about 150 nationwide based primarily in urban centers. Of the female sex workers diagnosed with STDs at government SHCs, an estimated 5 percent received treatment at the SHC, while the remainder sought care at private clinics or went untreated. [2] Self treatment was common, and patients

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<sup>1</sup> Social Hygiene Clinics, operated by local government health departments, perform STD screening for registered female sex workers. Although sex work is illegal in the Philippines, it is not common for women (and men) employed in entertainment establishments such as night clubs, saunas, or videoke/karaoke bars to offer sexual services to customers during or after work hours. These women are commonly known by such terms as “hospitality workers” or “guest relations officers.” ASEP refers to them as registered female sex workers (RFSWs). Freelance female sex workers (FFSWs) work on the street or in unregistered establishments.

reportedly often took inappropriate drugs based on advice from friends or even uninformed health providers or took antibiotics for a couple of days until symptoms disappeared. In a 1993 study, 89 percent of female sex workers reported taking antibiotics to protect themselves from STDs and HIV. [2] This practice is not only ineffective, it can lead to increased antimicrobial resistance. [18] With the growing body of evidence showing sexually transmitted infection (STI) as a co-factor for HIV/AIDS transmission, in 1996 USAID added improved STD management to ASEP's prevention strategies.

### **ASEP's STD Component**

Risky sexual behavior had been found among all sentinel groups in all ASEP cities. In 1994, ASEP's surveillance component included testing blood samples for syphilis as well as HIV, revealing high syphilis rates and validating that risky sexual behavior was common. For example, in 1994 freelance sex workers had syphilis rates ranging from 4 percent in Quezon and Pasay, to 12 percent in Davao and 16 percent in Angeles. Among MSMs, the figures ranged from 5 percent in Cebu and Davao, to 11 percent in Quezon and Angeles. [32] This suggested a serious potential for widespread HIV transmission. And although the promotion of safer sexual practices was the centerpiece of the ASEP education program, WHO also recommends reduction in the incidence and duration of curable STDs as an important strategy in preventing HIV transmission. This is based on evidence that people with STDs are more susceptible to HIV infection if exposed, [7] and that those with HIV and concurrent STD infections may be more infectious. [8]



Three key problems were identified as contributing to high STD rates in the Philippines: lack of awareness of the protective effects of condoms against STDs and HIV, lack of appropriate STD care-seeking behavior, and lack of access to affordable STD services. [7] USAID provided incremental funding in January 1996 for PATH to integrate STD interventions into the ASEP education component. The objectives of the sub-project were to institutionalize private- and public-sector mechanisms to:

- Reduce the prevalence and duration of STDs and, in turn, the spread of HIV among primary risk groups;
- Encourage behaviors which reduce individual risk for contracting and transmitting STDs; and
- Promote social norms that reduce individual and collective vulnerability to STDs/HIV. [15]

PATH recommended a focus on STD syndromic management as early as the first ASEP annual report [30]. The ASEP mid-term evaluation in 1995 strongly recommended that USAID/Manila consider providing assistance for STD treatment and management in the public and private sector. By mid-1996 several STD sub-projects were in process under the ASEP Education component, including syndromic case management training, public service advertising about STD signs and symptoms, outreach education and referrals, and the development of alternative service points for people unwilling or unable to obtain care from the SHCs. [32] The first initiative was to train public and private health providers in syndromic case management for STDs because prior to ASEP few providers in the Philippines had been trained in improved approaches to STD management. During this training, it became clear that lack of

appropriate drugs was a major constraint to effective STD treatment. The drug supply in the SHCs was uncertain, and in any case men, freelance sex workers, and underage sex workers were either precluded or felt unwelcome because of the insensitive and discriminatory attitude of some SHC workers. Clients with symptoms often went straight to pharmacies, and, to save money, many bought only one or two doses of antibiotics at a time and only continued taking them until their symptoms disappeared. [17]

As commodities were not covered under the technical assistance package of ASEP, PATH obtained a grant from the Dutch Government to procure STD drugs and condoms and pilot test Triple S<sup>2</sup>, a compliance pack that contains a full course of DOH-recommended antibiotics for common male and female STD syndromes, as well as condoms, IEC, and partner notification cards. Local and regional professional associations, such as the Mindanao Federation Pharmacists Association, were mobilized to provide logistical and training support for Triple S social marketing activities. With support from ASEP and technical backstopping from the city health offices (CHOs), drugstore personnel were trained to promote and use Triple S to manage urethral discharge cases in pharmacy settings. ASEP also supported several NGOs in establishing STD outreach posts or expanding their clinic services. Some NGO service points also served as Triple S outlets.

