

**Evaluation of Harm Reduction Service Delivery
in Cebu City, Philippines (2013–2015)**

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ACRONYMS

ADB	Asian Development Bank
ART	Antiretroviral Treatment
BCP	Big Cities Project
CADAC	Cebu City Anti-Drug Abuse Council
DDB	Dangerous Drugs Board
DIC	Drop-in Center
DOH	Department of Health
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HTC	HIV Testing and Counseling
KC3	Kamagayan Comprehensive Care Center
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NA	Narcotics Anonymous
OR	Operations Research
OST	Opioid Substitution Therapy
PNAC	Philippines National AIDS Council
PSI	Population Services International
PWID	People Who Inject Drugs
ROMP	Reaching Out to Most-at-risk Populations
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TRC	Treatment and Rehabilitation Center
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNSW	University of New South Wales
USAID	United States Agency for International Development
WHO	World Health Organization

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This report highlights the critical role of peers—people who use drugs in the Philippines—in the implementation of the BCP in Barangay Kamagayan and beyond. Without their involvement, the project would likely not have been as successful and the preparation of this publication would not have been possible. Finally, our sincere thanks to every project client for investing their trust and sharing personal details about their lives with the project representatives and ultimately for making this report possible.

EXECUTIVE SUMMARY

The Philippines has been identified as one of nine countries in the world where HIV continues to increase at an alarming rate of more than 25 percent.¹ HIV transmission among people who inject drugs (PWID) expanded rapidly in recent years, from less than 1 percent in 2005 to more than 5 percent in the past five years.² There are between 12,304 and 16,607 PWID living in the Philippines, with the majority—an estimated 6,000 PWID—in Metro Cebu and between 2,000 and 2,500 in Cebu City.³ HIV and Hepatitis C Virus (HCV) rates among this group have been estimated at 41.6 percent and 70 percent, respectively.⁴ In Cebu City, up to 74 percent of people living with HIV contracted the virus through needle sharing,⁵ and 99 percent of infections among PWID were reported in Metro Cebu.⁶

Global evidence unequivocally shows that distribution of sterile injecting equipment reduces the transmission of HIV and other blood-borne infections like Hepatitis C among PWID; does not lead to an increase in drug use in general or in intravenous injection, in particular; increases demand for health and social care services, often resulting in better monitoring, care, and treatment; and that results are enhanced when such efforts are included in a comprehensive package of health and social care services.⁷ However, the Comprehensive Dangerous Drugs Act of 2002 prioritizes public security over public health objectives and specifically criminalizes possession and distribution of drug paraphernalia such as needles and syringes.

In March 2013, Population Services International (PSI) was contracted to lead the implementation of the Big Cities Project (BCP) between April 15, 2013 and December 31, 2015 with a total budget of US\$1,840,000 committed by the World Bank and the Asian Development Bank (ADB). The ultimate goal of the project was to reduce HIV transmission by reducing risk behaviors among PWID. Specifically, implementation of the BCP aimed to develop friendly drop-in center (DIC) and outreach services; increase demand and uptake of health services through improved peer education and support; and strengthen governance for development and implementation of sustainable, evidence-based policies and interventions.

While the operations research (OR) arm of the PWID component of the BCP in Cebu was not in a position to generate the expected outcomes—with regard to quantitative evidence of the impact of needle and syringe distribution on HIV transmission among PWID—the BCP produced significant positive results that should not be overlooked. Based on a thorough review of monitoring and evaluation (M&E) data collected by implementing agencies as well as inputs from focus group discussions and key stakeholder interviews, this evaluation finds that the BCP objectives were largely met. Specifically, the project data shows a significant uptake in HIV-related services through

¹ UNAIDS (Joint United Nations Program on HIV/AIDS). 2012. *Global Report on the AIDS Epidemic*; see also Casauay, A. 2012. "Rising HIV cases in PH Buck Global Decline." *Rappler*, November 21. <http://www.rappler.com/nation/16494-rising-hiv-cases-in-ph-buck-global-decline>.

² Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

³ Harm Reduction International. 2014. *Global State of Harm Reduction*; Tac-an, I. A., G. Bellimac, and Z. Pengfei. 2012. *Advocacy Briefing Paper: A Time for Urgent Action - Responding to the HIV Epidemic Among People Who Inject Drugs in Cebu City*.

⁴ Harm Reduction International. 2014. *Global State of Harm Reduction*.

⁵ Cabaero, N. B. 2015. "Cabaero: 'Ayaw'g puli-puli.'" *SunStar Cebu*, May 25.

<http://www.sunstar.com.ph/cebu/opinion/2015/05/25/cabaero-ayawg-puli-puli-409446>.

⁶ Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

⁷ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.

peer-led outreach and DIC-based services. Coverage among project clients is impressively high—between 67.1 percent and 99.7 percent—for the short implementation period and the multiple challenges encountered. Implementation of project activities has also shown that there is great demand among PWID for needles, syringes, and comprehensive sterile injecting equipment sets; for health and HIV-related services; for drug dependence treatment and rehabilitation; and for employment, especially as peer educators.

The impact of the BCP results are corroborated by the recent Integrated HIV/AIDS Behavioral Sentinel Surveillance showing a reduction in sharing of injecting equipment among PWID from 35 percent to 25 percent (BCP target 30 percent); an increase in the proportion of PWID who never shared needles, from 37 percent to 82 percent (BCP target 45 percent); and an increase in the percentage of PWID who were tested for HIV in the past 12 months and who know their result, from 6 percent to 23 percent (BCP target 15 percent).⁸

One of the most important achievements of the PWID component of the BCP in Cebu was the roll out of a comprehensive package of HIV prevention, demand reduction, and community development services. Though the distribution of sterile injecting equipment was suspended after only five months of implementation, the majority of services continued to operate with great success, as indicated by the coverage levels recorded by the project team. In essence, Kamagayan Comprehensive Care Center (KC3) became the first and only one-stop-shop where PWID felt comfortable and respected and could voluntarily access a wide range of health and social care services without fear of stigma or legal consequences.

The KC3 clients report being very satisfied with the comprehensive package of health services offered under the BCP and they feel welcome and accepted at the KC3. Community members in Kamagayan, including family members of the KC3 clients, also praise the service as an excellent intervention. Virtually all key stakeholders interviewed noted that the KC3 team had performed especially well in building trust between clients and their health service providers, families, and community. In that sense, community-based advocacy efforts were successful at generating an enabling environment for service delivery. The KC3 clients, family members, and community representatives also appreciated efforts from the KC3 team to promote demand reduction through counseling, Narcotics Anonymous (NA) sessions, and privileged access to the Argao Treatment and Rehabilitation Center (TRC).

Efforts were invested by the project team to develop an enabling environment for the PWID component of the BCP to be implemented in Cebu. Those efforts led to an official legal exemption to Section 12 of the Comprehensive Dangerous Drugs Act of 2002 through Resolution 298: 'Approving the Proposed Operations Research on Community-Based Comprehensive Services for People who Inject Drugs (PWID) in Barangay Kamagayan, Cebu City, and the Creation of a Technical Working Group (TWG) that will Formulate its Implementing Guidelines,' that approved legal implementation of needle and syringe distribution in the context of scientific research. The project team was also able to mobilize local government support from a wide range of agencies to initiate the project, and strategic partnerships contributed to mobilizing approvals. In the end, the KC3 operations were integrated into local government units at the Barangay level. The assessment of the OR also showed that efforts were deployed to strengthen the capacity of project workers and clients as well as other key stakeholders involved in the project.

⁸ DOH (Department of Health). Forthcoming. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

There is great demand and genuine interest among the KC3 clients and patients' clients to become peer educators and provide support to PWID. The professionalization of PWID through peer educator roles has also reportedly reduced stigma and discrimination and increased acceptance of PWID in the community. Should services for PWID be scaled up in Cebu and beyond, recruiting a workforce of peer educators should not be a critical challenge—an important lesson learned for future harm reduction projects in the Philippines.

Another critical lesson learned is the impact of suspending distribution of sterile injecting equipment. Uptake of services radically decreased, contacts with the KC3 project workers fell, and referrals almost stopped. Multiple clients were lost to follow up and the bond of trust cultivated by the KC3 workers was suddenly compromised. Several key stakeholders noted the critical enabling role of distributing sterile injecting equipment:

If we don't provide them with needles, they won't come to the clinic even if our services are free. Distribution of sterile injecting equipment is critical to stimulate enrollment in health services and hopefully in treatment for HIV and other infections. – Dr. Ilya Tac-An, Manager, Social Hygiene Clinic, Cebu City Health Office.

Though the BCP objectives were largely met, some important areas have been identified as critical gaps. The evaluation identified significant weaknesses in M&E; implementation timelines were delayed by factors often beyond the control of implementing partners; limited provisions were included in the project design for strategic advocacy interventions across the entire project life cycle; and governance structures were largely ineffective.

As of January 1, 2016, Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) resources will be channeled through 'Save the Children to Cebu Plus' to take over operations at the KC3 and ensure continuity of services to PWID. Such a handover is especially timely and the Cebu Plus team is enthusiastic and strategically positioned to maintain the KC3 services and potentially expand on the strengths, lessons learned, and good practices identified in this report. To facilitate such a handover, this report includes a set of recommendations specifically related to continuation of health and social care services for PWID.

Recommendations

1. Mobilize leadership of Dangerous Drugs Board (DDB) and the Department of Health (DOH).
2. Review and reform drug laws and policies.
3. Complete the operations research.
4. Make evidence-based decisions.
5. Ensure good governance.
6. Strengthen capacity of all project workers.
7. Improve monitoring and evaluation.
8. Deploy Syrex as a national data management system.

9. Meaningfully involve PWID.
10. Develop risk management plans.
11. Develop advocacy and communications plans.
12. Coordinate regionally and mobilize technical support.
13. Expand distribution of sterile injecting equipment.
14. Strengthen referral systems and strategies.
15. Improve support mechanisms for peer educators.
16. Consider geographical expansion.
17. Develop and enforce a drug-free workplace policy.
18. Consider working in prisons.
19. Consider piloting substitution pilot study.
20. Consider piloting HCV treatment.

INTRODUCTION

HIV and Drugs in the Philippines

The greatest growth [in Asia] can be seen in the Philippines, where a 28 percent increase in HIV among people who inject drugs was seen between 2012 and 2014.⁹

While global trends indicate a significant reduction in HIV transmission, the Philippines has been identified as one of nine countries in the world where HIV continues to increase at an alarming rate of more than 25 percent.¹⁰ Everyday, 22 new HIV cases are reported in the Philippines, compared to fewer than 10 per day in 2012 (see Table 1). As of September 2015, a total of 28,428 unique cases of HIV have been reported, representing a 22 percent increase compared to 2014.¹¹ HIV disproportionately affects men, with 92 percent of cumulative cases reported among males and 51 percent of cases found among those ages 25–34, irrespective of gender.¹²

Table 1. Average Number of New HIV Infections Reported Per Day in the Philippines

Year	Average Number of New Cases
2008	1
2010	4
2012	9
2014	17
2015	22

HIV transmission is predominantly concentrated in urban centers such as Metro Manila and Metro Cebu, but important differences in transmission vectors have been identified. For example, half of the infections among men who have sex with men (MSM) were reported in the national capital region (Metro Manila), 99 percent of infections among PWID were reported in Metro Cebu (region 7), and 48 percent of infections among women and girls were reported from Central Luzon (region 3).¹³ Up to 80 percent of cumulative HIV cases have been identified among MSM while 14 percent of cases were transmitted through unprotected heterosexual contact and 5 percent through needle sharing among PWID.¹⁴

HIV transmission among PWID expanded rapidly in recent years, from less than 1 percent in 2005 to more than 5 percent in the past five years.¹⁵ There are between 12,304 and 16,607 PWID living in the Philippines, with the majority—an estimated 6,000 PWID—in Metro Cebu and between 2,000 and 2,500 in Cebu City.¹⁶ HIV and HCV rates among this group have been estimated at 41.6 percent and 70 percent, respectively.¹⁷ In contrast, HIV prevalence among women who inject drugs in the Philippines has been estimated at 27

⁹ Stone, K. A. 2015. "Reviewing Harm Reduction for People who Inject Drugs in Asia: The Necessity for Growth." *Harm Reduction Journal* 12: 32.

¹⁰ UNAIDS (Joint United Nations Program on HIV/AIDS). 2012. *Global Report on the AIDS Epidemic*; see also Casauay, A. 2012. "Rising HIV cases in PH Buck Global Decline." *Rappler*, November 21.

<http://www.rappler.com/nation/16494-rising-hiv-cases-in-ph-buck-global-decline>.

¹¹ Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

¹² Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

¹³ Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

¹⁴ Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

¹⁵ Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

¹⁶ Harm Reduction International. 2014. *Global State of Harm Reduction*; Tac-an, I. A., G. Bellimac, and Z.

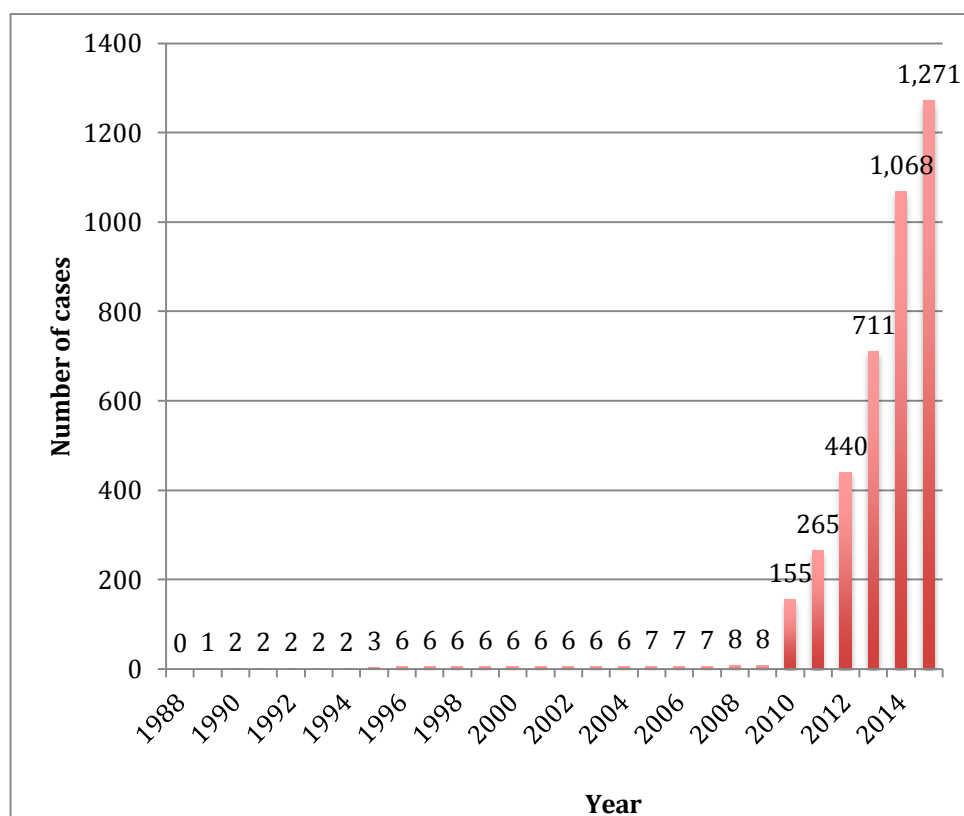
Pengfei. 2012. *Advocacy Briefing Paper: A Time for Urgent Action - Responding to the HIV Epidemic Among People Who Inject Drugs in Cebu City*.

¹⁷ Harm Reduction International. 2014. *Global State of Harm Reduction*.

percent.¹⁸ Recent surveillance data among PWID in Cebu City show that HIV prevalence has dropped: from 52.3 percent among male PWID in 2013 to 42.8 percent in 2015 and from 30.4 percent among female PWID in 2013 to 25.2 percent in 2015.¹⁹ In Cebu City, up to 74 percent of people living with HIV contracted the virus through needle sharing.²⁰ PWID in the Cebu region are reported to inject every month, on average 18 days in a month, and up to 12 times per day.²¹

Meanwhile, coverage of HIV testing and counseling (HTC) among PWID has increased—from 1 percent in 2009 to 5 percent in 2011,²² to 7 percent at the latest estimates—though uptake of HTC remains the lowest when compared to other key populations (see Figure 2),²³ and well below the recommended coverage threshold of 40 percent.²⁴ National data from 2013 shows that only 6 percent of PWID were ever tested for HIV,²⁵ while recent surveillance results indicate a significant increase to 23 percent.²⁶ There is no data currently available on the past or present coverage of the antiretroviral treatment (ART) among PWID living with HIV.

