④ The National HIV Surveillance System, Operational Pian, Sep.'93-Sep.'94

THE NATIONAL HIV SURVEILLANCE SYSTEM

DEPARTMENT OF HEALTH

REPUBLIC OF THE PHILIPPINES

Operational Plan
Sept 1993 - Sept 1994

Introduction

The National HIV Surveillance Strategy is a systematic and regular collection of information on the distribution and trends of infection in the different high risk groups identified at a given time. This information will be used to develop, prioritize and direct effective education interventions and risk reduction activities. It will also be used to evaluate the effectiveness of the prevention and control strategies of the National AIDS Prevention and Control Program.

This operational plan is for the period September 1993 -September 1994 and has been developed according to the guidelines of the National HIV Surveillance Strategy. The general objective of the National HIV Surveillance System is to provide early warning of increases in HIV infection or the high risk behaviors that may predispose the country to HIV infection so that necessary interventions can be instituted.

The specific objectives of the National HIV Surveillance System are:

1) to provide early warning of dangerous levels of HIV infection;
2) to estimate the incidence/prevalence of HIV infection among the sentinel groups;
3) to monitor trends in HIV infection;
4) to identify surveillance groups or subgroups and sites with high and low risk for infection;
5) to identify risky behavior patterns for HIV transmission;
6) to project future occurrence of HIV infections; and
6) to provide information for prioritizing intervention programs.

Operations

The HIV surveillance system was implemented during the first year after an initial pilot study in 1992. This pilot study, conducted in Baguio City (CAR), pre-tested procedures and protocols. The first round of surveillance was implemented on the second half of 1993 in Quezon City and Cebu City. This surveillance system is a semestral series of testing, each lasting for 8 weeks and adding new sites incrementally until 1997.

Surveillance Sites

Surveillance sites have been selected based on the following criteria:

1. the number of HIV positive individuals identified in a particular area or known to come from the area;
2. availability of risk or sentinel groups;
3. a reliable laboratory is available to perform serologic tests for HIV;
4. geographical representativeness of the site; and

5. on-site staff must be willing to cooperate and be capable of conducting surveillance for at least 5 years.
6. urban/big cities (highest risk geographical areas)
7. data from previous HIV prevalence assessments

The second round will commence in January 1994. This round will involve 4 cities: Quezon City (NCR), Pasay City (NCR), Cebu City (Region VII) and Davao City (Region XI). The third round shall have no more than 6 sites to ensure adequate planning and coordination.

Surveillance or Sentinel Groups

When the prevalence of HIV remains low, scarce resources should be focussed on groups with the highest risk or risk behaviours for HIV infection. High risk behaviours include having multiple sexual partners with demonstrated unsafe sexual practices and the use of injectable drugs. These groups warrant preventive interventions in their own right and represent the most cost-effective application of resources at this stage in the epidemic.

HIV sentinel groups shall then be selected according to the following criteria:

1) predominant modes of transmission[1] in the Philippines;
2) known prevalence of HIV infection in the Philippines;
3) can be easily identified and accessed in adequate numbers to meet sample size requirements;
4) and whose behaviour make them targets for HIV/AIDS prevention and control activities.

These groups shall be tested twice during the next twelve months. Once in the first quarter of 1994 and again in the third quarter of 1994. The sample size of each group per site has been determined at 300 except for the MCSWs and FLSWs (Free Lance FCSWs). This sample size has been calculated to allow detection of 1% prevalence using the estimated 95% confidence interval.

The surveillance groups to be tested during the second round shall be:

. injecting drug users (IDUs)
. male STD patients (MSTDs)
. male commercial sex workers (MCSWs)
. men who have sex with men (MSM)
. female commercial sex workers in establishments (FCSWs)
. free lance FCSWs (FLSWs)

[1] Though variations in the predominant modes of transmission may occur between and within regions, these major transmission patterns should be considered when selecting surveillance groups.

Sample Size

It is important that each site monitor the level and trend of HIV prevalence, since these values can vary substantially between sites. Sample sizes must detect a 1% prevalence if possible, which requires at least 300 individuals in each group. For groups which may be difficult to access like the FLSWs and MCSWs, the target should be 100 individuals, which will allow detection of 5% prevalence.