These activities, in addition to mass media public service advertising and COPE activities that were ongoing in ASEP sites, evolved into a

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<sup>2</sup> "Solusyon sa Sikretong Sakit" or Solution to a Secret Sickness (SSS or Triple S)

comprehensive intervention program that addressed multiple issues to improve STD management and treatment-seeking behavior in target sites, with a unique partnership between the private drugstore sector, the local government health system, the local NGO sector, and local professional associations.

#### **ASEP achievements in STD prevention and control**

- A total of 2,105 public and private service providers trained in improved STD management including 905 government workers and 1,200 pharmacy workers.
- Trained health workers had increased knowledge and confidence to identify, manage, and refer STD cases at the time of first encounter. The proportion of caregivers providing STD care rose from 44 to 69 percent one year after the training; proportion of caregivers who used STD syndromic management in the previous six months increased from 0 to 62 percent in the same period.
- Total sales of about 8,300 Triple S treatment packs.
- Pharmacy outlets for Triple S: 133.
- Customers screened in drugstores and NGO clinics: 10,051. [41]
- COPE clients referred for STD or HIV testing and treatment: 33,177.

### **STD Syndromic Case Management Training**

One of the first steps in the STD project was to train providers in Syndromic Case Management for STDs, a proven methodology that relies on clinical signs and symptoms, rather than laboratory results, to treat symptomatic STDs. In addition to government health workers from SHCs

and Barangay<sup>3</sup> Health Stations, the program trained staff of ASEP partner NGOs, staff from pharmacies in red-light districts, and private physicians in the same areas. [16] Initial surveys showed that many health care providers had limited experience in managing STDs, and that pharmacy personnel were the main source of information about STD treatment for people at high risk for HIV. [19] By training these health workers, especially the non-physicians, ASEP provided many new points of service for STD care.

PATH adapted and modified WHO guidelines, flowcharts, and a risk assessment tool to match the service delivery needs and educational levels of primary health care workers in urban Philippines. Eventually, four separate training curricula were developed, each for a different audience and modified to match the learners' skills and education level. The materials were pre-tested with the four target audiences: health professionals, NGO staff, pharmacists, and pharmacy clerks. As a follow-up, trained personnel were offered regular updates, which allowed the providers to discuss and resolve issues that emerged in the field and provided an opportunity for continuing education on STD management. [19]

Training content included: information on various STDs, including HIV; common syndromes including genital discharge, genital ulcer disease, lower abdominal pain, and scrotal swelling; and the management of STDs, including history taking, referrals, basic health messages, and the four C's of STD syndromic case management: counseling, compliance, condom promotion, and contact tracing (partner notification). [21] In 1997, the

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<sup>3</sup> The barangay is the smallest municipal unit in the Philippines.

Professional Regulatory Commission of the Philippines accredited PATH as a provider of continuing medical education; participants in the training and updates received continuing education credits, which proved to be a strong draw, especially for pharmacists. [33]

In addition to providing new service points for STD care, as a result of this training and policy and advocacy efforts under ASEP, SHCs in some sites started to become mechanisms for education, counseling, and outreach, not just implementation of requirements under the Sanitation Code. The SHC clinic in Angeles was renamed the Reproductive Health and Wellness Center, reflecting the CHOs interest in providing more comprehensive and prevention oriented services. [29] In Davao, special clinic days were set aside for freelance sex workers working in the pier areas, and the Cebu City SHC brought services to freelance sex workers in Kamagayan, the city's red-light district. [7]