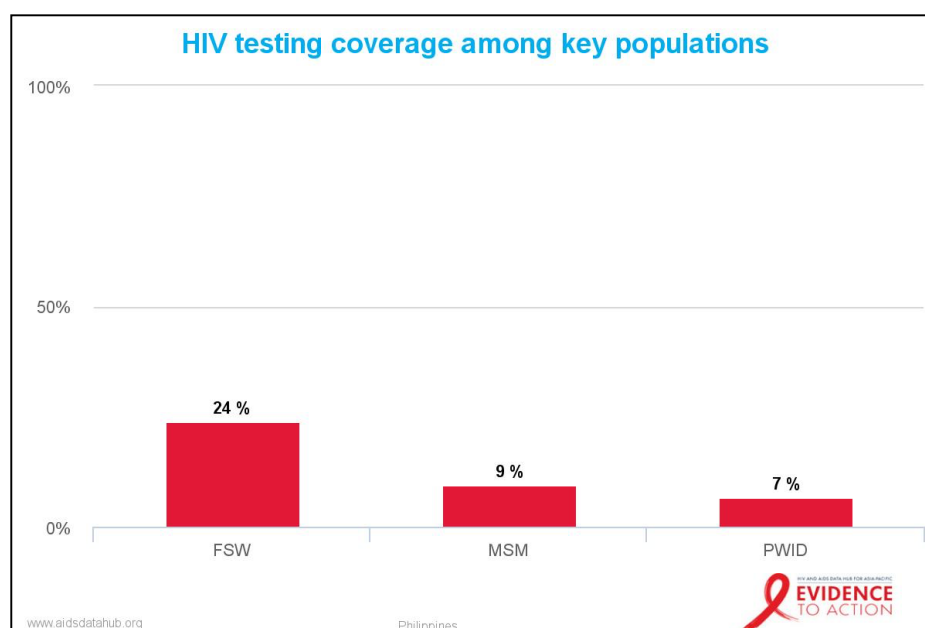
Figure 1. Cumulative Number of HIV Cases Reported Among PWID



¹⁸ UNAIDS (Joint United Nations Program on HIV/AIDS). 2012. *Global Report on the AIDS Epidemic*.
¹⁹ DOH (Department of Health). Forthcoming. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.
²⁰ Cabaero, N. B. 2015. "Cabaero: 'Ayaw'g puli-puli'." *SunStar Cebu*, May 25. <http://www.sunstar.com.ph/cebu/opinion/2015/05/25/cabaero-ayawg-puli-puli-409446>.
²¹ DOH (Department of Health). 2013. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.
²² WHO (World Health Organization). 2010. *A Strategy to Halt and Reverse the HIV Epidemic Among People who Inject Drugs in Asia and the Pacific: 2010–2015*.
²³ HIV and AIDS Data Hub for Asia and the Pacific. Undated. *Philippines Country Profile*. <http://www.aidsdatahub.org/Country-Profiles/Philippines>.
²⁴ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.
²⁵ DOH (Department of Health). 2013. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.
²⁶ DOH (Department of Health). Forthcoming. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

Source: Epidemiology Bureau. 2015. *HIV/AIDS and ART Registry of the Philippines*.

Figure 2. HTC Among Key Populations in the Philippines



Note: FSW = Female sex worker.

Data from 2013 showed that more than two-thirds of PWID usually inject drugs in a shooting gallery.²⁷ Needle sharing increased between 2007 and 2013, from 52 percent of PWID sharing needles and syringes the last time they injected to 61 percent.²⁸ In contrast, data from 2009 shows that 85 percent of PWID had used sterile injecting equipment at their last injection, down to 25 percent in 2011,²⁹ and up to 30.7 percent in 2014.³⁰ Local data shows that sharing of needles among those who received free sterile injecting equipment was 15 percent lower compared those who did not.³¹ Needle sharing remains one of the most rapid and effective mechanisms for HIV transmission.³²

The Philippines has one of the lowest documented rates of condom use in Asia,³³ where consistent condom use rate is estimated at 11 percent among the general population.³⁴ In contrast, condom use among PWID was reported at 24 percent in 2007,³⁵ 22 percent in 2009, and 15 percent in 2011,³⁶ indicating a worrying, rapidly decreasing trend with profound implications for HIV prevention. Among PWID, condom use at the last sexual encounter has been estimated at 13.4 percent.³⁷

²⁷ DOH (Department of Health). 2013. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

²⁸ DOH (Department of Health). 2007. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*; DOH (Department of Health). 2013. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

²⁹ WHO (World Health Organization). 2010. *A Strategy to Halt and Reverse the HIV Epidemic Among People who Inject Drugs in Asia and the Pacific: 2010–2015*.

³⁰ UNAIDS (Joint United Nations Program on HIV/AIDS). 2014. *Global AIDS Response Progress Reporting – Philippines Country Progress Report*.

³¹ DOH (Department of Health). 2013. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

³² UN (United Nations). 2001. *The Cosponsors of UNAIDS*.

³³ HIV and AIDS Data Hub for Asia and the Pacific. 2011. *Philippines Country Review*.

³⁴ UNAIDS (Joint United Nations Program on HIV/AIDS). 2014. *2014 Global AIDS Response Progress Reporting – Philippines Country Progress Report*.

³⁵ DOH (Department of Health). 2007. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

³⁶ WHO (World Health Organization). 2010. *A Strategy to Halt and Reverse the HIV Epidemic Among People who Inject Drugs in Asia and the Pacific: 2010–2015*.

³⁷ UNAIDS (Joint United Nations Program on HIV/AIDS). 2014. *2014 Global AIDS Response Progress Reporting – Philippines Country Progress Report*.

Drug control in the Philippines has long espoused a prohibitionist approach enshrined in several laws and policies that favor criminalization and punishment over public health objectives.³⁸ Specifically, the Revised Penal Code of 1930 is largely modeled on the United States' Harrison Act (1914) which seeks to identify individuals and organizations who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away specific substances to impose penalties while framing drug control measures around a strict law enforcement and criminal justice approach with secondary objectives of prevention and education as well as treatment.³⁹ Additional controls were put in place through Republic Act No. 6425 or the Dangerous Drugs Act of 1972 as well as through Republic Act No. 9165 or the Comprehensive Dangerous Drugs Act of 2002, both of which prioritize public security over public health objectives.

The 2002 Act specifically criminalizes possession and distribution of drug paraphernalia such as needles and syringes. Specifically, Section 12 of the Comprehensive Dangerous Drugs Act of 2002 states:

The penalty of imprisonment...shall be imposed upon any person, who, unless authorized by law, shall possess or have under his/her control any equipment, instrument, apparatus, and other paraphernalia fit or intended for smoking, consuming, administering, injecting, ingesting, or introducing any dangerous drug into the body. The possession of such equipment, instrument, apparatus, and other paraphernalia fit or intended for any of the purposes enumerated in the preceding paragraph shall be prima facie evidence that the possessor has smoked, consumed, administered to himself/herself, injected, ingested, or used a dangerous drug and shall be presumed to have violated this Act.

However, global evidence unequivocally shows that distribution of sterile injecting equipment reduces the transmission of HIV and other blood-borne infections like Hepatitis C among PWID; does not lead to an increase in drug use in general or in intravenous injection, in particular; increases demand for health and social care services, often resulting in better monitoring, care, and treatment; and that results are enhanced when such efforts are included in a comprehensive package of health and social care services.⁴⁰

In that respect, several agencies have invested and worked to remove criminal penalties associated with distribution of sterile injecting equipment. For example, the Global Fund's Office of the Inspector General recommended in 2010 that recipients should invest significant efforts to address the conflicting laws and policies that prevent the distribution of sterile injecting equipment.⁴¹

Given the legal and policy context, the vast majority of drug-related arrests involved amphetamines (locally known as *shabu*), accounting for 84 percent in 2013 and 89

³⁸ de Jesus, A. F., M. P. Calimag, M. C. A. Gonzales, and F. I. Rey. 2012. *Unsafe Injecting Drug Use, a Growing Source of HIV Transmission in the Philippines: Implications to Policy*. <http://www.ph.undp.org/content/dam/philippines/docs/HIV/Policy%20Brief%20Unsafe%20Injecting%20Drug%20Use.%20a%20Growing%20Source%20of%20HIV%20Transmission%20in%20the%20Philippines%20Implications%20to%20Policy.pdf>.

³⁹ IDPC (International Drug Policy Consortium). 2013. *Drug Policy Advocacy in Asia: Challenges, Opportunities, and Prospects*.

⁴⁰ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.

⁴¹ Office of the Inspector General. 2010. *Audit Report on Global Fund Grants to the Philippines*. (see Recommendation #25, paragraph 267)

percent in 2014, while arrests related to cannabis was the second most significant.⁴² Law enforcement agencies in the country report that 8,000 Barangays are affected by illicit drugs with 92 percent of Barangays in Metro Manila reporting illicit drug activities.⁴³ Males are overrepresented in drug-related arrests (87 percent in both 2013 and 2014).⁴⁴ Surprisingly, the Philippines Drug Enforcement Agency makes no mention in its Annual Reports of Nubain or nalbuphine hydrochloride, the most commonly injected drug in the country. Alarming, reports dating back to 2009 indicate increasing trends of injecting combined *shabu* and nalbuphine hydrochloride (also known as ‘speedballs’ or ‘milkshakes’).⁴⁵ Nalbuphine hydrochloride was formally included in the list of dangerous drugs in January 2011, making its possession and use a criminal act.⁴⁶

According to United Nations Office of Drugs and Crime’s 2012 World Drug Report, the Philippines has the highest rate of methamphetamine use in East Asia.⁴⁷ National agencies report that 2.1 percent of Filipinos ages 16 to 64 have used *shabu*.⁴⁸ An estimated 1.6 million individuals are dependent on illicit drugs and an additional 1.8 million use illicit drugs recreationally across the Philippines.⁴⁹

Responding to HIV among PWID⁵⁰

The DOH is the lead government agency responsible for the national response to HIV/AIDS and chairs the Philippines National AIDS Council (PNAC), a multisectoral policy-making body. Since the detection of the first recorded case of HIV in the Philippines in 1984,⁵¹ the PNAC has developed strategies to prevent transmission and provide treatment, care, and support to those affected by and living with HIV. Interventions targeting PWID have been included in national strategic plans at least since 2005.⁵² Despite the absence of formal commitments from government agencies to scale up core interventions like distribution of sterile injecting equipment and opioid substitution therapy (OST) to prevent HIV transmission among PWID, a number of initiatives were nonetheless implemented. The following is a chronological account of the evolution of service delivery targeting PWID in the Philippines.

In 1995, the Program for Appropriate Technology in Health and the University of Southern Philippines Foundation, with support from the United States Agency for International Development (USAID) initiated the country’s first harm reduction project

⁴² Philippines Drug Enforcement Agency. 2013. *Philippine Drug Enforcement Agency 2013 Annual Report*; Philippines Drug Enforcement Agency. 2014. *Philippine Drug Enforcement Agency 2014 Annual Report*.

⁴³ Carcamo, D. 2015. “PDEA: 92% of Metro Manila Barangays Drug-affected.” *PhilStar*, February 19. <http://www.philstar.com/nation/2015/02/19/1425462/pdea-92-metro-manila-barangays-drug-affected>.

⁴⁴ Philippines Drug Enforcement Agency. 2013. *Philippine Drug Enforcement Agency 2013 Annual Report*; Philippines Drug Enforcement Agency. 2014. *Philippine Drug Enforcement Agency 2014 Annual Report*.

⁴⁵ UN (United Nations). 2011. *The Non-medical Use of Prescription Drugs Policy Direction Issues*.

⁴⁶ Sumacot, N. G. 2011. “Nubain is Dangerous Drug Starting Jan. 28.” *The Freeman*, January 19. <http://www.philstar.com/cebu-news/649161/nubain-dangerous-drug-starting-jan-28>.

⁴⁷ United Nations Office on Drugs and Crime. 2012. *World Drug Report*.

⁴⁸ Esplanada, J. E. 2012. “UN Drug Report: Philippines Has Highest Rate of Shabu Use in East Asia.” *Philippine Daily Inquirer*, March 27. <http://newsinfo.inquirer.net/168143/un-drug-report-philippines-has-highest-rate-of-shabu-use-in-east-asia>.

⁴⁹ House of Representatives. 2013. “House Bill 1069 – An Act Establishing a Drug Abuse and Alcoholism Rehabilitation and Treatment Center in Every Region of the Philippines and Appropriating Funds Therefor (sic).” *Sixteenth Congress, Regular Session*. http://www.congress.gov.ph/download/basic_16/HB01069.pdf.

⁵⁰ This section retraces the evolution of harm reduction service delivery in the Philippines. However, the summary presented here may not be fully comprehensive and was developed based on available evidence.

⁵¹ HIV and AIDS Data Hub for Asia and the Pacific. 2011. *Philippines Country Review*.

⁵² PNAC (Philippines National AIDS Council). 2005. *4th AIDS Medium Term Plan - 2005–2010 Philippines*; Harm Reduction International. 2010. *The Global State of Harm Reduction: Key Issues for Broadening the Response*.

covering six Barangays of Cebu City where drug use and injecting is widespread. Operating through outreach, clients were provided with education on the risks of needle sharing and strategies to reduce risks such as sterilization of injecting equipment as well as consistent condom use. Additional services included behavior change counseling, distribution of bleach, water, condoms, and sterile needles and syringes,⁵³ primary health care services, and job referrals.⁵⁴

Throughout the early 2000s, a number of civil society groups such as Remedios AIDS Foundation, KABALIKAT, Caritas, the AIDS Society of the Philippines, Social Health, Environment and Development, USAID's Local Enhancement and Development for Health Project, and Cebu City Health delivered outreach education targeting PWID.⁵⁵ Global Fund recipients have implemented behavior change interventions targeting PWID since 2004 (under Rounds 3 and 5).⁵⁶ In 2008, Global Fund recipients continued to target PWID with behavior change interventions to reduce the transmission of HIV and initiated distribution of sterile injecting equipment.⁵⁷

USAID also provided financial support to FHI360 to implement the Reaching Out to Most-at-Risk Populations (ROMP) project between 2012 and 2015. The project targeted PWID in Cebu, Mandauae, and Lapu-Lapu with the objectives of identifying and enhancing HIV service delivery models; increasing the demand and utilization of such services; and capacitating local service providers and partner organizations to implement, manage, and sustain a comprehensive package of HIV/sexually transmitted infection (STI) prevention and management services. The project operated through strategic outreach, peer-led intervention, improved HTC, and effective linkages to HIV care and treatment but did not include distribution of sterile injecting equipment.⁵⁸

The Cebu City Health Office's Social Hygiene Clinic has also been delivering a comprehensive package of HIV treatment, care, and support services, targeting PWID since 2013. This effort was a unique local initiative established through multisectoral collaboration between local government agencies and civil society groups as well as multilateral partners that resulted in facility-based distribution of sterile injecting equipment. However, the distribution of sterile injecting equipment from the Social Hygiene Clinic operated informally, without formal legal support and in 2014, the Cebu City Anti-Drug Abuse Council (CADAC) sent an official letter to demanding that such efforts be halted immediately:

The Cebu City Anti-Drug Abuse Council (CADAC) does not question the notability of the purpose of the said project [BCP] but it contradicts Section 12 of Article 2 of

⁵³ Anecdotal evidence indicates that the distribution of needles and syringes under the Program for Appropriate Technology in Health project was operated on a small scale, underground, without legal approvals.

⁵⁴ Jereza, L. D. 1997. "IDU Harm Reduction and Prevention Program in Cebu City, Philippines." Paper presented at 4th International Congress on AIDS in Asia and the Pacific, Manila, the Philippines, October 25–29.