Inclusion/Exclusion Criteria for Sentinel Groups

A. **Injecting drug users (IDUs)** - are individuals who use or have used injectable drugs recreationally whether intravenous, subcutaneous, and/or intramuscular within the last 5 years.

Inclusion criteria:

a. IDUs who are attending treatment facilities (rehabilitation centers, detoxification centers, etc.) for drug abuse. They may be either residential or treated as out-patient.

b. IDUs outside treatment clinics who are encouraged/advised to consult treatment centers (e.g. voluntary submissions, prisoners who are incarcerated because of possession or use of prohibited drugs)

Exclusion criteria:

a. IDUs who have not injected drugs during the past 5 years.

b. Re-attending IDUs in treatment centers whose blood has been extracted within the study period since it is likely that such patients have been previously enrolled as subjects.

To verify whether re-attending patients have already been enrolled in the study, subjects should be asked the date of the last visit to check whether blood has been extracted. When no medical record is available to prove the patients claim, blood should be extracted and subsequently enrolled as subjects.

B. **Male patients of STD Clinics** (MSTDs) - are men who consult private and government sexually transmitted disease (STD) clinics for treatment of STD.

Inclusion criteria:

a. men who are consulting private/government STD clinics for the treatment of STD.

b. they may be first time clients or re-attending clients.

Exclusion criteria:

a. re-attending male STD patients whose blood has been extracted within the study period since they are already considered enrolled in the study.

Again, re-attending patients should be asked the date of the last visit to check whether blood has been extracted. The patient is enrolled as subject if no medical record is available.

C. **Female commercial sex workers** (FCSWs) - are women who exchange sex for money and work in establishments for this purpose.

Inclusion criteria:

a. are those who work in establishments and exchange sex for money - whether regular workers or contractuals (dancers and models).

Establishments may include bars, casa, massage parlors, night clubs, beer houses, etc.

Exclusion criteria:

a. ancillary staff, such as cashiers and floor managers who do not engage in sex work.

D. **Male commercial sex workers** (MCSWs) - are individuals who exchange sex for money and work in establishments for this purpose.

Inclusion criteria:

a. men who work in establishments and exchange sex for money. The clients of the male CSW may be male or female.

b. all identified men who engage in sex in exchange for money and voluntarily agree to

participate in the study (e.g. paid partners of MSMs).

Exclusion criteria:

a. Ancillary staff such as security guards, floor managers and other staff in the establishment who do not engage in sex for money.

Reminder: Male clients of male CSWs are eligible for inclusion in the "Men who have sex with men" surveillance group. They do not meet the inclusion criteria for male CSWs.

E. **Free lance FCSW (FLSWs)** - are women who exchange sex favors for money and do not work in establishments (streetwalkers)

Inclusion criteria:

a. CSWs who do not work from establishments shall be deemed eligible subjects.

Exclusion criteria:

a. CSWs who work from establishments shall be excluded.

F. **Men who have sex with other men** (MSMs) - are men who have sex with other men for their own pleasure.

Inclusion criteria:

a. men who negotiate sex with male commercial sex workers.

b. MSMs in establishments or gay venues such as gay bars, beauty parlors, dress shops or gay organizations.

c. all identified MSMs who voluntarily want to participate.

Exclusion criteria:

a. male commercial sex workers

Schedule of Surveillance testing - according to surveillance groups, sites and sizes.

Surveillance groups	Collection Site	Method of Testing	Sample Size
1. Injecting drug users	Treatment facilities Rehabilitation centers	Voluntary anonymous	300
2. Male STD patients	Social Hygiene Clinics Private laboratories	Anonymous unlinked	300
3. Male commercial sex workers	Gay bars & sex venues	Voluntary anonymous	100
4. Men who have sex with men	Gay venues & bars	Voluntary anonymous	300
5. Female commercial sex workers in establishments	Streets of trade	Voluntary anonymous	300
6. Free lance female commercial sex workers	Commercial establishments	Voluntary anonymous	100

Data collection

After blood extraction, the subject will be given a card with a code number. This card is presented to the local surveillance unit after a specified period of time (to be determined by the local surveillance team in collaboration with the local testing laboratory) in order to obtain the result of the test. The result shall be released upon request from the subject. The subject should agree to undergo counselling. The local surveillance unit will not initiate the notification of subjects for their results.