**Bidlisiw Health Resource Center  
and the Cebu Social Hygiene Clinic:  
Partners for Better STD Outreach Care**

Cebu's SHC physician, Dr. Ilya Abellanosa Tac-an, was a strong ASEP supporter from the start, when she helped carry out surveillance activities. But in 1995, Dr. Ilya took the initiative to expand the SHC activities into outreach for freelance sex workers with a weekly clinic in Kamagayan, the city's red-light district. At first, Dr. Ilya went house to house introducing the service and screened as few as 20 clients per month. Referrals from NGO outreach workers contributed to increased demand for services. Now, over 240 clients per month come to the outreach clinic, and a second site in Barangay Kalubiran has been added. At the same time, another ASEP partner, Bidlisiw Foundation, provided STD services to gay men and prostituted youth at its Health Resource Center (established with ASEP support). The two service points worked together whenever possible. For example, the SHC provided free STD drugs to freelance sex workers when possible, but when supplies ran short they would refer the clients to the Health Resource Center, which sold Triple S for 37 percent of the price retailed in pharmacies. Dr. Ilya acknowledged the value of working with NGO partners. "We accept our limitations, that we really can't do it on our own," she said. "We need help from other agencies, especially in reaching the hard-to-reach."

### **Triple S: Social Marketing of STD Treatment**

Once PATH realized that the cost and shortage of drugs was a major constraint to proper STD treatment, it attacked that issue with social marketing, a strategy that has been applied to condoms and family planning, but has been less commonly used for STD treatment. Social marketing promotes subsidized products designed to improve health using commercial marketing methods, in particular the five Ps: product,

promotion, place, price, and position. The Triple S strategy added the four Cs of STD syndromic case management: counseling, compliance, condom promotion, and contact tracing. Triple S packs were sold at pharmacies and NGO clinics where ASEP had already trained personnel in syndromic management of STDs. Whereas pharmacy outlets targeted “walk-in” clients and referrals from collaborating physicians and health centers, NGO clinics targeted STD symptomatics that could not afford the cost of Triple S in drugstore outlets.

The two Triple S compliance packs – green for men and blue for women – contained a full seven-day treatment course using Doxycycline and Cefixime for management of urethral discharge in men, and Doxycycline, Cefixime, and Metronidazole for vaginal discharge in women. (A red kit for genital ulcers was also developed, [17] but was only made available to selected NGO clinics and SHCs as it contained an injectable medication for syphilis treatment that had to be administered by a qualified medical practitioner.) The Triple S package also included information about STDs, seven condoms, and two partner notification cards with a consultation voucher. To develop the packaging, content, name, and pricing, PATH used focus groups and in-depth discussions with members of high-risk groups, including female sex workers, male customers of sex workers, MSM, and with pharmacy personnel.

To enhance providers’ counseling and social marketing skills, ASEP supported a number of job aids that were developed with and for drugstore clerks and partner pharmacists. One example is a laminated card showing the price advantage of the Triple S kit compared to the “shelf” price of each item in the kit, if sold separately. A 1999 evaluation documented the

effectiveness of the job aid, which proved to be an important selling point for pharmacy staff promoting Triple S to their customers

### *Securing funds and commodities*

A major barrier to effective STD treatment in the Philippines is the high cost of drugs. The retail price of antibiotics in the Philippines is one of the highest in the region and in the developing world. For someone in the lowest economic groups a seven-day treatment using branded antibiotics could represent 5 to 10 percent of monthly income. [17]

It was anticipated that national and local government units (LGUs) would provide counterpart contributions for STD drugs in ASEP sites. However, shortage of STD commodities was a chronic problem for several CHOs. To meet the increasing demand for STD treatment, generated in part by ASEP's trainings for government and private caregivers, PATH worked together with USAID and the DOH to mobilize resources from other donors to support STD efforts. In 1997 PATH submitted a proposal to the Embassy of the Netherlands Government requesting funds for STD social marketing activities, including assembly of 4,000 Triple S kits for distribution in ASEP sites. [33] USAID endorsed PATH's proposal and the grant was awarded later that same year.