⁵⁵ Mesquita, F., et al. 2008. "Accelerating Harm Reduction Interventions to Confront the HIV Epidemic in the Western Pacific and Asia: The Role of WHO (WPRO)." *Harm Reduction Journal* 5:26; Health Action Information Network. 2003. *HIV/AIDS Country Profile – Philippines*.

⁵⁶ Bridge, J., et al. "Global Fund Investments in Harm Reduction from 2002 to 2009." *International Journal of Drug Policy* 23 (4): 279–85.

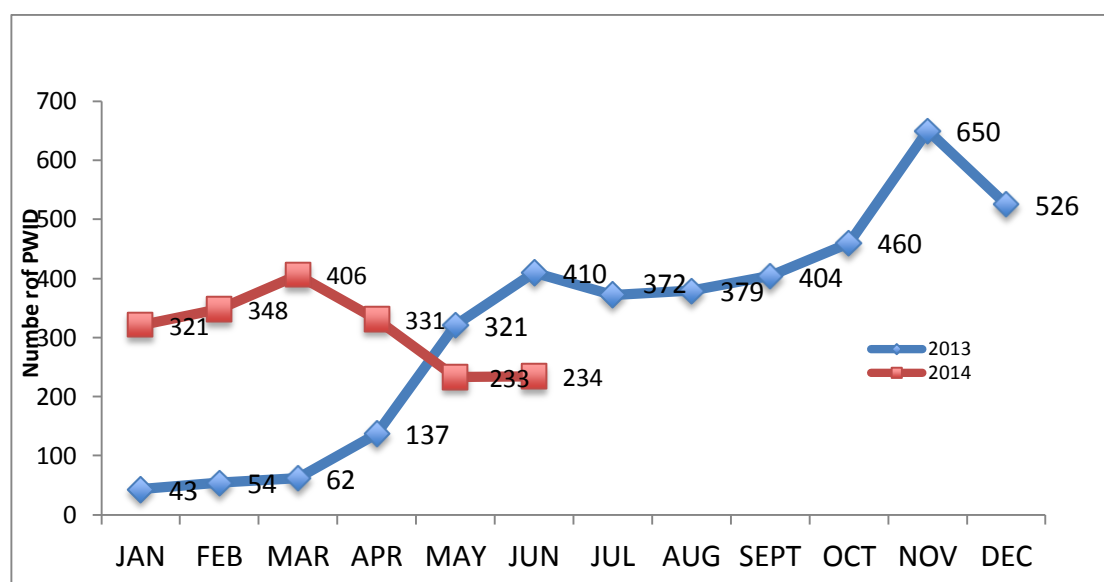
⁵⁷ Mesquita, F., et al. 2008. "Accelerating Harm Reduction Interventions to Confront the HIV Epidemic in the Western Pacific and Asia: The Role of WHO (WPRO)." *Harm Reduction Journal* 5: 26.

⁵⁸ For more information about ROMP, visit <https://www.usaid.gov/philippines/health/romp>.

*the Republic Act 9165 [...] and strongly recommends its suspension until the legality of such act can be resolved.*⁵⁹

Reports from the Social Hygiene Clinic indicate that distributing free sterile injecting equipment has led to significant increase in health service uptake among PWID. Figure 3 shows the frequency of contacts since initiation of the harm reduction component at the clinic.

Figure 3. Number of PWID Accessing Sterile Injecting Equipment from Cebu Social Hygiene Clinic (2013–2014)



Source: Tac-an, I. A. 2014. *Submission of Country Best Practice Thematic Segment on 'Halving HIV transmission among people who inject drugs.'* Paper presented at the 35th meeting of the UNAIDS Programme Coordinating Board.

Reports from 2010 and 2012 indicate that PWID in the Philippines received 2.5 and fewer than 10 needles and syringes per person per year respectively.⁶⁰ The clinic has plans to scale up coverage to 12.5 needles and syringes per person per year.⁶¹ Other reports show that only 14 percent of PWID were reached by HIV prevention programming in a 12-month period in 2010.⁶² However, the current and planned coverage of sterile injecting equipment among PWID remain well below the effective threshold to meet the needs of PWID in preventing the spread of HIV, which is set at 200 needles and syringes per person per year as recommended by UNAIDS.⁶³

Other calculations estimated the cost of needle and syringe distribution at US\$122 per client, with an investment of US\$0.15 per needle and syringe distributed.⁶⁴ Based on these

⁵⁹ Cebu City Anti-Drug Abuse Council. 2014. *Resolution 004-14: A Resolution Showing Strong Opposition to the Cebu City Health Department's Program of Distributing Free Syringes to Persons Who Inject Drugs or PWID*, June 10.

⁶⁰ WHO (World Health Organization). 2010. *A Strategy to Halt and Reverse the HIV Epidemic Among People who Inject Drugs in Asia and the Pacific: 2010–2015*; Harm Reduction International. 2012. *The Global State of Harm Reduction: Towards an Integrated Response*.

⁶¹ World Bank and UNSW (University of New South Wales). 2013. *Policy Brief: Epidemiological Impact and Return on Investment of Needle-syringe Programs in Cebu, Philippines*.

⁶² WHO (World Health Organization). 2010. *A Strategy to Halt and Reverse the HIV Epidemic Among People who Inject Drugs in Asia and the Pacific: 2010–2015*.

⁶³ UNAIDS (Joint United Nations Program on HIV/AIDS). 2014. *The GAP Report*.

⁶⁴ World Bank and UNSW (University of New South Wales). 2013. *Policy Brief: Epidemiological Impact and Return on Investment of Needle-syringe Programs in Cebu, Philippines*.

estimates, additional return on investment calculations were developed, showing significant long-term savings and health benefits, as summarized in Table 2.

Table 2. Financial Return on Investment Data

Number of Needle-Syringes Distributed Per Person Per Year	12.5	50	100
Five-year investment (US\$)	36,000	143,000	286,000
Health care costs saved (5 years) (US\$)	37,000	130,000	183,000
Cost/DALY averted (5 years) (US\$)	740	860	1,220
Cost per infection averted (5 years) (US\$)	450	510	n.a.
Infections averted (5 years)	80	280	400
Deaths averted (5 years)	5	17	23
Lifetime return on investment (per US\$1)	6.21	6.02	4.27
Total health care costs saved (lifetime) (US\$)	420,000	1.6 million	2.3 million

Source: Wilson, D. P., et al. 2013. *Return on Investment of Needle-syringe Programs in the Philippines*.

Note: DALY = Disability Adjusted Life Year.

OST is not available in the Philippines⁶⁵ and medicines for substitution—methadone and buprenorphine—are classified as dangerous drugs⁶⁶ despite the fact that the most commonly injected drug—nalbuphine hydrochloride—is an opioid that could potentially be substituted with buprenorphine.⁶⁷ In parallel, the opioid overdose antidote naloxone is in the core list of essential medicines and is classified as “medicines requiring specific expertise, diagnostic precision, or special equipment for use.”⁶⁸ Given the classification, naloxone is not available in community settings in the Philippines.

The Big Cities Project and PWID Operations Research

In June 2011, at the high level meeting on HIV/AIDS in New York, the ADB and the Bank committed to providing financial assistance to the government of the Philippines to support the development and strengthening of HIV prevention service delivery models targeting MSM in Metro Manila and PWID in Metro Cebu. In March 2013, PSI was contracted to lead the implementation of the BCP, between April 15, 2013 and December 31, 2015. In total, the ADB committed US\$1,840,000 for the period of April 2013 to December 31, 2014, and the Bank committed an additional US\$500,000 from April 15, 2013 to December 31, 2015, to support the implementation of the BCP. While the total project timeline represents 32.5 months, the original expectation was to implement the operations study, embedded in the BCP, for a period of 24 months.

The ultimate goal of the project was to reduce HIV transmission by reducing risk behaviors among MSM and PWID. Specifically, implementation of the BCP aimed to develop friendly DICs and outreach services; increase demand and uptake of health services through improved peer education and support; and strengthen governance for development and implementation of sustainable, evidence-based policies and interventions.

The BCP component in Cebu was designed as an OR to determine the effectiveness of a comprehensive package of services—including distribution of sterile injecting equipment—on HIV transmission and on drug demand among PWID in Barangay Kamagayan, Cebu City. In addition to the BCP objectives and as a result of the OR design,

⁶⁵ Harm Reduction International. 2014. *Global State of Harm Reduction*.

⁶⁶ Philippines National Formulary Committee. 2008. *Philippine National Drug Formulary: Essential Medicines List*.

⁶⁷ Personal communication with Robert Ali on December 13, 2015.

⁶⁸ Philippines National Formulary Committee. 2008. *Philippine National Drug Formulary: Essential Medicines List*.

the project integrated new, more targeted objectives to measurably reduce the HIV risk behaviors and increase demand for drug dependence treatment and rehabilitation.

PSI established local partnerships with several nongovernmental organizations, namely, the Philippine Nongovernmental Organization Council on Population, Health and Welfare, Cebu Plus (in Cebu), and LoveYourself (in Manila), to facilitate project implementation. In addition, at least six consultants were hired to provide technical support to the BCP in Cebu, including from two of the world's leading centers of excellence on HIV/AIDS—the University of Manitoba and the University of New South Wales (UNSW). The Bank also supplied technical assistance through internal experts to support the BCP.

The KC3 was opened as a DIC for PWID on September 1, 2014, on the third and fourth floors of the Kamagayan Barangay Hall, a local government office, to deliver comprehensive HIV prevention services. The KC3 was designed to deliver basic health care services, including the comprehensive package of HIV services through both DIC- and outreach-based services; facilitate access to voluntary drug dependence treatment and rehabilitation services; and contribute to the development of an enabling policy and implementation environment. The BCP supports seven full-time staff, two part-time medical doctors, one outreach worker, and eight peer educators.

Barangay Kamagayan is in the city's central business district, a block away from Colon Street, the country's oldest street. Kamagayan is within the periphery of the Central Visayas offices of the Philippine National Police, the Philippine Drug Enforcement Agency, and the City Hall. The short distance between the Barangay and the law enforcement and government offices, however, does not deter prostitution and illegal drug trade, which are rampant. Kamagayan is on the list of the top 10 drug-prone villages in the city's 80 villages.⁶⁹

The BCP interventions implemented in Cebu were expected to generate the following outcomes:

- Reduced percentage of sharing injecting equipment among PWID, from 35 percent to 30 percent.
- Increased percentage of PWID who never shared needles, from 37 percent to 45 percent.
- Increased percentage of PWID who were tested for HIV in the past 12 months and who know their result, from 10 percent to 15 percent.

⁶⁹Asutilla and Bongcac. 2014. "Kamagayan: Cebu City's Dark Side." *Inquirer.net*, August 9.

METHODOLOGY

This report is the result of an evaluation of the PWID component of the BCP implemented in Cebu commissioned by the Bank. This evaluation was designed to assess the impact of the BCP in Cebu and review project performance against a range of quantitative and qualitative expectations. The present evaluation was prepared with the objective of providing a range of key stakeholders, especially in the Philippines, with a comprehensive assessment of the results achieved under the PWID component of the BCP in Cebu and its implications on national response to HIV among PWID. To assess the performance of the BCP in Cebu, the OR component will be measured against its quantitative objectives while achievement of the BCP objectives will also be analyzed to derive quantitative as well as qualitative lessons learned.

The evaluation process was initiated with a thorough literature review that included published academic and media materials, project narrative reports, and quantitative project data. The independent evaluator visited the Philippines from December 1 to 13, 2015, and spent ten days in Cebu and three days in Manila. A range of site visits, key stakeholder interviews, and focus group discussions were conducted during the visits as summarized in annex 1.

After a comprehensive analysis of all the collected information, the evaluator provided a comprehensive review of results, including highlighting lessons learned and good practices based on experiences in implementing the BCP. The results of the analysis are presented in a conclusion, with recommendations addressed to key stakeholders that will be responsible for the continued implementation of harm reduction services targeting PWID in the Philippines beyond the BCP. Before finalization, the Bank and UNAIDS peer reviewers provided feedback and suggestions that were integrated into this evaluation report.

This report has several limitations. First, the data provided to evaluate the implementation of the BCP and the OR component was often incomplete and it was challenging to triangulate and verify the accuracy of results. Second, the evaluator was dependent on PSI to obtain the necessary data and access key individuals. Though logistical support was covered by the Bank, PSI managed the local schedule and facilitated access to clients and their relatives, community members, and key stakeholders. Third, the evaluator had limited contact with key political figures that supported and challenged the BCP in Cebu, not for lack of trying. In that sense, the conclusions related to the political situation and harm reduction in the Philippines have limited value and should be read carefully. Fourth, the evaluator had the opportunity to engage with key local organizations that challenged the implementation of the BCP in Cebu, though there were limited opportunities to engage with national level political leaders who also challenged implementation of the project. Aside from a meeting with CADAC and the City Office on Substance Abuse Prevention on December 1, 2015, there was limited official input from drug control representatives and other sectors that have voiced their opposition. Finally, it is important to note that this evaluation relies on observational data, without a control population. Many of the limitations listed above are related to tight project implementation timelines as well as the timelines for the conclusion of the BCP. There was a limited window for the evaluator to collect, analyze, and report the findings and not all respondents were available during the evaluation period.

EVALUATION OF BCP IN CEBU

As noted in the previous section, the evaluation of the BCP in Cebu will require a review of the OR component as well as project performance under the broader BCP programmatic objectives. However, before looking into the results of either component to evaluate their performance, it is relevant to present a summary of the key milestones that have marked the implementation of the BCP in Cebu.

While the BCP formally started on April 15, 2013, the illegal nature of drug paraphernalia in the Philippines was a critical barrier to the initiation of project implementation. To address this critical barrier, the BCP team designed the project to consider the political sensitivities based on PSI's recognized experience in managing the national response to HIV among PWID in Thailand since 2009. The original project design was slightly revised into an OR to allow implementing agencies to obtain a legal exemption from Section 12 of the Comprehensive Dangerous Drugs Act of 2002 and initiate distribution of needles and syringes, on a scientific research basis. Essentially, the project was adapted to address important legal barriers. Consensus-building efforts led to a tentative agreement between the DOH and the development partners that an OR framework would facilitate rapid implementation and provide tangible evidence to policy makers to reform existing laws and policies.

The implementation contract between the ADB, the Bank, and PSI was amended to integrate the OR component in November and December 2013. Meanwhile, study protocols were finalized in May 2014 and the DOH appointed a principal investigator in early July 2014. At the end of the same month, the Chong Hua Hospital Institutional Review Board formally approved the protocols for the OR. The Cebu City Mayor endorsed the OR component on August 19, 2014. In September 2014, the first standard operating procedure (SOP) to guide service delivery was approved by the DOH and later that month, the DDB provided the final approvals to initiate the study by issuing Resolution 298 in early October 2014.⁷⁰

The exemption provided through the DDB Resolution 298 enacted on October 8, 2014 defined a circumscribed geographical area within which the project was expected to operate as well as a strict and limited timeframe. The Bank team shared evidence related to the effectiveness and cost-effectiveness of needle and syringe distribution with the DDB in an effort to mobilize high-level support for the BCP. The approval of the DDB Resolution 298 was a long, time-consuming process that significantly affected project implementation timelines.

Recruitment of study participants started on October 14, 2014. The full complement of 787 study participants was achieved on January 31, 2015. Unfortunately, on April 29, 2015, the distribution of sterile injecting equipment under the OR was suspended because of local political pressures that received significant media coverage in the following months.⁷¹ Since May 2015, distribution has not been resumed at the KC3 (though agreements are in place to resume in late December 2015).

Despite the suspension of needle and syringe distribution, the KC3 team has continued to reach out to PWID and deliver the most comprehensive package of services available given the restrictions in place. Though the BCP is set to officially end on December 31,

⁷⁰ DDB (Dangerous Drugs Board). 2015. *Approving the Proposed Operations Research on Community-based Comprehensive Services for People who Inject Drugs (PWID) in Barangay Kamagayan, Cebu City, and the Creation of a Technical Working Group (TWG) that will Formulate its Implementing Guidelines.*

⁷¹ See annex 2 for a list of media coverage regarding the BCP in Cebu.