The time period for each sera collection, to be known as collection time, will be eight weeks in duration. It is anticipated that the documented total of sera required for all surveillance groups and sero-survey groups may not be collected during the collection time available. Prevalence rates shall be determined if possible with the available sera during the collection time.

During the surveillance, the City Health and Regional Health Laboratories including the Bureau of Research and Laboratories (as the NCR Regional Laboratory) will perform all tests for surveillance groups at the surveillance sites.

Sera collected by the local surveillance units shall be sent to the designated laboratory for testing.

In the instance of linked testing, results with appropriate counselling will be given to individuals concerned by a designated officer of the local surveillance unit. All information on tests performed and data collected will be forwarded to the data management unit at the central office which will handle the analysis and interpretation of data.

Reporting

A feedback of semestral results shall be given to Field Epidemiology Training Program of the Department of Health (DOH) and subsequently to local officials concerned.

At the completion of each round of surveillance a report shall be coordinated by the Field Epidemiology Training Program of the National HIV Surveillance System. Surveillance reports shall be completed according to the following timelines: 1st Round - 3rd quarter 1993; and 2nd Round - 1st quarter 1994.

These reports shall include data on the following: the surveillance sites involved; the surveillance groups involved; the number of subjects in each group; the prevalence rates of groups upon which it can be determined and the conclusions drawn. Also included in the reports

shall be the problems encountered and recommendations to overcome these problems.

Recommendations concerning the surveillance groups to be included and excluded in the next round of surveillance and the reasons why shall also be included in the reports. Also recommendations concerning the size of the surveillance groups and the surveillance sites to be included/excluded in the next round of surveillance shall be included.

The recipients of such reports shall include the Secretary of Health; the DOH AIDS - Unit; local government officials; local DOH personnel; field personnel at all surveillance sites; NGOs concerned with HIV control; the media; and international agencies including WHO and USAID.

Operations Manual

The manual of practices and procedures shall be utilized by the National HIV Surveillance System detailing all aspects of operations, serving as an on-site guide to undertaking the surveillance.

Laboratory Testing

Serum pooling shall be utilized in HIV-testing for the surveillance program. This is recommended in areas where the prevalence of HIV infection is low and resources are scarce. The cost of HIV-testing can be significantly reduced.

A pool of five samples shall be tested with the use of Particle Agglutination (PA). If an HIV antibody-positive is found among the pooled samples tested, individual samples of that particular pool shall be tested. Example: With 20 individual samples, 4 pools of 5 samples shall be tested. If one pool is found positive, individual testing of all 5 samples in the positive pool shall be conducted. Hence, only a total of 9 screening tests shall be performed instead of 20. Confirmatory tests of positive individual tests shall be done using Western Blot.

Laboratory procedures

The following laboratory testing procedures for all sera shall be as follows:

1) preparation of pooled sera from every five consecutively-numbered serum samples for testing.
2) testing of pooled sera using Particle Agglutination (Serodia HIV) test kits.
3) repeat testing of individual serum samples comprising the pooled sample which gives a PA-positive or inconclusive result.
4) supplemental testing of positive or inconclusive individual serum samples by the Western Blot technique using Diagnostic Biotec. Ltd. kits

[All collected serum samples (n=individual serum samples plus pooled sera) shall be stored in the freezer for future reference.]

Data Management and Analysis

The general flow of the surveillance activity commences at the blood/data collection site. Screening for HIV antibodies by PA shall be done by the regional laboratories/Social Hygiene Clinics. Confirmatory tests using Western Blot shall be done by RITM. All indeterminate WB tests shall also be referred to RITM.