In 1999, the DOH requested commodities from JICA for SafePack, a similar treatment kit designed by PATH and distributed free or at nominal cost to ASEP client groups at SHCs, barangay health stations, and other government service points. However, due to supply limitations, SafePacks were only distributed in three sites: Angeles, Cebu, and Zamboanga. [34, 36] These cities were prioritized because of their high rates of syphilis



seroprevalence. SafePack included a kit for syphilis treatment and management of genital ulcers. Some SafePacks were also used in a DOH study that reconfirmed the appropriateness of STD syndromic management in Philippines settings.

### *Three models: Angeles, Cebu, General Santos*

Following pre-pilot activities in 1997, the Triple S pilot was launched in 1998 in three cities, using three operational models. In Cebu, the selected outlet was the reproductive health clinic operated by Bidlisiw Foundation, an ASEP NGO partner. In General Santos, ten pharmacies whose staff had already been trained in STD syndromic management were selected as outlets, with management from the local pharmaceutical association. The pharmaceutical association hired a coordinator, selected pharmacies in designated red light districts, and distributed kits, collecting a 2 percent charge to cover its costs. The third model, launched in Angeles, tested a combined model of community pharmacy outlets and an NGO clinic. [16, 18] In all of the models, the city's SHC physician acted as a technical resource to pharmacies and NGOs. [19]

No one model proved most effective in all places, although a 1999 evaluation suggested that the community pharmacy model is most sustainable, particularly for symptomatic males who comprised the bulk of Triple S consumers. Each site's model developed according to the local situation. For example, in General Santos, which has a strong pharmaceutical organization and pharmacists committed to the program, the pharmacy model was quite effective. In Angeles in 2001, funding (non-ASEP) for the local NGO clinic was discontinued, and Angeles continued with the pharmacy-only model. In Cebu, Bidlisiw had the

interest and capacity to lead the program so pharmacy outlets were added, resulting in a successful integrated approach. [16] At first, the only Triple S clients that came to the Bidlisiw clinic were those referred by ASEP Community Health Outreach Workers (CHOWs). Later, people sought treatment on their own and brought in their friends as well.

Of the three models, working with pharmaceutical associations and the community pharmacies was unique. Initially, pharmaceutical associations and their member pharmacies were approached principally to create a private business outlet for the Triple S kits and to open a private-sector channel for information about STDs. But, whether intentionally the Triple S project tapped the strong sense of community involvement to deal with social problems so characteristic of the Philippines. With Triple S, the pharmaceutical associations acquired new capacities as implementers of public health and strengthened linkages between the associations, the local government offices, and the NGOs. Concurrently, the role of pharmacies as health delivery sites was strengthened.

### *Scaling Up Triple S Distribution*

Based on the results of the Triple S pilot, PATH planned to replicate the integrated approach in other ASEP sites. Two different strategies were applied to mobilize the commodity requirements for the expansion plan. While some project staff wrote proposals to donor organizations, others stepped up efforts to negotiate aggressively with local pharmaceutical companies for deeper discounts on STD antibiotics. With the help of a prominent member of its Board of Directors in the Philippines, PATH succeeded in negotiating a significant discount from one local

manufacturer of STD drugs. This enabled PATH to reduce its subsidy and expand distribution of Triple S packs to other pharmacy and NGO outlets in ASEP sites.

In 1999 a small grant from PATH and the Brush Foundation enabled Triple S to be scaled up to other drugstore outlets in ASEP sites, albeit in far fewer outlets than the numbers originally envisioned. [36]. By year-end, Triple S was ongoing in all eight ASEP sites. The network comprised 143 implementing partners including four NGO clinics, six local pharmaceutical associations, and 133 community pharmacies. [38] Monitoring activities implemented by the CHO and PATH staff included periodic site visits to drugstores, records reviews, group discussions with participating pharmacists, and mystery shopper surveys implemented by independent research assistants. [34] Partners shared experiences across sites and monitoring results were made available at special meetings and workshops organized by PATH to cross-fertilize learning.

### *Raising Awareness and Creating Demand*

Activities such as training of health care workers and pharmacists in STD syndromic management and providing affordable treatment in the form of Triple S packs addressed the *supply* side of STD management by improving treatment access. ASEP also worked to address the *demand* side through a variety of methods. COPE program helped create demand through risk assessment, information and education, counseling, and referrals for STD treatment. COPE's clients were those most at risk of STD and HIV infection, including registered and freelance sex workers, customers of sex workers, MSM, IDUs and sexual network members of the above groups.