2015, agreements are already in place to ensure continuation of service delivery targeting PWID in Cebu with Global Fund support, through 'Save the Children' (the principal recipient).

Operations Research

Operations Research Design

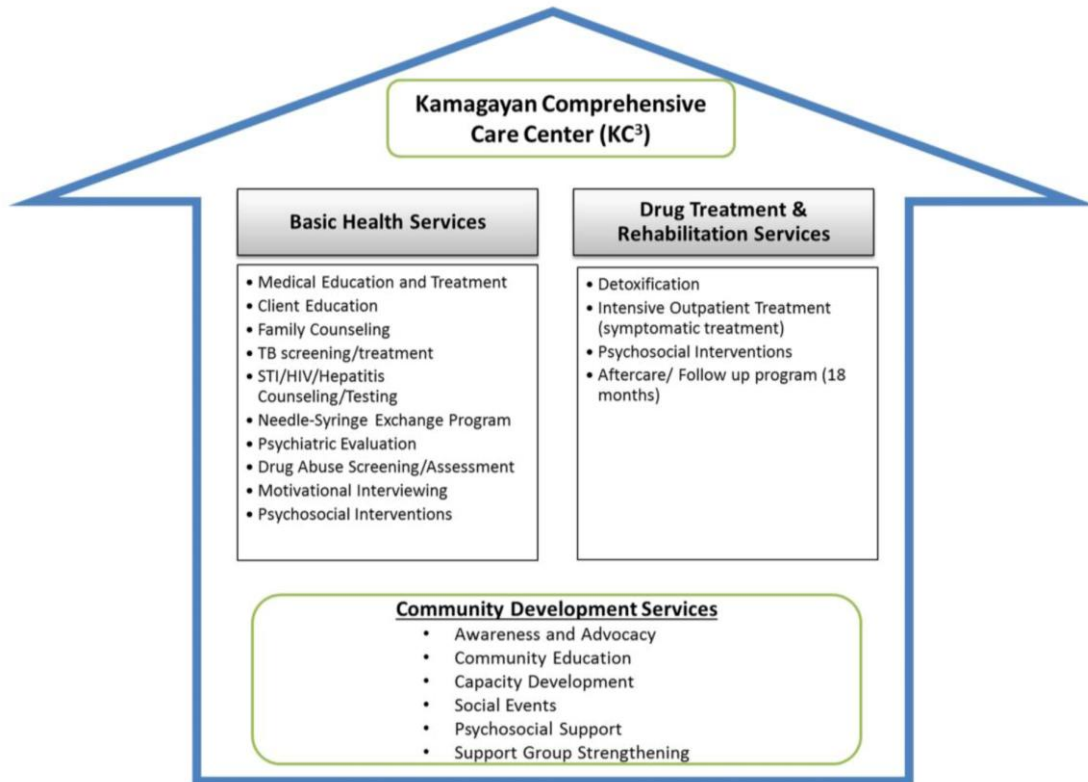
The OR was designed to evaluate the effectiveness of a comprehensive package of interventions, which include basic health services (including harm reduction), drug dependency treatment, and rehabilitation services as well as community development services delivered to PWID in community settings. In that sense, the OR was intended to yield high-quality evidence to measurably demonstrate the impact of community-based harm reduction services on health. The results of the OR were intended to convince decision makers and policy makers in the Philippines and unequivocally show that harm reduction services are effective and community-based interventions targeting PWID are critical to reducing HIV transmission at the national level.

Effectiveness was intended to be measured through a single cohort dose-response analysis where the analyses would ideally measure the impact of the services offered by the KC3 on (a) changing unsafe injecting behavior and thus reducing known risks for HIV infections and/or (b) directly reducing HIV transmission, that is, a decreased rate of new infections. Additionally, the single cohort study design was also intended to yield a reliable evaluation of the project's impact on reducing HIV transmission among the overall PWID population.

The package of services offered under the OR arm of the BCP included three intervention components (see Figure 4):

1. **Basic health services:** These include outreach, distribution of sterile injecting equipment and condoms, counseling and screening for STI, HIV, Hepatitis B and C, tuberculosis, and drug and harm reduction education.
2. **Demand reduction services:** These include intensive outpatient treatment, focusing on symptomatic treatment, residential treatment, and rehabilitation program through supervised detoxification, aftercare, and follow-up.
3. **Community development services:** These are community-based interventions, including, but not limited to, awareness and advocacy campaigns, community education, and capacity building.

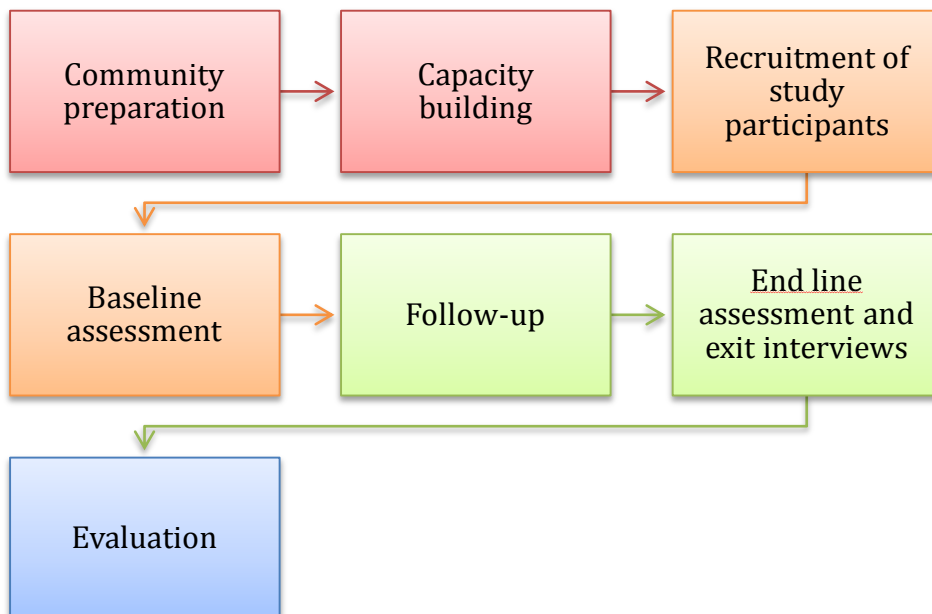
Figure 4. Model for Community-Based Comprehensive Health Services for PWID



Note: TB = Tuberculosis.

To achieve the objectives of the OR, its implementation was broken down into a step-by-step algorithm as presented in Figure 5. Even before the recruitment of clients, the implementation team had acknowledged in their concept note the need to adequately set the scene and invest in community preparation to obtain the necessary approvals.

Figure 5. Operations Research Implementation Algorithm



With regard to recruitment of study participants, a minimum of 386 HIV negative clients needed to be enrolled in the OR to generate statistically relevant results. Participant

eligibility was based on a history of injecting nonprescribed drugs at least once in the past six months; assessment for substance use disorder according to the DSM5; and age (at least 18 years). A comprehensive consent form was developed and translated in Cebuano to formally enroll clients in the OR, detailing that the study is anonymous and includes consent for at least four serological tests, to participate in face-to-face interviews, allow the research team to access his or her records from the intervention program, remain in the study for the next 12 months, and return for follow-up sessions when required.

All PWID, regardless of their enrollment in the OR, were encouraged to access the KC3 services, including sterile injecting equipment, and assigned a unique identifier code to protect their identity while facilitating data collection and analysis. After confirming informed consent, baseline information was meant to be collected from study participants and coded into the appropriate forms. Baseline data required administration of the following components (which included about 150 questions):

- PWID-OR Questionnaire (Appendix D)
- Individual client record (Appendix F)
- Drug dependency examination report (Appendix G)
- World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test v3.0 interview on substance use (Appendix H)
- Standard mini mental status examination
- Serological tests for HIV, HBV, HCV, and syphilis

The OR evaluation protocol was intended for serological testing of HIV negative clients at regular three-month intervals, as well as an end line evaluation using the same tools as for the baseline assessment and an exit interview. The data collected throughout the intended 24-month study period were to be analyzed using rigorous statistical analysis of baseline versus end line data to determine the impact of the KC3 services on client behaviors and serological status.

Evaluation of the Operations Research Component

Following the implementation algorithm presented in Figure 5, the results and achievements of the BCP OR component can now be evaluated.

Community Preparation

Given the sensitive nature of harm reduction projects in the Philippines, the BCP team was careful to establish strategic partnerships with a range of organizations to support the implementation of the project. Project documents highlight the need for a tailored, culturally appropriate, and sensitive approach to minimize potential negative backlashes. In that context, a local PWID specialist was hired early on to assist the BCP team to mobilize the necessary support locally and to roll out the project. Key stakeholder interviews confirm that the PWID specialist played an invaluable role in community preparedness ahead of the launch of the OR. Local and well-respected partners like Cebu Plus were contracted to support service delivery.

The BCP team invested considerable time and resources in mobilizing support for the project. A significant proportion of time over the course of 2013–2014 was invested to

mobilize high-level endorsements from the Cebu City Mayor, from the DOH, and the DDB. In September 2014, a study visit to Kuala Lumpur, Malaysia, was organized for 10 high-level government officials to facilitate approval of the OR in Cebu. In November 2014, a workshop specifically targeting police from the Cebu City area was organized that led to the mobilization of their support for the OR. Policy advocacy interventions were successful and ultimately, the project was formally approved by the DDB Resolution 298: Approving the Proposed Operations Research on Community-based Comprehensive Services for People who Inject Drugs (PWID) in Barangay Kamagayan, Cebu City and the Creation of a Technical Working Group (TWG) that will Formulate its Implementing Guidelines.

The DDB Resolution 298 is an unprecedented document that allowed the distribution of needles and syringes for medical research purposes and considerably reduced operational risks by making Barangay Kamagayan a ‘safe zone’:

“ . . . where there will be no arrests or apprehensions in relation to Section 12 (Possession of Equipment, Instrument, Apparatus and other Paraphernalia for Dangerous Drugs) only, insofar as the needle/syringe exchange program is concerned, with respect to identified and registered PWID participants and Kamagayan Health Personnel, for the period of the aforesaid study.”⁷²

It is also worth highlighting that the KC3 services are operating out of the local government office—the Kamagayan Barangay Hall—that is a significant achievement in the context of legitimizing harm reduction services and the OR. The BCP team was able to secure permissions from the Barangay Captain after the project was endorsed officially by the Cebu City Mayor. The KC3 thus benefits from a large office space that is provided rent-free, demonstrating a significant level of integration with the local government and within the Kamagayan community.

Unfortunately, the partnerships between PSI and a number of local groups were strained quickly due to the challenges in management and communication styles and the tension led to conflicts that the partnerships could no longer sustain. Key stakeholder interviews confirm that as the partnership with Cebu Plus weakened and eventually ended, so did the BCP’s position weaken in the eyes of many external key stakeholders. In parallel, the project PWID specialist, who had facilitated many of the project’s approvals, opted not to renew his contract with the project. Meanwhile, the project’s Technical Working Group, designed as a multisectoral governance and oversight committee, and empowered under Resolution 298, only met once in November 2014. The lack of engagement between the implementers and the Technical Working Group further compromised opportunities for growing discontent in the community and beyond.

Meanwhile, the tensions between project partners were exacerbated by external political sensitivities and media coverage of the BCP OR in Kamagayan. In the end, the achievements generated by the DDB Resolution 298 were temporarily suspended in April 2015. Already in late February 2015, the Cebu CADAC had issued a formal resolution to oppose the temporary exemption to Section 12 of the Comprehensive Dangerous Drugs Act as well as the implementation of the OR in Kamagayan. Starting in May 2015, Senator Vicente Sotto III brought even more media attention to the efforts in Kamagayan that were still plaguing implementation in December 2015 during the evaluator’s visit.

⁷² DDB (Dangerous Drugs Board). 2015. *Approving the Proposed Operations Research on Community-based Comprehensive Services for People who Inject Drugs (PWID) in Barangay Kamagayan, Cebu City and the Creation of a Technical Working Group (TWG) that will Formulate its Implementing Guidelines.*

In that respect, though significant advocacy efforts were invested to secure approvals in the early phases of the project, the impact of those advocacy efforts was clearly not sustainable. Indeed, sterile injecting equipment was only distributed for a total of five months over the 24-month life cycle of the OR. It is important to note that the BCP team did not develop a communications or advocacy plan.⁷³ Though there was no formal plan, some communication and advocacy activities obviously occurred, especially in the start-up phase of the project, though there is limited evidence of such efforts beyond securing the approval through DDB Resolution 298. Beyond reporting to donors, the vast majority of external key stakeholders were never informed about project plans, developments, achievements, and challenges. The fact that the Technical Working Groups only met once in November 2014 is also testament to the lack of effective and strategic planning around communications and advocacy.

Capacity Building and Orientation

The KC3 project reports indicate that few training workshops were held to build capacity of the KC3 staff, peer educators, and outreach workers across the OR life cycle. In June 2014, a multistakeholder training workshop was organized with the BCP support to strengthen delivery of psychosocial support services for PWID and during the same time, project peer educators were trained by an expert consultant while a comprehensive training curriculum was also developed to facilitate local implementation of capacity building on a regular basis. In February 2015, a refresher workshop was organized for nine participants. However, the BCP team has integrated refreshers in their weekly team meetings, showing adaptability and effective financial management.

However, despite the development of technical and operational SOPs, there is little evidence that any trainings have been rolled out to ensure that project workers had sufficient capacity and understanding to manage and implement project activities. For example, the research protocol was developed in May 2014, but there is no evidence that training was rolled out to inform project workers of the expectations. Similarly, a technical SOP on DIC management was developed in August, revised in September, and again in December 2014, but there is no evidence that training was delivered to project workers following finalization of these documents.

Another key example relates to the development and implementation of the OR evaluation protocol. Though the evaluation protocol was meant to be developed through technical support from the UNSW and lead to capacity development of the BCP team, the protocol required the prior development and deployment of the SOP on DIC management and health service delivery. In the end, the evaluation protocol was finalized but the majority of the project workers were either unaware of this document or confused it with technical SOPs.

Despite these important limitations, discussions with project workers showed that they were generally confident to very confident about managing the tasks assigned to them. They also expressed that their formal education had generally prepared them well to conduct their tasks and they reported being generally comfortable with managing their workload. However, virtually all workers interviewed showed a very high interest for opportunities to further develop their professional capacity, especially in areas related to drugs, drug counseling, and harm reduction service delivery.

⁷³ PSI developed a Marketing Communication Plan (2015) to enhance outreach through a social marketing approach. However, the plan does not include external communications or advocacy activities geared at maintaining high-level approval and understanding of the project modalities.

Finally, it is worth highlighting that, during interviews and focus group discussions, virtually all project workers highlighted the negative impact of a very high internal turnover of workers. The inherent instability of the project had an impact on job security and workers' commitments, especially in the start-up phase, given the lack of clarity on official legal approvals that remained pending at the time. However, it is worth pointing out that even after the distribution of sterile injecting equipment was suspended in April 2015, there has been very little staff turnover. Similarly, the BCP workers showed tremendous loyalty when they remained with the project for several months without pay due to administrative constraints. At the time of the evaluation visit, orientation for new project workers were taking place on an ad hoc basis as needed.

Recruitment of Study Participants

By January 31, 2015, a total of 787 clients provided informed consent to participate in the OR, as shown in Table 3. All clients—irrespective of their participation in the OR—were provided with a unique identifier code and ID cards to protect their confidentiality. All project workers were very sensitive to protecting client confidentiality and reminders were posted as signs in the DIC common areas and in the offices.

Table 3. Schedule of Participants Recruitment for Operations Research

Month	Number of Participants
October 2014	48
November 2014	172
December 2014	274
January 2015	293

Baseline Assessment

Although the comprehensive baseline assessment tools were scheduled to be applied to all study participants upon enrollment, Appendix D (PWID-OR Questionnaire) was completed only 113 times, Appendix F (Individual Client Record) for only 260 clients, and Appendix H (WHO Alcohol, Smoking and Substance Involvement Screening Test) only 208 times. Complete baseline information through administration of the comprehensive assessment tools is only available for 24 clients.