The Regional laboratory/Social Hygiene Clinic is responsible for notifying the data collection sites of the test results. The responsible member of the local surveillance unit will relay the test results to the person concerned and administer post-test counselling (in the instance of voluntary linked testing and the individual returning for the test result).

Statistics on HIV sero-positives, number of tests performed and all other related information obtained by all the laboratories involved are relayed to the Field Epidemiology Training Program for review. This information shall be relayed by both the local surveillance units and RITM. Data obtained by this central unit shall be entered into the computer using the EPI INFO software. Tables and statistical analyses shall likewise be generated. The frequency of the presence of HIV infection among the study groups shall be estimated from the data collected. For surveillance A groups, results should be presented as prevalences with 95% confidence intervals or as LQAS tables.

Provisional budget

Second round

A.	Training Workshop	
	Transport costs (30 participants)	25 000
	Gasoline	1 500
	Daily subsistence allowances (30 participants)	16 200
	Daily subsistence allowances (20 resource persons)	10 800
	Honoraria	5 000
	Training materials	25 000
	Miscellaneous	8 350
	Subtotal	91 850
B.	Supervisory visits	
	Land transportation	45 000
	Air transportation	22 050
	Gasoline	7 500
	Per diem	10 000
	Miscellaneous	8 455
	Subtotal	93 005
C.	Coordination of local surveillance units	
	Land transportation	67 500
	Training materials	15 000
	Transport of specimens	21 000
	Per diem	8 000
	Miscellaneous	11 150
	Subtotal	122 650
D.	Supplies and equipment	450 000
E.	Submit reports to central office	
	Transport	45 000
	Materials	30 000
	Subtotal	75 000
	TOTAL	832 505

Third round

A.	Training Workshop	
	Transport costs (50 participants)	50 000
	Gasoline	3 000
	Daily subsistence allowances (50 participants)	27 000
	Daily subsistence allowances (20 resource persons)	12 000
	Honoraria	5 000
	Training materials	40 000
	Miscellaneous	20 000
	Subtotal	157 000
B.	Supervisory visits	
	Land transportation	45 000
	Air transportation	35 000
	Gasoline	10 000
	Per diem	25 000

	Miscellaneous	11 500
	Subtotal	126 500
C.	Coordination of local surveillance units	
	Land transportation	80 000
	Training materials	20 000
	Transport of specimens	30 000
	Per diem	18 000
	Miscellaneous	14 800
	Subtotal	162 800
D.	Supplies and equipment	450 000
E.	Submit reports to central office	
	Transport	60 000
	Materials	40 000
	Subtotal	100 000
	TOTAL	996 300

Schedule of activities

To attain the objectives of the HIV surveillance the following activities have been identified.

Activities											Agency responsible
Second round											
Establish linkages/coordinate with local units/NGOs	XX										FETP
Revision of guidelines, data instruments, report forms, training design		XXXX									Admin/implementors/lab
Training workshops for second round			XX	XX							FETP/LAB
Field visits to surveillance sites and labs			XX	XX							FETP/LAB
Delivery of supplies to surveillance sites				XX							FETP
Make schedule for establishments or units for data collection					XX						FETP
Collection of sera and data					XX	XXXX	XX				Sentinel Site Staff
Supervision of health staff at surveillance sites; review of sera and data collection process					X	X					FETP/LAB
HIV testing					XX	XXXX	XX				Social Hygiene Clinics/BRL/RITM
Submission of reports to central office							XX				Surveillance Site Managers
Management of results from the first round							XX	XX			FETP
Interpretation of results								XXXX			FETP
Preparation of report on results of the first round								XXXX	XX		FETP
Dissemination of results of first round; *feedback of results to surveillance sites*									XX		FETP
Technical Review										XX	Admin/implementors/lab scientific/technical group/FETP

Schedule of activities

To attain the objectives of the HIV surveillance the following activities have been identified.