ASEP also developed a series of mass media campaigns designed to raise awareness of STDs and encourage those with symptoms to seek treatment. The Triple S program carried out a number of promotional activities, ranging from point-of-service leaflets, posters, and banners to job aids and flowcharts for the pharmacy staff. ASEP tracked awareness of Triple S through the Behavioral Monitoring Surveys carried out by partner NGOs. Respondents were asked, “There is a new product called Triple S. In your opinion, what is it?” In 1998, the year the product was launched, fewer than 2 percent of respondents answered that Triple S was an STD treatment. A year later, when the same question was asked, awareness had clearly increased to as high as 22 percent among men in the pilot cities and more than 30 percent of female sex workers in Cebu and 42 percent of MSM in Zamboanga correctly identified the product. [35]



### Triple S Coordinator in General Santos City

In a given week in General Santos City, Triple S Coordinator Mely Plete might give a talk on STDs at the local land transportation office, the Rotary Club, a department store, and a school. That's in addition to her job as a community pharmacist and her responsibilities visiting and monitoring participating Triple S pharmacies. It's partly due to her tireless efforts that General Santos City had some of the highest sales figures for Triple S. "What keeps me involved is, I can see from the faces of my audiences that they want to learn, and they ask questions," she said.

Mely started with the project in 1998 when she was asked to participate in ASEP's three-day training in syndromic case management for STDs. The local pharmaceutical association then hired her to work as the project coordinator.

First, she asked ten drugstore owners (previously trained in STD by PATH) to get involved by stocking Triple S. They agreed, but sales were weak. So Mely decided to work on the demand side and began approaching workplaces to reach men at risk, including police and military, drivers, and security guards. She found out when professional and civic organizations met and offered to give talks on STDs and HIV. "If they meet once a month," Mely said, "there I am."

The pharmaceutical association realized that for every company or group or society that received the information, the nearest drugstore would get higher Triple S sales in the days that followed. And Mely has kept up the effort, expanding to other groups, clubs, and schools. Now, groups come to her and ask for her services. She says she loves the work. "You feel you are a great help to your community people, and it's very fulfilling," she said. "You have achieved something that is of great benefit to your people."

### *Social Marketing*

At the start of the pilot test in 1998, PATH was subsidizing Triple S by about 50 percent. While gradual price increases have enhanced the sustainability of Triple S over the years, they also have contributed to a decline in sales in some sites, particularly among client groups with low purchasing power. Through aggressive negotiations with local pharmaceutical companies for discount commodities plus additional services, PATH was able to lower the cost of Triple S components and reduce its subsidy to about 5 percent by 2001.

In 2002 the pharmacy price for the green men's pack reached 400 pesos (\$8.00) while the blue women's pack retailed for 425 pesos (\$8.50). Cost recovery at that level was 98 percent for the green pack and 95 percent for the blue pack. Referral of sexual partners was encouraged by offering 50 percent discount to individuals bringing the partner notification card to pharmacy outlets. [16] The NGO clinics, however, were charging about half as much as pharmacy outlets for Triple S. However, data showed that majority of the clients purchasing treatment kits at reduced price from NGO clinics were registered sex workers referred from SHCs lacking adequate supplies. Since the city health offices were responsible for treating those clients (rather than PATH subsidizing the treatments) and because registered sex workers were employed (and had some disposable income), the NGO clinics were reluctantly phased out of the Triple S network. Instead, SHCs and NGOs were encouraged to refer registered sex workers and other clientele to nearby pharmacy outlets for treatment packs. [37]

By mid-2003, 8,280 Triple S packs had been sold in the eight sites (Table 1). Sales revenues had totaled about \$21,000, and proceeds had been

used to procure additional stocks and subsidize treatment for low-income groups.