Ideally, baseline data would have been available for the minimum 386 study participants to generate statistically relevant conclusions about the impact of services. Unfortunately, comprehensive baseline data is extremely limited and compromises the possibility of deriving meaningful conclusions about effectiveness of needle and syringe distribution on HIV transmission in Cebu. Given this important constraint, this evaluation will limit its review and conclusions regarding the PWID-OR component of the BCP and further, quantitative review of project data will be analyzed in the next section evaluating the BCP's overall performance.

As an example, although serological testing for HIV at baseline covered 100 percent of participants enrolled in the OR, the process and results of serological testing will be discussed in the next sections of the evaluation report.

Further discussion regarding service delivery and follow-up will also be discussed in the next section covering the BCP's overall performance.

End line Assessment

At the time of the evaluator's visit to Cebu, no end line data had been collected and the majority of project workers were unaware of plans to initiate end line data collection. End line assessment was expected only if PWID-OR, including distribution of sterile injecting equipment, had been resumed. PWID-OR could not effectively be implemented given the compromised timelines and political challenges.

Performance Evaluation

At the time of the evaluation in December 2015, there was sufficient evidence to conclude that the OR component of the BCP did not conclusively demonstrate within the project timelines the impact of the distribution of sterile injecting equipment on HIV transmission among PWID. Without complete baseline data for the minimum 386 clients, with no end line data to compare results to, and compromised timelines—much of it beyond the control of the implementing agencies—it is clear that no conclusions can be formulated regarding the effectiveness of needle and syringe distribution on reducing HIV transmission. However, despite this critical quantitative limitation, it is important to look back and draw key lessons learned from the process based on qualitative findings from the overall analysis.

Despite the lack of hard evidence regarding the effectiveness of needle and syringe distribution in Cebu, the BCP implementation team and partners should be commended for generating significant positive results. For example, Resolution 298 is largely the result of concerted advocacy efforts, which represents a significant milestone in drug policy advocacy in the Philippines. Similarly, the integration of the KC3 in the local government office is an important achievement that legitimized the efforts in Barangay Kamagayan.

Mobilizing local government support for the PWID component of the BCP was an important achievement despite the lack of sustainability of such arrangements. Local government officials from the DOH, the Mayor's office, and the local Barangay played important roles in negotiating the requirements for the project to be allowed to be initiated. Technical support was also mobilized locally from the Social Hygiene Clinic where some PWID had been getting sterile injecting equipment before the start of the BCP. A tentative truce was negotiated with the police through Resolution 298 that seemed to be effective in limiting arrests of clients around the KC3. In essence, the project team was able to mobilize significant multisectoral support locally to initiate and carry out the majority of project activities.

It is also worth pointing out that the efforts deployed by the project workers to obtain genuinely informed consent and protect client confidentiality was sustained as a core value throughout the performance of their duties.

Needle and syringe distribution operated only from December 1, 2014 to April 30, 2015, because of both a lengthy process to secure the necessary approvals and a targeted political media campaign that polarized issues around the implementation of the OR. This situation was compounded with earlier delays in the start-up phase because of revised contracts between donors and implementers, and in the end, only five months' worth of needle and syringe distribution data is available.

Though implementation of the OR was negatively affected by many external factors, the development of a project risk assessment plan could have identified these external bottlenecks and developed contingencies, accordingly. In addition, knowing the

criminalized nature of needle and syringe distribution in the Philippines, the OR should have included a very targeted external communications and policy advocacy plan with activities to ensure continued support of key stakeholders. Finally, the BCP team should have developed strategies to mobilize support from members of the Technical Working Group.

BCP Implementation

BCP Implementation Results

Originally, the BCP was designed to reduce HIV transmission and increase demand and uptake of comprehensive health services among PWID through improved peer-led DIC and outreach services. Though limited conclusions can be drawn about the effectiveness of the intervention package, an analysis of project data collected through regular M&E mechanisms will provide insight into the BCP’s overall performance. As with the OR component, the M&E records were often incomplete. That said, sufficient project data was made available to the evaluator to assess overall project performance.

The performance of the BCP cannot be evaluated against specific indicators intrinsic to the project as those were specifically designed to meet the requirements of the OR. However, implementation of the BCP can be assessed with regard to coverage against recommendations formulated by the UN agencies,⁷⁴ and good practices and lessons learned can be identified to determine overall performance.

The results presented in the following paragraphs are organized according to the overall programmatic structure, as described in Figure 4. Essentially, the results of the PWID component of the BCP in Cebu are organized around three programmatic pillars: basic health services, demand reduction services, and community development services.

BCP Reach

A total of 1,042 PWID were reached by the KC3 services between October 2014 and December 2015 (see Table 4). Clients were from 14 municipalities, with the majority from Cebu City (n = 788; 76 percent) and Mandauae, the second most important municipality (n = 34; 3 percent). This implies that in a 15-month period, the KC3 services covered 32–39 percent of the estimated PWID in Cebu City based on the latest population size estimates of 2,000 to 2,500 PWID.⁷⁵

Table 4. Schedule of Enrollment of KC3 Clients

Month	Number of Clients Enrolled
October 2014	49
November 2014	174
December 2014	277
January 2015	332
February 2015	60
March 2015	20
April 2015	0

⁷⁴ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.

⁷⁵ Harm Reduction International. 2014. *Global State of Harm Reduction*; Tac-an, I. A., G. Bellimac, and Z. Pengfei. 2012. *Advocacy Briefing Paper: A Time for Urgent Action - Responding to the HIV Epidemic Among People Who Inject Drugs in Cebu City*.

Month	Number of Clients Enrolled
May 2015	0
June 2015	2
July 2015	6
August 2015	14
September 2015	2
October 2015	n.a.
November 2015	n.a.
December 2015	n.a.
<i>No data</i>	106
TOTAL	1,042

Clients were from 60 Barangays, with the highest number from Kamagayan. Table 5 summarizes the distribution of the KC3 clients across the most important Barangays for the project. This shows that the BCP was effective at reaching PWID even beyond the immediate target ‘safe zone’ and managed to attract a significant number of PWID clients to receive services in Kamagayan. This also shows that there is considerable demand for client-centered HIV prevention services for PWID.

Table 5. Barangay of Residence for KC3 Clients

Barangay	Number of Clients
Kamagayan	76
Apas	11
Basak Pardo	36
Campurthaw	51
Capitol	19
Cogon Ramos	16
Day-as	16
Guadeloupe	42
Labangon	38
Lahug	34
Lorega Miguel	59
Mabolo	30
Mambaling	17
Pasil	16
Sambag 2	26
Zanto Niño	16
T. Padilla	48
No data	240

Though there was limited M&E data available to track number of client visits at the KC3 during the 15 months of operations, discussions with project workers indicate that between 50 and 60 clients visited the DIC per day while sterile injecting equipment was being distributed. However, after suspension of the distribution at the end of April 2015, attendance at the KC3 dropped to 10–15 client visits per day. A DOH representative expressed admiration for the achievements of the KC3 team noting that:

“KC3 is the strongest, most effective mechanism to reach people who inject drugs and facilitate access to a comprehensive package of health services in Cebu, if not all of the Philippines.” Key informant.

Overall, the PWID component of the BCP in Cebu reached a considerable number of PWID from a range of locations in and around Barangay Kamagayan. The reach of the project indicates that the services were sufficiently attractive for clients to undertake journeys to the KC3. Participants in focus group discussions repeatedly described the KC3 as a unique initiative and underlined that they felt greater trust toward the KC3 services compared to other health and HIV prevention services.

Distribution of Commodities

With regard to the distribution of sterile injecting equipment, the KC3 team was able to operate this service only for five months, between December 2014 when Resolution 298 was issued and April 2015 when the services were suspended due to political pressures. During the five months the services were operated, the KC3 team distributed a total of 37,322 sterile needles and syringes (Terumo, #27) across 2,199 client-contacts, or an average of 16 needles and syringes per client-contact per month. If the service had been sustained and performance maintained, this would have provided an effective coverage of 196 needles per client per year. Such coverage is considered high by the UN guidelines and it is worth highlighting that such results, achieved in such a short time and in such a challenging implementing environment, are even more commendable.

The KC3 needles are generally distributed in packs of five and labeled with a sticker from the ROMP. A weekly limit of 10 needles and syringes was put in place. Unfortunately, despite the very high coverage among the KC3 clients, incidents of theft of injecting equipment were reported by project workers, indicating a significant unaddressed gap in the needle and syringe market. Key stakeholder interviews and focus group discussions revealed that clients stole injecting equipment to resell, again indicating that many PWID have not been covered by the project and that demand for such services remains very high. Nonetheless, all clients interviewed expressed a significant preference for collecting free sterile injecting equipment from the KC3 over the Cebu City Health Center or compared to purchasing from private sector pharmacies. Clients described the services at the KC3 as friendly, client-centered, tailored to their needs, and comfortable and free of stigma and discrimination.

The KC3 team also collected a total of 32,116 used needles and syringes through 1,501 client-contacts or an average of 15 used needles per client-contact. The KC3 performance results are summarized in Table 6. Used injecting equipment is collected by the project workers in disposal boxes using universal precautions on a daily basis while special clean-up activities have been organized with clients and community members. During one clean-up day, up to 40 kg of used injecting equipment was collected in large barrels for disposal. However, the local hospital does not have an incinerator and disposal is often delayed, leaving potentially unsecured quantities of unsterile injecting equipment in the open and reports confirm that a number of clients have broken into the disposal barrels to get injecting equipment. Additional reports from early in the project implementation life cycle indicate that issues were raised about unsecured unsterile blood products at the KC3. However, these issues were thoroughly addressed by PSI and no additional incidents have occurred in relation to used injecting equipment and blood products at the KC3 after the first year.

Table 6. KC3 Needle Distribution and Collection Results

Month	Number of Needles and Syringes Distributed	Number of Client-Contacts for Needle and Syringe Distribution	Ratio of Needles and Syringes Per Client	Number of Needles and Syringes Collected for Disposal	Number of Client-Contacts for Needle and Syringe Disposal
October 2014	n.a.	n.a.	n.a.	n.a.	n.a.
November 2014	n.a.	n.a.	n.a.	n.a.	n.a.
December 2014	2,591	202	13	3,262	254
January 2014	11,747	766	15	8,633	348
February 2015	12,350	639	19	4,089	403
March 2015	7,419	354	21	5,096	302
April 2015	3,215	238	14	2,036	194
May 2015	n.a.	n.a.	n.a.	n.a.	n.a.
June 2015	n.a.	n.a.	n.a.	n.a.	n.a.
July 2015	n.a.	n.a.	n.a.	n.a.	n.a.
August 2015	n.a.	n.a.	n.a.	n.a.	n.a.
September 2015	n.a.	n.a.	n.a.	n.a.	n.a.
October 2015	n.a.	n.a.	n.a.	n.a.	n.a.
November 2015	n.a.	n.a.	n.a.	n.a.	n.a.
December 2015	n.a.	n.a.	n.a.	n.a.	n.a.
TOTAL	37,322	2,199	16	23,116	1,501

Since the distribution of sterile injecting equipment was suspended, demand for bleach has increased significantly, as reported by key stakeholder interviews and focus group discussions. It is worth pointing out that there was a high degree of agreement among project workers and key stakeholders related to the KC3 that distribution of additional equipment should be seriously considered. For example, bleach, alcohol swabs, tourniquets, and cotton balls were requested by the majority of clients interviewed.

A partnership with the ROMP project has led to a public awareness campaign in Kamagayan where large posters remind PWID to clean their injecting equipment if it is not sterile (see Figure 6 and media reports⁷⁶).

⁷⁶ Cabaero, N. B. 2015. "Cabaero: 'Ayaw'g puli-puli.'" *SunStar Cebu*, May 25. <http://www.sunstar.com.ph/cebu/opinion/2015/05/25/cabaero-ayawg-puli-puli-409446>; Gonzales, G. A., P. Bilar, and O. C. Manlosa. 2015. "Unsay pasabot sa 'ayaw'g puli-puli'?" *SunStar Philippines*, May 13. <https://www.youtube.com/watch?v=DtOPriDK5RU>.

Figure 6. Public Awareness Campaign Operated by ROMP



During the implementation of the BCP in Cebu, a total of 7,785 male latex condoms were distributed to project clients (see details in Table 7). The KC3 condoms are prepackaged and each pack contains three individually wrapped condoms. Clients were also provided with free sachets of lubricant though there is no official record of their distribution.⁷⁷ In total, the project team recorded 660 condom distribution contacts, implying that about 12 condoms (or four packs) were distributed on average for every client-contact. In the end, the KC3 condom coverage among all its clients is 7.5 condoms per person over the 11-month period when condoms were being distributed and data recorded to that effect.

Table 7. Summary of Condom Distribution to KC3 Clients

Month	Number of Condoms Distributed (Packs of 3)	Number of Client-Contacts for Condom Distribution
October 2014	n.a.	n.a.
November 2014	n.a.	n.a.
December 2014	90	14
January 2014	190	3
February 2015	0	0
March 2015	157	20
April 2015	144	18
May 2015	0	0
June 2015	368	148
July 2015	654	214
August 2015	721	195
September 2015	104	21
October 2015	167	27
November 2015	n.a.	n.a.
December 2015	n.a.	n.a.
TOTAL	2,595	660

⁷⁷ Focus group discussions and key stakeholder interviews revealed that lubricants were initially included in the packs with condoms; however, clients reported discarding the lube so the project team decided to make the lube 'optional' and the sachets can be collected on a voluntary basis.

While the UN guidelines recommend a minimum coverage of 50 condoms per person per year and a high coverage of 100 condoms per person per year,⁷⁸ the KC3 results fall well short of these targets. However, knowing that consistent condom use among PWID in the Philippines is extremely low, the results achieved by the BCP implementation of condom distribution are important in scale and scope. Despite these important achievements, there was virtually no mention of condoms in focus group discussions with clients or key informant interviews.

In addition, the KC3 team confirmed that condoms were being distributed as early as October 2014 all the way through to December 2015. Unfortunately, regular M&E data records were incomplete, so it is likely that the results presented here are an underestimation of the project achievements.

Condoms and injecting equipment are stocked at the KC3. The project commodities are stored on the outdoor balcony of the third floor office, under plastic tarps. While the limited amount of physical space in the KC3 explains why commodities are stocked in such a way, exposure to the elements will inevitably reduce those commodities' shelf-life while leaving project commodities unsecured could lead to negative political, legal, and health consequences. In parallel, there was no evidence of a proper stock management system—from bin cards to performing physical counts of commodities.

HIV Testing

Out of the 1,042 PWID who were reached by the KC3 services, 1,039 were tested for HIV (99.7 percent) by trained medical professionals at the KC3 center. Table 8 summarizes the results of HIV testing from the KC3 services. Such coverage of project clients is impressive and warrants recognition, especially given that data show that only fewer than 10 percent of PWID have been tested for HIV in the Philippines.⁷⁹ Similarly, the results achieved in relation to HIV testing under the BCP are significant given that the UN agencies recommend a minimum coverage of 40 percent and consider coverage above 75 percent as high coverage.⁸⁰

Table 8. Schedule of HIV Testing Among KC3 Clients

Month	Number of KC3 Clients Tested for HIV	HIV- at Baseline	HIV+ at Baseline
October 2014	77	39	38
November 2014	220	101	119
December 2014	216	92	124
January 2014	325	182	143
February 2015	61	33	28
March 2015	21	9	12
April 2015	0	0	0
May 2015	0	0	0
June 2015	17	11	6
July 2015	19	12	7

⁷⁸ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.

⁷⁹ HIV and AIDS Data Hub for Asia and the Pacific. Undated. *Philippines Country Profile*. <http://www.aidsdatahub.org/Country-Profiles/Philippines>.

⁸⁰ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.