### *Sustainability of Triple S*

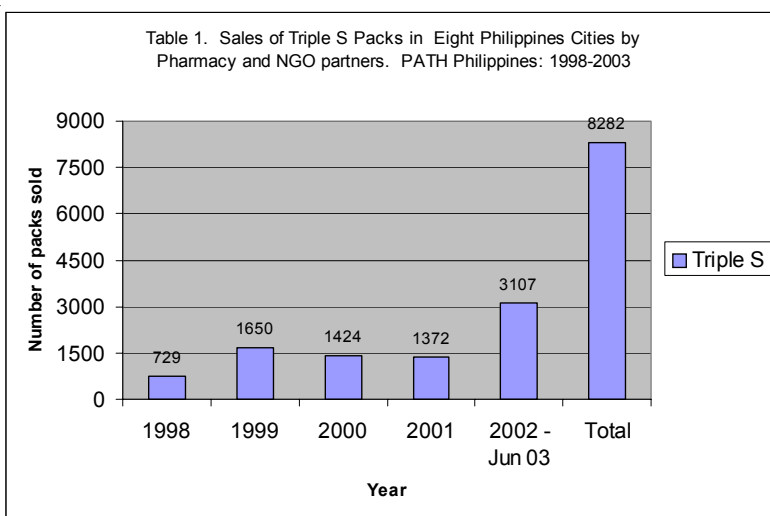
At the time this report was written, PATH was in discussions with the national social marketing group, DKT Philippines Inc., which has expressed interest in taking over Triple S distribution after the closure of ASEP. DKT remains

optimistic about the social marketing potential of Triple S, particularly the men's green pack which has consistently outsold the women's blue pack in pharmacy outlets. Both the 1997 and 2002 evaluations of Triple S also recommended that future

directions focus on expanding availability of the green pack in drugstore outlets, as the data show men prefer to seek STD care from drugstores whereas women turn to clinics for services when experiencing STD signs and symptoms.

### *Transfer of Skills*

Starting in 2003, PATH and partner NGOs continued ASEP's effort to build capacity in LGUs by transferring behavior change communication (BCC) know-how to SHC staff in ASEP sites. Although BCC has been largely the domain of the partner NGOs implementing the COPE



program, with the end of ASEP, PATH hoped this training would raise SHC staff's understanding and appreciation of the importance of BCC and improve their ability to advocate for behavior change among sex workers and other members of high-risk groups. In addition, since LGUs have shown themselves more willing to fund activities carried out by government staff, it is hoped that this effort will increase the level of education activities carried out by LGUs after the project ends.

SHC staff received skills training in interpersonal communications and counseling aimed to increase the SHC's expertise in dealing with registered sex workers, who are captive audiences for prevention education in the SHCs. Other inputs such as exposure visits to NGO outreach posts and immersions in COPE projects also provided SHC staff with first-hand insights into risk reduction counseling and outreach education methods. Some SHC personnel acknowledged that they had under rated the NGOs' work and now have a better appreciation of the complexities and hardships involved in COPE service delivery. Others have come to realize that outreach work is extremely labor intensive and incompatible with other SHC responsibilities. The experience in ASEP and in other countries suggests that indigenous leaders and peers of at-risk groups make the best change agents. [38] Rather than taking over the outreach work of NGOs, PATH is hopeful that SHC staff will advocate for city governments to appropriate funds for ASEP NGO partners to continue service delivery of the project life.



## The Crying Room

The Philippines public health system includes more than 150 social hygiene clinics, mandated by the Sanitation Code. Since prostitution is illegal in the Philippines, establishment-based sex workers are known by euphemisms such as “entertainers,” “bar girls,” or “guest relations officers.” However, the law requires that these workers undergo regular STD testing as often as once a week. In most cases, cervical swabs are taken which are then gram-stained and examined under a microscope. This detects gonorrhea but does not detect many other infections such as syphilis, chlamydia, or HIV.

In Cebu, the ASEP partner NGO University of Southern Philippines Foundation (USPF) realized in 1995 that the SHC routine offered a valuable opportunity: each day, several hundred sex workers came to the city health building and had to wait for up to two hours. Odette Jereza, the USPF executive director, negotiated with the city for some space down the hall from the SHC, and opened a Crying Room and Extra Caring Hand for Education (crèche) where the women could leave their young children. This served as an incentive for women to attend SHC sessions, and USPF subsequently provided activities that the women asked for, including computer and crochet lessons, exercise, dancing, singing, and fashion.

In 1996, PATH contracted USPF to create a structured peer education program at the Crying Room. USPF trained a group of peer educators, called Social Health Educators (SHEs). Risk reduction counseling is offered in the Crying Room while women wait for their results, and the SHEs also bring their education into the establishments where the women work.

Apple, a SHE who works as a floor manager at a video karaoke bar, meets regularly with the entertainers in her establishment. “I just love to help somebody,” Apple said, “and I want to learn more.” Another SHE, Marlene, who works as a cook in a bar, talks to the entertainers from her establishment during their regular SHC time about diseases, condoms, and how to negotiate with customers. “Now if the girls have a problem, they automatically come to me,” she said proudly.

## Key Findings

ASEP's STD component demonstrates the benefits of partnership between the government, NGOs, pharmacists associations, private physicians, and community drugstores, all of which have an interest in managing STDs and have a particular value to bring to the project. Government has the SHC and other health services, the possibility of additional public health funding, and drug supplies; NGOs have community organizing experience and access to vulnerable groups; and pharmacies represent an easily accessible outlet for health delivery, one that is already commonly used by at-risk groups. PATH provided the training and overall development and management needed to forge the partnership and build the capacity of each of the partners.

While developing and refining the STD component of ASEP, PATH and ASEP partner NGOs developed key best practices and learned important lessons for future programs. A list of key lessons follows.

- **Build on existing infrastructure.** The program used existing service points, such as SHCs, NGO, clinics, and pharmacies, as a basis for improved STD treatment and care. A number of SHC clinics expanded their services to other risk groups and took a broader reproductive health focus as a result of ASEP intervention. Pharmacies and pharmaceutical associations in high-risk areas became enhanced sources of care. Partnerships were forged between the SHC, NGOs, pharmacies, and professional associations of pharmacists.
- **Try different models.** While piloting Triple S, ASEP tried three different models in the three pilot sites. When the program was

scaled up, other sites used the model that made the most sense for that setting.

- **Enlist and train pharmacy staff to offer an important additional point of service for STD care.** Since many people use pharmacies to self-treat for STDs and other health problems, training pharmacy staff can greatly improve the quality of the service high-risk individuals receive. Pharmacy staff offer a unique combination of access and salesmanship that can help provide appropriate treatment and education to many clients who are reluctant to use public-sector services or cannot afford private doctors. ASEP experience shows that peripheral health workers' skills can be adequately upgraded using simple guidelines, flow charts, and about 24 hours of classroom and practical tutoring.
- **Offer STD training as an opportunity for providers to fulfill their continuing education requirements.** The entry point for PATH with the pharmaceutical associations was providing free training on STD case management. When PATH was accredited as a provider of continuing medical education, participants had additional incentive to attend the training and updates. For trainings organized by the pharmaceutical associations, PATH allowed the associations to charge participant modest fees.
- **Adapt training materials to each group of trainees and provide regular update meetings and sessions to make health service providers continually aware of STDs.** ASEP's syndromic case management training was offered to a variety of professionals, ranging from physicians and nurses to pharmacy clerks. Materials were therefore adapted to fit the education and skills levels of the various participants. ASEP's experience showed that it was not enough to train pharmacists, who rarely serve customers directly.

It was absolutely necessary to also train clerks in Philippines' drugstore outlets as they are the ones directly interacting with consumers. Regular meetings with previously trained Triple S partner implementers, both public and private health service providers, is necessary to keep their knowledge and skills updated, to provide an opportunity to discuss issues in STD case management, and to raise consciousness about the seriousness of managing STDs.