Month	Number of KC3 Clients Tested for HIV	HIV- at Baseline	HIV+ at Baseline
August 2015	19	11	8
September 2015	16	10	6
October 2015	25	9	16
November 2015	21	13	8
December 2015	2	1	1
<i>No data</i>	3	<i>n.a.</i>	<i>n.a.</i>
TOTAL	1,042	523	516

Clients who tested positive on an HIV test were referred to the Cebu City Social Hygiene Clinic. Unfortunately, referral data was not integrated in the regular M&E mechanisms and it was impossible for the evaluation team to determine follow-up actions. However, focus group discussions with clients indicated that all those who were living with HIV were now on ART.

Table 9 shows that out of the 1,039 clients who were tested at baseline, only 224 came back for a second test, 46 came back for a third test, and 12 for the fourth end line test. The OR protocol required that at least four HIV tests be conducted during the 24-month study period. At repeat, a total of 13 clients were identified with serodiscordant results compared to the baseline test—all 13 clients were identified after about three months after baseline testing. No additional serodiscordant results compared to baseline were identified at the third and fourth tests.

Table 9. Schedule of HIV Retests at KC3

Month	Repeat1 (#NR->R)	Repeat2	Repeat3
October 2014	n.a.	n.a.	n.a.
November 2014	n.a.	n.a.	n.a.
December 2014	n.a.	n.a.	n.a.
January 2014	7 (1)	n.a.	n.a.
February 2015	21	n.a.	n.a.
March 2015	10 (1)	n.a.	n.a.
April 2015	0	n.a.	n.a.
May 2015	4	1	n.a.
June 2015	43 (1)	3	n.a.
July 2015	30	4	n.a.
August 2015	31 (1)	7	n.a.
September 2015	31 (1)	10	3
October 2015	21 (5)	8	2
November 2015	26 (3)	8	6
December 2015	0	5	1
TOTAL	224	46	12

Note: #NR->R =

Out of the 523 KC3 clients who tested negative for HIV, only 112 came back for a second test, only 26 for a third test, and only 9 for the fourth end line test. While efforts should have been deployed by the KC3 team to focus their interventions on the 112 PWID who tested negative for HIV to retain and retest them, there seems to have been no specific efforts to do so. However, it is important to note that the KC3 services had been presented to the community and potential clients as a source of sterile injecting equipment; when distribution was suspended, clients' motivation to return to the KC3—and get retested—

dropped dramatically. Despite efforts to reincentivize clients by providing free multivitamin packs, clients' return visits to the DIC were significantly reduced and compromised opportunities for retesting.

Evidence in the BCP M&E records shows that 235 clients received a confirmation test from the Cebu City Social Hygiene Clinic. Among the 516 PWID who tested positive for HIV at the KC3, only 228 received a confirmation test. Despite the low coverage with regard to confirmatory testing, the testing conducted at the KC3 is robust and conforms to national protocols and expectations set forth by the DOH with regard to HTC. Finally, it is worth pointing out that several PWID clients have highlighted the importance of HIV testing services and its impact on their lives, particularly with regard to managing their health better. The KC3 clients reported that they felt comfortable accessing HTC services at the DIC and felt confident about the capacity of the KC3 workers.

Testing for Viral Hepatitis and STI

Out of 1,042 clients reached by the KC3 services, 801 (76.9 percent) received on-site serological screening for HCV. Again, the coverage of project clients is impressive and though there are no clear HCV testing coverage recommendations, it can be assumed from the recommendations from the UN agencies on HIV testing that coverage above 75 percent should be considered high.

Table 10 shows that 688 of the 801 KC3 clients who received serological screening for HCV were reactive at baseline (85.9 percent). Furthermore, it is important to note that of the 516 clients who tested positive for HIV at baseline, only 5 were nonreactive to HCV compared to 372 who were reactive. This shows that a very high proportion of PWID are coinfecting with both HIV and HCV. However, key stakeholders' interviews and focus group discussions confirmed that there were no options available for treatment of HCV for PWID in Cebu.

Table 10. Schedule of HCV Testing and Retests at KC3

Month	Number of KC3 Clients Tested for HCV	Number of KC3 Clients Reactive at Baseline	Repeat1 (#NR->R)	Repeat2	Repeat3
October 2014	4	4	n.a.	n.a.	n.a.
November 2014	96	86	n.a.	n.a.	n.a.
December 2014	120	108	n.a.	n.a.	n.a.
January 2014	304	250	3	n.a.	n.a.
February 2015	73	65	7	n.a.	n.a.
March 2015	21	21	5	n.a.	n.a.
April 2015	0	0	0	n.a.	n.a.
May 2015	1	0	3	1	n.a.
June 2015	37	33	26	2	n.a.
July 2015	31	27	20	2	n.a.
August 2015	28	22	27	2	n.a.
September 2015	29	21	24 (1)	5	3
October 2015	29	26	18	8	1
November 2015	26	24	25	8	1
December 2015	2	1	4	2	0
TOTAL	801	688	162	30	5

Note: : #NR->R =

Project data also shows that only 162 clients returned for a retest after three months, only 30 returned after six months, and only 5 returned after nine months. Data also show that among those who were retested, only one test yielded serodiscordant results from nonreactive at baseline, at the first retest. It is also worth pointing out that though coverage was high, clients who returned for retests were all HCV reactive at baseline. As noted above with regard to HIV testing, the KC3 team would have done well to develop targeted strategies with nonreactive clients to prevent HCV transmission. In parallel, given the high prevalence of HCV among the KC3 clients, additional information, education, and communication materials could have been developed to raise awareness regarding prevention of transmission, management of the liver, and options for treatment.

In contrast to HCV testing, 416 KC3 clients received HBV testing (40 percent). Coverage is comparable to the minimum coverage levels recommended by the UN agencies for HIV testing. Table 11 shows that out of the 416 KC3 clients who received serological screening for HBV, only 85 came back for retest after three months, 13 after six months, and 4 after nine months.

Table 11. Schedule of HBV Testing and Retests at KC3

Month	Number of KC3 Clients Tested for HBV	Repeat1 (#NR->R)	Repeat2	Repeat3
October 2014	2	n.a.	n.a.	n.a.
November 2014	92	n.a.	n.a.	n.a.
December 2014	1	n.a.	n.a.	n.a.
January 2014	2	n.a.	n.a.	n.a.
February 2015	44	5	n.a.	n.a.
March 2015	10	0	n.a.	n.a.
April 2015	0	0	n.a.	n.a.
May 2015	3	1	1	n.a.
June 2015	52	11	1	n.a.
July 2015	44	6	2	n.a.
August 2015	46	10	1	n.a.
September 2015	41	17	1	n.a.
October 2015	38	16	1	2
November 2015	39	16	4	1
December 2015	2	3	2	1
TOTAL	416	85	13	4

Finally, out of the 1,042 KC3 clients, 699 were tested for syphilis (67 percent), a significant proportion again indicating high service coverage. Table 12 summarizes the schedule of testing and retests for syphilis among the KC3 clients.

Table 12. Schedule of Syphilis Testing and Retests at KC3

Month	Number of KC3 Clients Tested for Syphilis	Repeat1 (#NR->R)	Repeat2	Repeat3
October 2014	76	n.a.	n.a.	n.a.
November 2014	211	n.a.	n.a.	n.a.
December 2014	154	n.a.	n.a.	n.a.
January 2014	43	n.a.	n.a.	n.a.
February 2015	30	18	n.a.	n.a.
March 2015	4	0	n.a.	n.a.
April 2015	0	0	n.a.	n.a.

Month	Number of KC3 Clients Tested for Syphilis	Repeat1 (#NR->R)	Repeat2	Repeat3
May 2015	2	2	1	n.a.
June 2015	28	34	1	n.a.
July 2015	25	25	2	n.a.
August 2015	32	21	4	n.a.
September 2015	31	22	6	2
October 2015	31	18	7	0
November 2015	30	20	7	3
December 2015	2	0	5	1
TOTAL	699	160	33	6

Across all the KC3 serological testing activities, a total of 411 clients were tested for HIV, HCV, HBV, and syphilis. In addition, comparing results across the four tests shows significant coverage at baseline, with a 20 percent to 22 percent return rate for the first retest after three months. At the third and final retest, clients return rates drop dramatically low, at around 1 percent for all four tests. Table 13 summarizes the coverage results achieved with the KC3 serological testing.

Table 13. Proportion of Clients Covered by Serological Testing

	Baseline Testing (%)	1st Retest (%)	3rd Retest (%)
HIV	99.7	21.6	1.2
HCV	76.9	20.2	0.6
HBV	39.9	20.4	1.0
Syphilis	67.1	22.9	0.9

Other Basic Health Services

All 1,042 KC3 clients were provided with a free health checkup at baseline. Additional services were provided free of charge to the KC3 clients on a voluntary basis. Significant efforts were invested to improve hygiene and general cleanliness among the KC3 clients. Special social events were organized to mobilize both clients and community members—on bath day and on haircut day—where facilities and equipment like soap, toothbrushes, and toothpaste were provided free to the KC3 clients.

All clients were encouraged to enroll in regular demand reduction and harm reduction counseling sessions with the KC3 staff. Counseling sessions are conducted in private with trained counselors. Harm reduction counseling sessions were in high demand, with an average of 1.9 harm reduction counseling session for all the 1,042 KC3 clients. In contrast, drug demand counseling was less popular, with only 224 recorded sessions. However, since August 2015, the KC3 team has established a partnership with the Society for the Divine Word, which facilitates weekly NA sessions accessed on a voluntary basis by the KC3 clients. There was no M&E data available but focus group discussions with clients indicated great appreciation for these sessions. Clients also noted that counseling sessions had been useful in developing strategies to control their drug use, reduce the frequency of their consumption, and seek assistance from professionals to better manage their drug use, their health, and their lives.

The cessation of needle and syringe distribution at the KC3 had a significant impact on the uptake of health services among clients starting May 2015. However, the KC3 team developed an innovative approach to incentivize clients to return to the DIC and continue to access basic health services. The KC3 team initiated distribution of multivitamin packs

in May 2015, which successfully motivated a number of clients to return to the DIC. A total of 1,201 multivitamin packs were distributed, providing 1.15 packs for every KC3 client.

Meanwhile, spotty M&E records show that very few referrals were completed but discussions with the KC3 staff indicates that many more clients were referred to expert health services. Specifically, key stakeholder interviews with representatives from the Cebu City Health Office indicated that 40 to 50 KC3 clients were being referred to their clinic on a monthly basis while needle and syringe distribution was in operation. However, the same stakeholders noted a drastic decrease in referrals to fewer than five per month after distribution of sterile injecting equipment was suspended.

Table 14. Summary of Results from Basic Health Services

Month	Number of Multivitamin Packs Distributed	Number of Demand Reduction Counseling Sessions	Number of Harm Reduction Counseling Sessions	Number of KC3 Client Referrals
October 2014	n.a.	n.a.	n.a.	n.a.
November 2014	n.a.	n.a.	n.a.	n.a.
December 2014	n.a.	n.a.	n.a.	n.a.
January 2014	n.a.	n.a.	n.a.	n.a.
February 2015	n.a.	n.a.	n.a.	n.a.
March 2015	n.a.	109	610	n.a.
April 2015	n.a.	115	689	n.a.
May 2015	45	0	11	n.a.
June 2015	257	0	0	1
July 2015	197	0	50	4
August 2015	212	0	221	8
September 2015	231	0	190	5
October 2015	259	0	225	6
November 2015	n.a.	n.a.	n.a.	n.a.
December 2015	n.a.	n.a.	n.a.	n.a.
TOTAL	1,201	224	1,996	24

Drug Dependence Treatment and Rehabilitation

The KC3 team has established a partnership with the Argao TRC, located about 160 km away from Cebu City. The Argao TRC is a closed government-certified facility that offers a strict Daytop therapeutic community treatment model with cold turkey approaches, with minimum seven months inpatient commitment followed by nine months of aftercare and follow-ups.

At the time of the evaluation in December 2015, there were 130 clients at the Argao TRC over a capacity of 100 beds, though the center was in process of expanding its capacity to 150 beds. Based on a sample of 161 records reviewed, the majority of clients at the center were referred through the criminal justice system (87 percent) while others were committed to the center by family members (13 percent). The majority of clients used *shabu* (46 percent), cannabis (36 percent), and nalbuphine hydrochloride (injected) (16 percent). Admission to the center costs PHP 3,000 per month and clients are not allowed to leave until the program is completed. Escapees are returned to the center and the duration of their detention increased.

Box 1. Drug Dependence Treatment

In 2012, the UN agencies released a joint statement calling on member states to close compulsory drug detention and rehabilitation centers without delay and to release the individuals detained therein.⁸¹ Such centers have been generally characterized as ineffective, unsafe for clients, costly and insufficiently capacitated, and that a great proportion of detainees there may not be clinically dependent and, therefore, in no need of intensive inpatient services.⁸² Instead, the UN agencies recommend that drug dependence treatment be based on the following principles:⁸³

- Multiplying treatment options on offer will better meet client's individual needs
- Evidence-based treatment options
- Selection of treatment options by the client on a voluntary basis, without coercion or pressure
- Culturally tailored and relevant treatment options
- Respect for human rights, guarantee of ethical compliance, and safeguarding clients' well-being and security
- Meaningful participation and engagement of the community (civil society, peer groups, people who use drugs)
- Integration of key interventions in low-threshold⁸⁴ health service outlets
- Multisectoral coordination and collaboration, especially between public health and public security

Nine KC3 clients were referred to the Argao TRC and voluntarily enrolled in the inpatient treatment program. All the KC3 clients were exempted of monthly fees. Though coverage here is very low, focus group discussions with the Argao TRC staff and the nine remaining KC3 clients at the center as well as key stakeholder interviews revealed that the BCP implementation has stimulated demand for drug treatment and rehabilitation services. More specifically, the KC3 clients who volunteered to register at the Argao TRC would not have done so without the KC3 services.

Without the KC3 counseling services, I know that my son would never have voluntarily enrolled in a drug treatment program. – Mother of KC3 client at Argao TRC.

My husband told me about this place [KC3] and that he wanted to volunteer for drug treatment in Argao, but I didn't believe him. It was just another one of his empty promises. But once I came to KC3 and met with the drug dependence counselor, the people here convinced me that my husband's situation can improve. – Wife of KC3 client at Argao TRC.

Focus group discussions with the TRC staff also indicated that the KC3 clients are considered more motivated to change and easier to manage most likely due to the fact that they volunteered instead of being forced into treatment. The TRC staff also noted that

⁸¹ UN (United Nations). 2012. *Joint Statement on Compulsory Drug Detention and Rehabilitation Centres*. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf.

⁸² Tanguay, P., A. Kamarulzaman, A. Aramrattana, A. Wodak, N. Thomson., R. Ali, G. Vumbaca, G. Lai, and A. Chabungbam. 2015. *Discussion Paper: Transition from Compulsory Centres for Drug Users to Voluntary Community-based Treatment and Services*.

⁸³ UNODC (United Nations Office on Drugs and Crime) and WHO (World Health Organization). 2008. *Principles of Drug Dependence Treatment*.

⁸⁴ Low-threshold services for people who use drugs have been defined as those that are easily accessible; do not impose abstinence from drugs as a condition of service access; and endeavor to reduce other documented barriers to service access. For more on low threshold services, see Islam, M. M., et al. 2013. "Defining a Service for People who Use Drugs as 'Low-threshold': What Should be the Criteria?" *International Journal of Drug Policy* 24: 220–222.

the KC3 team had been instrumental in building confidence among clients and community members.

Focus group discussions with the KC3 clients at the Argao TRC revealed that clients were grateful for the opportunity to access free drug dependence treatment at the Argao TRC. There was consensus among the KC3 clients currently enrolled in rehabilitation at the Argao TRC that there were few other options for drug dependence treatment available to them—even accessing the Argao TRC on their own would have been very challenging for mainly financial and legal reasons. Clients indicated that they felt safe, significantly more so compared to being in prison. Many of the clients expressed a desire to apply for peer educator jobs upon release from the center. One of the clients interviewed at the Argao TRC worked as a peer educator at the KC3 before enrolling and initiating this rehabilitation program.

Focus group discussions with families of the KC3 clients at the Argao revealed immense gratitude for the opportunity to access free drug treatment. One family member noted the significant financial savings that were generated:

He used to spend about PHP 6,000 per month to buy drugs. Now, I have more money take care of the family. My kids eat better food! – Wife of KC3 client at the Argao TRC.