- **Use multiple outlets and pricing schemes.** Triple S packs were available in pharmacies, NGO clinics, and public-sector clinics, with different levels of subsidies and packing in each case. For the most part, this helped to ensure that those who could pay a higher price did not receive unnecessary subsidies and that those who could not afford the full cost of drugs still had access to treatment.
- **Bargain aggressively with suppliers to keep costs low.** For Triple S, PATH negotiated with drug companies for lower prices for STD drugs, with the drug companies planned and projected procurement needs for three-five years. Both parties signed memoranda of understanding specifying support to the social marketing of Triple S and providing additional marketing support in the form of IEC materials, accessing and supporting STD syndromic management trainings for private physicians, storage of drugs and change of near expiry drugs. This allowed the price of the Triple S packs to compare favorably with the retail cost of the drugs alone, while still providing high-cost recovery and a small profit for pharmacies selling the packs. .
- **Create demand through other project components.** The STD care component was greatly enhanced by ASEP's interpersonal

communication and mass media efforts that helped raise demand for quality STD diagnosis and treatment.

## **Constraints**

The chief constraint to the success of the STD program recalled the reason it was needed: the high cost of STD drugs. As noted in the 2002 review of the Triple S experience, “Price setting is a balancing act between trying to work toward covering costs for program sustainability while encouraging broad acceptance and use.” [49]. While the Triple S and SafePack compliance kits cost less than the drugs would cost at a pharmacy and included condoms, the amount was still too much for many customers, especially those unaccustomed to buying in quantity. As a result, some customers would ask for the packs to be split or ask for a cheaper medication, often taking the medicine only until their symptoms disappeared. Even NGOs that sold the packs at half the pharmacy price sometimes reported that the cost of the pack was too high for their clients. “They want to be cured,” said Josephine, pharmacist in charge at Carasco Drugstore in Cebu. “They’re really convinced. Only the problem is the money. If they have the budget, they buy.”

Early in the Triple S program, Bureau of Food and Drugs (BFAD) registration was another issue. Because Triple S was piloted as a model activity, the lack of registration deterred some pharmacies from carrying the packs or displaying them prominently. While PATH worked closely with the CHOs who assumed responsibility in the project through MOUs and active involvement, [16] PATH submitted an application to the bureau in 2000 requesting approval for the Triple S pack. In 2001, with the

endorsement and advocacy of the Department of Health, the bureau issued its certificate of product registration (Triples S), and licensed PATH to operate as a wholesaler and distributor of medical devices and pharmaceutical products. [36] With that approval, Triple S became the first compliance product in the Philippines with multiple drugs registered by an NGO.

Although partnership between NGOs and SHCs was an important achievement for the project, in some cases the partnerships experienced difficulties. In 2000, the project reported that the social hygiene system was unable to cope with the volume of FFSWs and prostitutes referred by partner NGOs for STD screening and care (more than 3,000 in eight sites in one year). In response, in two sites the CHO and SHC delegated responsibility for specimen collection for FFSWs to NGOs operating outreach posts for education purposes. Since this activity was not authorized under PATH's cooperative agreement with USAID, and it was inappropriate for CHOWs to be collecting specimen, these activities could not be funded under PATH's subgrant agreement with the NGOs. The CHOs eventually dispatched a nurse from the SHC to collect specimens at the NGO outreach post and STD screening continued for FFSW groups. [36]

Partner notification remained difficult. The partner notification cards in the Triple S kits were seldom used, with fewer than 10 percent of Triple S consumers known to be partners of previous customers. The most likely explanation for this is the stigma of an STD: most STD patients simply can't face the idea of informing their partner, either verbally or by way of

a card. [17] Those willing to notify a partner might have found it difficult to convince an asymptomatic partner to come for treatment.

Despite these constraints, a 2002 evaluation of the STD program called it “a highly successful pilot that has shown that the private sector can be actively engaged in STD treatment and prevention, contributing to keeping HIV prevalence at current low levels.” [16]. In its final evaluation, ASEP was lauded for having developed “a highly effective approach to providing treatment for STDs.” The evaluators added that “the Triple S and SafePack programs definitely warrant expansion.” [14] The STD control program, including syndromic management training and Triple S, have been cited as a UNAIDS Best Practice. Other groups are reportedly adapting similar strategies in neighboring countries. Over the life of the project, ASEP has greatly improved both the access and the quality of STD diagnosis and treatment for Filipinos at highest risk of STD and HIV infection. Equally important, it has supported enhanced STD treatment access in combination with other cost effective and high-impact HIV prevention strategies including COPE, condom promotion, and harm reduction programs for injecting drug users.





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