Overall, the nine clients and their family members who were interviewed during the evaluator's visit to the Philippines in December 2015 showed a high level of satisfaction and appreciation for the opportunity to enroll and benefit from the KC3 partnership with the Argao TRC.

Community Development Services

As noted earlier in the section covering the operation research component, significant efforts were invested by the project team to develop an enabling environment for the PWID component of the BCP to be implemented in Cebu. The previous section has highlighted how efforts made to obtain a legal exemption to Section 12 of the Comprehensive Dangerous Drugs Act of 2002 were rewarded with the passing of Resolution 298: Approving the Proposed Operations Research on Community-Based Comprehensive Services for People who Inject Drugs (PWID) in Barangay Kamagayan, Cebu City and the Creation of a Technical Working Group (TWG) that will Formulate its Implementing Guidelines, that approved legal implementation of needle and syringe distribution in the context of scientific research. The same section of this report underlined how the project team was able to mobilize local government support from a wide range of agencies to initiate the project, how strategic partnerships contributed to mobilizing approvals, and how the KC3 operations were integrated in local government units at the Barangay level. The assessment of the OR also showed that efforts were deployed to strengthen the capacity of the project workers, clients as well as other key stakeholders involved in the project.

BCP Performance Evaluation

The BCP was designed to reduce HIV transmission and increase demand and uptake of comprehensive health services among PWID through improved peer-led DIC and outreach services. Specifically, the project aimed to reduce needle sharing and increase uptake of HIV testing. National sentinel surveillance data collected in Cebu between April and June 2015 shows that the BCP contributed to achieving these objectives. Integrated HIV/AIDS Behavioral Sentinel Surveillance results from 2015 indicate that sharing of

injecting equipment decreased from 35 percent in 2013 to 25 percent; the proportion of PWID who had not shared needles and syringes at their last injection increased from 31 percent in 2103 to 82 percent; and the proportion of PWID testing for HIV increased from 6 percent in 2013 to 23 percent.⁸⁵

In addition, based on a thorough review of M&E data collected by implementing agencies as well as inputs from focus group discussions and key stakeholder interviews, this evaluation finds that the BCP objectives were largely met. Specifically, data shows a significant uptake in HIV-related services through peer-led outreach and DIC-based services. Coverage among project clients is impressively high for the short implementation period and the multiple challenges encountered. Table 15 summarizes coverage of the KC3 services.

Table 15. Summary of KC3 Service Coverage

Services (Proportion Covered Among All KC3 Clients)	Coverage (%)
HIV	99.7
HCV	76.9
HBV	39.9
Syphilis	67.1
Commodities (Units Distributed Among All KC3 Clients)	Number (units)
Needle and syringe distribution	35.8
Condoms	7.5
Multivitamins	1.2

The KC3 clients report being very satisfied with the comprehensive package of health services offered under the BCP and feel welcome and accepted at the KC3. Community members in Kamagayan, including family members of the KC3 clients, also praise the service as an excellent intervention. Virtually all key stakeholders interviewed noted that the KC3 team had performed especially well in building trust between clients and their health service providers, families, and community. In that sense, the community around Kamagayan has a very good understanding of the need for free distribution of sterile injecting equipment in their neighborhood.

The KC3 clients, family members, and community representatives also appreciated efforts from the KC3 team to promote demand reduction, through counseling, NA sessions, and privileged access to the Argao TRC. Many key stakeholders interviewed noted that the demand reduction component of the KC3 was often overlooked and misunderstood though the majority felt that integration of demand reduction services would support the legitimacy of harm reduction services and approaches. However, it is not possible to assess to what extent the BCP contributed to supporting abstinence among PWID reached.

One of the most important qualitative achievements of the PWID component of the BCP in Cebu was the rollout of a comprehensive package of HIV prevention, demand reduction, and community development services. Though the distribution of sterile injecting equipment was suspended, the majority of services continued to operate with great success, as indicated by the coverage levels recorded by the project team. In essence, the KC3 became the first and only one-stop-shop where PWID felt comfortable and respected

⁸⁵ DOH (Department of Health). Forthcoming. *Integrated HIV/AIDS Behavioral and Serologic Surveillance*.

and could voluntarily access a wide range of health and social care services without fear of stigma or legal consequences.

The KC3 clients reported great appreciation for the opportunity to become peer educators and those clients who became peer educators explained multiple benefits they now enjoyed, including getting a small salary, reducing their drug use, and feeling valued and valuable. One peer specifically said:

Becoming a peer educator improved my life. I feel more confident, I'm useful and productive, and I help others.

There is great demand and genuine interest among the KC3 and Argao clients to become peer educators and provide support to PWID. The professionalization of PWID through peer educator roles has also reportedly reduced stigma and discrimination and increased acceptance of PWID in the community. Should services for PWID be scaled up in Cebu and beyond, recruiting a workforce of peer educators should not be a critical challenge—an important lesson learned for future harm reduction projects in the Philippines.

Another critical lesson learned is the impact of suspending distribution of sterile injecting equipment. Uptake of the services radically decreased, contacts with the KC3 project workers fell, and referrals almost stopped. Multiple clients were lost to follow up and the bond of trust cultivated by the KC3 workers was suddenly compromised. Several key stakeholders noted the critical enabling role of distributing sterile injecting equipment:

If we don't provide them with needles, they won't come to the clinic even if our services are free. Distribution of sterile injecting equipment is critical to stimulate enrollment in health services and hopefully in treatment for HIV and other infections.

Despite the lack of continuity, it is clear from the evidence analyzed in this report that needles and syringes are in high demand. Stocks remain available from the BCP at the end of the project and those should be used for HIV prevention among PWID, as originally intended.

Though the BCP objectives were largely met, some important areas have been identified as critical gaps. First, the evaluation identified significant weaknesses in M&E. The project did not have a clear M&E framework and while outcome indicators and some output indicators were developed, the data collection and M&E systems did not effectively capture the data to measure performance and data collection was irregular. Project reports do not indicate the rollout of any training or skills building sessions around M&E, data collection, and data analysis. While the absence of data and documentation does not necessarily imply that these activities did not take place, these weaknesses have certainly compromised the opportunity to draw strong conclusions about the role of harm reduction services in Cebu.

Second, significant delays in project setup, mobilizing allies, and securing approvals combined with the cessation of needle and syringe distribution compromised the entire BCP timeline. Originally intended as a 24-month project, services were only delivered for 15 months, only five of which included distribution of sterile injecting equipment. The shortened timeline also compromised the capacity to generate reliable conclusions for the future.

Third, knowing that distribution of sterile injecting equipment is a criminal act in the Philippines, the BCP should, by default, have included provisions for strategic advocacy

interventions across the entire project life cycle. The absence of advocacy staff at the KC3 and the lack of advocacy plans have been identified as critical gaps, especially given the immense political and media pressures exerted on the project. In parallel, the absence of an external communications plan—to regularly keep both allies and opponents supplied with strategic evidence—and dedicated workers to implement communications activities are critical gaps that should have been addressed.

In the same context, when the project attracted the attention of key political figures—Senator Vincente Sotto and Senator Grace Poe—the project implementation team was taken aback and progress slowed significantly, given that their focus was diverted from service delivery and data collection to negotiating what had in their minds been already approved. Though these external challenges could have been foreseen and risk management strategies developed in advance of such events, this by no means implies that foresight and planning could have resolved this very sensitive political issue. However, the legally contentious nature of the project should have compelled the implementer to develop such strategies as well as the DOH and donor agencies to demand such plans be in place as part of their oversight roles. Extensive experience from the region could also have been mobilized to reduce the risk of such vocal opposition, as highlighted in Box 2.

Box 2. Scaling-up Harm Reduction in Southeast Asia

Of the 23 countries in Southeast and South Asia, 17 countries are implementing needle and syringe programs and 15 countries are offering OST to PWID in need.⁸⁶ Across the region, governments have demonstrated their leadership in responding to HIV among PWID by scaling up harm reduction and working toward an enabling legal and policy environment to facilitate service delivery.

In Malaysia, the government had invested RM 69.7 million of the national budget to support the implementation of harm reduction programs through partnerships with civil society organizations by the end of 2011.⁸⁷ Financial contributions for NSEP between 2006 and 2015 show that 69 percent of funds came from national donors, compared to 31 percent from external sources.⁸⁸ Overall, the government of Malaysia has demonstrated that early interventions with significant investments in harm reduction service delivery targeting PWID are effective at reducing HIV transmission. WHO has also recognized Malaysia's investment of national resources as a model of good practice,⁸⁹ while the Bank's assessment of return on investment and cost-effectiveness of harm reduction programming in Malaysia shows conclusively that even with the present moderately low coverage, priority harm reduction services such as distribution of sterile injecting equipment and OST are effective and cost-effective interventions for averting HIV infections.⁹⁰

Driven by the rapid spread of HIV, Vietnam's response to drug use has undergone significant transformation in the past decade. The last decade has witnessed a progressive change in the mindset of political leaders in Vietnam around illicit drug use and HIV issues. This has led to adoption of evidence-based interventions and the evolution of drug policy that support the scale-up of these interventions. Significant policy changes have allowed the implementation of HIV prevention and drug dependence treatment services. In 2005, the Communist Party and the National Assembly became significantly and proactively involved in the drug and HIV policy-making process. The 2005 Directive No. 54 shows a remarkable shift in the mindset of the Communist Party, shifting away from 'social evils' toward a more holistic and balanced approach. Decree 108, approved in 2007 to guide the implementation of the HIV Law, created a crucial legal corridor for the implementation of a harm reduction program for people who use drugs.⁹¹

⁸⁶ Harm Reduction International. 2014. *Global State of Harm Reduction*.

⁸⁷ Tanguay, P., et al. 2015. *Community-Based Drug Treatment Models for People who Use Drugs: Six Experiences on Creating Alternatives to Compulsory Detention Centres in Asia*.

⁸⁸ Malaysian AIDS Council. 2015. *Needle and Syringe Exchange Program (NSEP): Marking 10 years of Smart Investment and Revitalizing*.

⁸⁹ WHO (World Health Organization). 2011. *Good Practices in Asia - Effective Paradigm Shift Towards an Improved National Response to Drugs and HIV-AIDS - Scale-up of Harm Reduction in Malaysia*.

⁹⁰ Naning, H., et al. 2015. *Return on Investment and Cost-Effectiveness of Harm Reduction Programme in Malaysia*.

⁹¹ Vuong, T., et al. 2011. "Drug Policy in Vietnam: A Decade of Change?" *International Journal of Drug Policy*.

In an attempt to focus criminal sanctions on drug production and trafficking, Vietnam made a series of revisions to the Law on Drug Control in 2008 and to the Penal Code in 2009 that downgraded drug possession from a criminal to an administrative offence. The Revised Law on Drug Control (2008) acknowledges that drug use is a social problem and that drug users should be provided with treatment instead of punishment. To harmonize the criminal and administrative frameworks, the Law on Handling Administrative Offences was approved in 2012. While the law allowed for diversion of sex workers away from compulsory detention centers, the same considerations were not applied to people who use and inject drugs.⁹² More recently, the government of Vietnam abolished the death penalty for illicit drug possession and procurement.⁹³

Vietnam significantly scaled up access and coverage of core harm reduction services, focusing on distribution of sterile injecting equipment and OST. Reports show substantial and consistent scale-up of harm reduction services in Vietnam from 2005 onward.⁹⁴ More than 1,000 sterile injecting equipment distribution sites were reportedly opened between 2008 and 2011.⁹⁵ Reported estimates from 2011 regarding needle-syringe coverage were very high—with 95 percent of clients accessing a sterile injecting equipment in a 12-month period and 189 needles-syringes per client per year).⁹⁶ Data from 2011 also show a nearly five-fold increase in the number of clients receiving OST in Vietnam,⁹⁷ reflecting rapid expansion of this program.⁹⁸ At the end of 2013, more than 15,000 people were receiving methadone maintenance therapy at 80 clinics and about 26.7 million needles and syringes were distributed to PWID that year.⁹⁹ Vietnam's efforts in scaling up harm reduction have also been acknowledged as a model of good practice by WHO.¹⁰⁰

PSI has implemented health programs targeting PWID since 1996 and covered 11 countries with such projects in 2013. However, since then, PSI's operations targeting PWID have been scaled back significantly, particularly in Asia where harm reduction services implemented by PSI have been suspended in China, the Philippines, and Thailand. Despite a wealth of experience with such projects in very challenging environments,¹⁰¹ PSI in the Philippines was unable to deliver on many of the project objectives. Key stakeholder interviews revealed time and again that significant issues compromised PSI's capacity to deliver on project expectations: start-up delays and political opposition, internal personality conflicts, internal miscommunications, conceptual misunderstandings in the implementation team and among key stakeholders in the Philippines, and limited technical expertise within the team on the ground in Cebu, as well as very limited internal and external oversight.

Finally, the evaluation has identified that project governance structures were largely ineffective. Roles of governance body members were not defined by reference; meetings were rarely held; some people did not even know they were members of the Technical

⁹² Baldwin, S. 2013. "Emerging from a Black Box: Drug Policymaking in Vietnam." *Drug Law Reform in East and Southeast Asia*. Lexington Books.

⁹³ 2015. "Vietnam Abolishes Death Penalty for 7 Crimes." *Al Jazeera*, November 27. <http://america.aljazeera.com/articles/2015/11/27/new-law-in-vietnam-abolishes-death-penalty-for-7-crimes.html>.

⁹⁴ Wilson, D., et al. 2011. *Evaluation of the Epidemiological Impact of Harm Reduction Programs on HIV in Vietnam*.

⁹⁵ Degenhardt, L., et al. 2014. "What has been Achieved in HIV Prevention, Treatment, and Care for People Who Inject Drugs, 2010–2012? A Review of the Six Highest Burden Countries." *International Journal of Drug Policy* 25 (1): 53–60.

⁹⁶ Mathers, B. M., et al. 2010. "HIV Prevention, Treatment, and Care Services for People Who Inject Drugs: A Systematic Review of Global, Regional, and National Coverage." *The Lancet* 375 (9719): 1014–1028.

⁹⁷ Degenhardt, L., et al. 2014. "What has been Achieved in HIV Prevention, Treatment, and Care for People who Inject Drugs, 2010–2012? A Review of the Six Highest Burden Countries." *International Journal of Drug Policy* 25 (1): 53–60.

⁹⁸ Mulvey, K., T. Nguyen, and N. Nhu. 2011. *Setting Up Nationwide Methadone Maintenance Therapy Program: A Vietnamese Case Study*. PEPFAR.

⁹⁹ Kato, M., et al. 2014. "Enhancing the Benefits of Antiretroviral Therapy in Vietnam: Towards Ending AIDS." *Curr HIV/AIDS Rep* 11: 487–495

¹⁰⁰ WHO (World Health Organization). 2010. *Good Practice in Asia: Targeted HIV Prevention for IDU and Sex Workers. Vietnam's first large-scale National Harm Reduction Initiative*.

¹⁰¹ Tanguay, P., and V. Ngamsee. 2015. *CHAMPION-IDU - Innovations, Best Practices, and Lessons Learned - Implementation of the National Response to HIV Among People who Inject Drugs in Thailand 2009–2014*.

Working Group; and members felt ill-equipped to defend and promote the project, given their limited communications with the BCP team. The DDB, the DOH, and PSI should have mobilized the support of members of the Technical Working Group to support both regular advocacy as well as stave off the challenges levied against the project in Cebu. Strong governance mechanisms could have been useful to weather some of the political and media challenges levied against the services offered at the KC3.

CONCLUSION

The ADB and the Bank made significant investments in Cebu to support the development and the strengthening of effective service delivery models targeting PWID, with the ultimate goal of reducing HIV transmission over a 24-month period. A DIC was opened at the Kamagayan Barangay Hall that offers comprehensive drugs and HIV prevention, treatment, care, and support services. Over 1,000 clients accessed a range of services over a 15-month period, with significant coverage achieved. The BCP delivered on the objectives to deliver a comprehensive package of HIV-related services to PWID and its high coverage results demonstrate that rapid and effective scale-up is possible. Indeed, coverage among project clients is impressively high for the short implementation period and the multiple challenges encountered.

The KC3 clients reported being very satisfied with the comprehensive package of health services offered at the KC3 and feel welcome and accepted. Community members in Kamagayan, including family members of the KC3 clients, also praised the service as an excellent intervention. Virtually all key stakeholders interviewed noted that the KC3 team had performed especially well in building trust between clients and their health service providers, families, and community. The KC3 clients, family members, and community representatives also appreciated efforts from the KC3 team to promote demand reduction, through counseling, NA sessions, and privileged access to the Argao TRC.

While the BCP objectives have been largely achieved, the specific objectives under the OR arm were not. The OR component was meant to yield reliable local evidence about the health impact of needle and syringe distribution, but insufficient baseline data, the suspension of needle and syringe distribution (which eliminated the possibility of collecting end line data), and the dramatically shortened implementation period compromised this valuable opportunity, often due to external factors beyond implementing agencies' capacity to redress. Politicians have already mobilized the media and polarized the discussion; local evidence would have been invaluable in addressing many of the concerns that have been raised to date.

Implementation of project activities has also shown that there is great demand among PWID—for needles, syringes, and comprehensive sterile injecting equipment sets; for health and HIV related services; for drug dependence treatment and rehabilitation; and for employment, especially as peer educators.

As of January 1, 2016, Global Fund resources will be channeled through Save the Children to Cebu Plus to take over operations at the KC3 and ensure continuity of services to PWID. Such a handover is especially timely and the Cebu Plus team is enthusiastic and strategically positioned to maintain the KC3 services and potentially expand on the strengths, lessons learned, and good practices identified in this report. To facilitate such a handover, this report includes a set of recommendations specifically related to continuation of health and social care services for PWID.

RECOMMENDATIONS

The following recommendations have been formulated for consideration by local, national, and international agencies working on HIV, drugs, and harm reduction in the Philippines. The recommendations have been formulated against best practice models from across Asia and beyond, to support the strengthening of the national response to HIV among PWID in the Philippines. The recommendations below have been grouped and prioritized to avoid start-up delays, ensure smooth implementation and scale-up of services, and long-term sustainability of the harm reduction response.

1. **Mobilize leadership of the DDB and the DOH:** Efforts should be urgently made to facilitate open and ongoing dialogue between public health officials and public security agencies in the Philippines. A national multisectoral task force could be mandated with overall coordination between various sectors to ensure that national objectives are achieved by all sectors. The DOH should be invited to play a leading role in responding to drug-related issues through effective, evidence-based interventions that are supported and aligned with public security objectives. Similarly, the DDB should be invited to play a lead role in reviewing and amending laws and policies that prevent the government from achieving national goals.
2. **Review and reform drug laws and policies:** Urgently conduct a thorough assessment of the legal and policy barriers generated by drug control mechanisms that hamper implementation of comprehensive HIV prevention services among PWID, including distribution of needles and syringes, and reform those policies to maximize both public health as well as public security outcomes. For example, Section 12 of the Comprehensive Dangerous Drugs Act of 2002 should be reviewed in the context of the original intention of drug control, as enshrined in the international conventions, and facilitate access to essential health services instead of prohibiting effective interventions. In addition, external technical support should be mobilized to strengthen national-level efforts and obtain expert guidance on effective legal and policy measures in the context of effective public health responses to drugs and HIV. The International Drugs Policy Consortium offers such support and advice that can be mobilized through existing technical support mechanisms.
3. **Complete the operations research:** Significant positive quantitative and qualitative results indicate that the PWID component of the BCP in Cebu generated positive results. In this context, it will be critical to complete the OR as soon as possible to generate local evidence that supports the effectiveness of needle and syringe distribution on HIV transmission. It will be imperative to pursue integration of such efforts within other HIV activity frameworks in the Philippines.
4. **Make evidence-based decisions:** The current report is a comprehensive summary of the evidence related to HIV prevention among PWID in the Philippines. The content of this report should be used as an additional tool to inform decisions related to drugs and HIV and support action that aligns with international evidence about effectiveness, cost-effectiveness, and safety of public health interventions. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.

5. **Ensure good governance:** Develop clear terms of reference for members of governing bodies; organize and facilitate regular meetings to troubleshoot and mobilize additional support; ensure wide distribution of project reports to ensure transparency and build trust; conduct regular financial, programmatic, and data audits and address major and minor findings in a timely manner; and consider setting up a community advisory board in hotspots. The DOH, the DDB, and other national agencies should consider increasing their oversight mandate to address obstacles, facilitate integration at national level, and avoid duplication, especially in the context of a challenging legal and policy environment. Similarly, donor agencies as well as other development partners should be ready to provide technical support and assistance to reinforce technical capacity at the national level both for programmatic issues as well as management, including oversight. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.
6. **Strengthen capacity of all project workers:** All the KC3 workers have performed to the best of their abilities, and, where possible, the handover to Cebu Plus should aim to retain as many of the current KC3 workforce. However, there is ample need and interest for additional skills building and training, covering staff, outreach workers, and peer educators. Training and skills building should focus on drugs and drug dependence, HIV and common infections, technical service delivery, and administrative functions like data collection and analysis for M&E. It is therefore recommended that a training needs assessment be performed with the retained KC3 workers and appropriate training sessions organized to ensure adequate capacity within the workforce. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.
7. **Improve monitoring and evaluation:** The challenges encountered in data collection and analysis have compromised many of the project objectives. In this context, it is strongly recommended that a comprehensive M&E framework be developed to capture the appropriate data for project performance analysis and production of local, reliable evidence. A comprehensive M&E framework should clearly spell out linkages between project objectives, service delivery, and performance indicators at outcome, output, and impact levels. Performance frameworks for interventions to address HIV among PWID should be based on the most recent WHO guidelines: the Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations¹⁰² and the Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users.¹⁰³ This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.
8. **Deploy Syrex as a national data management system:** Syrex is a data management system designed and developed by Alliance Ukraine, a key

¹⁰² WHO (World Health Organization). 2014. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations*.

¹⁰³ UNAIDS (Joint United Nations Program on HIV/AIDS), United Nations Office on Drugs and Crime, and WHO (World Health Organization). 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment, and Care for Injecting Drug Users – 2012 Revision*.

partner of the International HIV/AIDS Alliance and currently deployed in 18 countries worldwide. Syrex offers easy-to-use apps on smartphones, linked to a computerized database to track client profiles, service uptake, and a range of other options. Syrex can generate reliable reports adapted and customized to each local harm reduction project that reduces the need for paper-based management. It is strongly recommended that Syrex be integrated as the management information system related to harm reduction service delivery in the Philippines. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.

9. **Meaningfully involve PWID:** PWID are essential participants in the development, implementation, and M&E of any and all interventions that affect their lives. Enshrined in the principles of meaningful involvement of the affected communities, PWID can provide invaluable information to tailor project as well as ongoing insights to ensure effective rollout of services, while enhancing project and programs outputs, outcomes, and impacts. This implies developing mechanisms to ensure meaningful participation and representation of people who use drugs in decisions that affect their lives. The Asian Network of People who Use Drugs can provide assistance to stakeholders in the Philippines with regard to project design, implementation, and evaluation as well as in policy advocacy by informing the decisions of authorities. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.
10. **Develop risk management plans:** Given the experience in implementing the BCP in Cebu, it is strongly recommended that future implementers of health services targeting PWID develop comprehensive risks prevention, mitigation, and recovery plans. These plans should include programmatic, financial, and political dimensions as well as other relevant issues that are likely to hamper implementation. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.
11. **Develop advocacy and communications plans:** In line with recommendation 3, it is strongly recommended that future implementers allocate resources for extensive advocacy and external communications activities, including the development of strategic advocacy and communications plans. Dedicated staff should be hired, trained, and empowered to manage these responsibilities. Targeted efforts should be made to reach out to vocal opponents of the BCP to better understand their position with regard to harm reduction and develop strategies to address those concerns with both evidence and multisectoral support. Additional advocacy efforts should continue to be deployed, targeting community members around the location of harm reduction service access points to prepare and sensitize the community and avoid backlash. Advocacy activities in a challenging legal environment need to be sustained across the entire implementation period to act as a shield against the kind of challenges that the BCP implementation team in Cebu faced. This recommendation should be operationalized up front as soon as a consensus is reached regarding the continuation of the OR and/or harm reduction service delivery.

12. **Coordinate regionally and mobilize technical support:** Consider leveraging support from technical experts based in the region such as the International Drug Policy Consortium through technical support providers such as the French government’s 5 Percent Initiative and UNAIDS Technical Support Facility. Coordination of national efforts with partners across the region—through regional grants and other relevant platforms such as Association of Southeast Asian Nations—could significantly enhance and accelerate the national response by integrating approaches and initiatives from neighboring countries in national systems. Finally, mobilizing high-level political and public support for harm reduction from within the Philippines and beyond would require a coordinated strategy to strengthen capacity of the national media and mobilize their communication channels to normalize harm reduction services and reduce the risk of political opposition.
13. **Expand distribution of sterile injecting equipment:** It is strongly recommended that quantity limits per client be removed and project equipment be specifically labeled ‘FREE – not for sale’ to minimize resale and ultimately maximize coverage, making secondary distribution work positively for the project. It is also strongly recommended that the needles and syringes be nestled in a kit containing other commodities—like bleach, alcohol swabs, cotton filters, and tourniquets—both to improve client health and better meet their needs while shifting the discourse away from the distribution of needles and syringes to the distribution of sterile injecting equipment. The project should also consider the distribution of needles and syringes through a partnership with pharmacy outlets. All these recommendations and suggestions are contingent on obtaining the necessary approvals from government authorities.
14. **Strengthen referral systems and strategies:** It is strongly recommended to rapidly explore opportunities to strengthen referral systems between civil society agencies and government health service providers. Implementation of the BCP demonstrated that important windows of opportunities have been missed in providing targeted information and support to clients. For example, messaging in the context of HIV testing should have focused on those who tested negative to encourage regular retesting. In the same vein, documentation of referrals should be significantly strengthened to allow triangulation of results and confirm that the referral has been completed and that clients are indeed receiving services.
15. **Improve support mechanisms for peer educators:** It is strongly recommended that additional support be provided to peer workers. Access to relapse prevention and general counseling should be included and tools to improve professionalization of peer educators should be adapted from existing resources. In addition, peer worker stipends were insufficient and peer educators regularly used their meager earnings to support clients. Peer workers should be provided with vehicles—bicycles and/or motorbikes—to reach clients more efficiently.
16. **Consider geographical expansion:** Given the very high demand for services among PWID, it is reasonable to assume that the remaining PWID population also has high interest in comprehensive harm reduction and HIV-related services. In that respect, it is recommended that a geographical mapping be conducted to assess opportunities for geographical expansion, with the possibility of opening additional DICs in new locations to reach new clients.

17. **Develop and enforce a drug-free workplace policy:** It is strongly recommended that implementers develop a comprehensive drug-free workplace policy to address significant concerns among government officials. Specifically, concerns were raised often about the presence of illicit drugs in the DIC, particularly given the KC3's location at the Barangay Hall and the children's day-care center operating on the second floor. A comprehensive drug-free workplace policy should focus on providing support rather than retire workers in breach. In addition, posters with clear rules about drugs and drug use in the DIC should be developed and posted to visibly reinforce the objective of a drug-free workplace. It is thus recommended that a set of small lockers be procured for the KC3 and other potential sites where clients can leave their personal belongings securely behind before entering the DIC.
18. **Consider working in prisons:** Key stakeholder interviews and focus group discussions revealed that a significant proportion of people who use and inject drugs are currently incarcerated, that injecting drug use frequently takes place in prisons, and that injecting equipment is often improvised and shared among many prisoners. In this context, there is urgent need to reach prisoners with drug and HIV education and counseling and, where possible, with commodities like condoms and sterile injecting equipment. It is therefore strongly recommended that linkages with prisons be established to access incarcerated clients and to conduct outreach in prison settings.
19. **Consider piloting substitution pilot study:** OST is one of the most effective, cost-effective, and safe interventions that can be implemented to reduce HIV transmission among PWID. Given that nalbuphine hydrochloride is an opioid and expert reports indicate that buprenorphine could be an effective substitute, it is recommended that partners be identified to conduct a clinical trial of buprenorphine substitution among people clinically dependent on nalbuphine hydrochloride.
20. **Consider piloting HCV treatment:** Given the very high rates of HCV among PWID in Cebu, it is strongly recommended that harm reduction implementing partners consider integrating HCV treatment in the package of services. Additional resource mobilization would be required to cover the high costs of medicines though strategic partnerships with academic and/or private sector agencies could contribute to piloting such services on a small scale. Additional investments should urgently be made in developing HCV prevention information, education, and communication materials as well as treatment literacy materials, including local language guides with key messages on managing the liver in the context of drugs and HIV.

ANNEX 1: Detailed Schedule of Visits and Activities in the Philippines for the BCP Evaluation

Date	Location	Details
1-Dec-15	Cebu DOH Office	<i>Attend meetings with Bank Implementation Support Mission Team:</i> <ul style="list-style-type: none"> • Meeting with the DOH Regional Director, Jaime Beranadas • Meeting with the DOH partners • Meeting with City Office on substance abuse prevention/CADAC
2-Dec-15	KC3	<i>Attend meetings with Bank Implementation Support Mission Team:</i> <ul style="list-style-type: none"> • Site visit, including outreach in Barangay Kamagayan, visit to new needle and syringe distribution site • Meeting with the KC3 staff • Meeting with Barangay Chairperson, Raquel Avila
3-Dec-15	KC3	<i>Key stakeholder interview:</i> BCP Program Manager <i>Focus group discussion:</i> five KC3 staff, including one registered nurse, one HIV counselor, one medical technologist, one research associate, and one research encoder
4-Dec-15	Cebu City Health Department Office	<i>Key stakeholder interviews:</i> <ul style="list-style-type: none"> • Ethel Dano, WHO Consultant • Ilya A. Tac-an, Manager, Social Hygiene Clinic, Cebu City Health Office • Marc Arnao, Cebu Plus Site Implementation Officer • Daisy Villa, City Health Officer, Cebu City • Jaime Beranadas, Cebu DOH Regional Director • Boel Wenceslao, DOH-RO7 HIV Program Nurse Coordinators • Mark Espinas, Nurse
5-Dec-15	KC3	<i>Focus group discussion:</i> 17 KC3 clients <ul style="list-style-type: none"> • 9 study participants (8 males and 1 female) and 8 nonparticipant clients
6-Dec-15	Marriott Hotel	<i>Key stakeholder interview:</i> Jerson See, Cebu Plus Executive Director
7-Dec-15	Argao TRC	<i>Key stakeholder interviews:</i> <ul style="list-style-type: none"> • David Baron, Chief of Hospital • Tomas Jonathan D. Refe, Argao Acting Chief Administrator and Program Coordinator <i>Focus group discussion:</i> Argao clients, including nine male clients referred through the KC3 <ul style="list-style-type: none"> • Site visit
8-Dec-15	KC3	<i>Focus group discussions:</i> <ul style="list-style-type: none"> • Five KC3 peer educators (three men, two women) • Seven KC3 clients (six men, one woman) • 13 members of the Kamagayan community (five men, of who two MSM, six women, two TG, and three children)
9-Dec-15	KC3	<i>Key stakeholder interviews:</i> <ul style="list-style-type: none"> • Raquel Avila, Barangay Chairperson • Jun-ray Prada, KC3 Drug Dependence Counselor <i>Focus group discussion:</i> family members of clients currently in Argao TRC (four women, one man, one child)
10-Dec-15	Travel to Manila	
12-Dec-15	Shangri-La Hotel EDSA	<i>Key stakeholder interviews:</i> <ul style="list-style-type: none"> • UNSW Consultant • Independent HIV expert • Bank Process Documenter, Independent Consultant
13-Dec-15	Departure from the Philippines	
16-Feb-2016	Amari Watergate Hotel, Bangkok, Thailand	<i>Key stakeholder interviews:</i> <ul style="list-style-type: none"> • Joselito Feliciano, PNAC, Principal investigator for the BCP PWID-OR

ANNEX 2: Media Coverage

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