Activities										Agency responsible
Third round										
Establish linkages/coordinate with local units/NGOs	XX									FETP
Revision of guidelines, data instruments, report forms, training design		XXXX								Admin/implementors/lab
Training workshops for second round			XX	XX						FETP/LAB
Field visits to surveillance sites and labs			XX	XX						FETP/LAB
Delivery of supplies to surveillance sites				XX						FETP
Make schedule for establishments or units for data collection					XX					FETP
Collection of sera and data					XX	XXXX	XX			Sentinel Site Staff
Supervision of health staff at surveillance sites; review of sera and data collection process					X	X				FETP/LAB
HIV testing					XX	XXXX	XX			Social Hygiene Clinics/BRL/RITM
Submission of reports to central office							XX			Surveillance Site Managers
Management of results from the first round							XX	XX		FETP
Interpretation of results								XXX		FETP
Preparation of report on results of the first round								XXX	XX	FETP
Dissemination of results of first round; feedback of results to surveillance sites									XX	FETP
Technical Review										XX Admin/implementors/lab scientific/technical group/FETP

⑤ Results of the First HIV Surveillance Round

Results of the First HIV Surveillance Round
National Capital Region and Metro Cebu
June - September 1993

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BRL:	Ms. Eleanor Pastrana, Ms. Amy Cabatic,
RITM:	Ms. Fems Julia Paladin
Cebu City:	Dr. Tomas Fernandez, Dr. Ilya Abellanosa
Quezon City:	Dr. Magdalena Ybañez, Dr. Annie Inumerable
WHO:	Geoff Manthey

Abbreviations

BRL	Bureau of Research and Laboratories
DOH	Department of Health
FETP	Field Epidemiology Training Program
FLSW	Freelance female sex worker
FSW	Female sex worker (registered)
IDU	Injecting drug users
LQAS	Lot Quality Assurance Sampling
MSM	Men who have sex with other men
MSTD	Male with sexually transmitted diseases
MSW	Male sex worker
NAMRU	U.S. Naval Medical Research Unit
RITM	Research Institute for Tropical Medicine

Executive Summary

The first round of HIV Sentinel Surveillance was conducted in the National Capital Region (NCR) and Metro Cebu in the period June-September, 1993. The National HIV Sentinel Surveillance System is designed to identify *hot spots* - areas where the risk for HIV transmission is highest and interventions are most needed. Interventions targeted at hot spots will have the greatest impact at the lowest cost.

Results:

NATIONAL CAPITAL REGION

HIV Seroprevalence. In NCR there was a *hot spot* because 1 tested positive for HIV Ab in the sample size of 300 (3 per 1000) female sex workers (FSWs) in the Quezon City sentinel site.

Risky Activities. *Risky activities was common in all groups.* Female sex workers (FSWs) reported a median of 2 partners a week and 45% reported they never used condoms. Freelance sex workers (FLSW) reported a median of 3 partners a week and 27% reported they never used condoms. Ninety-three percent of Men who have sex with other men (MSMs) reported they never used condoms. Some FLSWs, MSWs, and MSMs admitted to injection drug use. Sixty-eight injecting drug users (IDUs) participated who injected a median of 2 times weekly.

METRO CEBU

HIV Seroprevalence. There was no serologic *hot spot.*

Risky activities. FSWs reported a median of 3 partners per week and 5% reported they never used condom. Freelance sex workers reported a median of **14 partners per week** and **34% said they never used condom**. Seventy-eight percent of MSTDs said they never used condom. Some FSWs, FLSWs, MSWs, MSMs,and MSTDs admitted to injecting drug use. There were 223 IDUs, 94% of them males who injected a median of 4 times weekly.

While seroprevalence is still low, the combination of HIV and widespread risky activities means ***the Philippines is at risk for widespread HIV transmission in the near future.*** If we are to prevent rapid transmission of HIV, interventions must be targeted on those practicing high risk activities now, particularly injecting drug users.
HIV transmission can only be stopped by decreasing risky activities.

Recommendations:

1. The DOH National AIDS/STD Prevention and Control Program and its partner governmental and non-governmental organizations interventions should target **sex workers, MSMs, MSTDs,** and **injecting drug users** in large cities.
   - intensify IEC
   - promote safe sex practices (i.e. consistent and correct condom use, provide condoms, etc.)
   - promote safe injection practices (e.g. access to clean injection equipment, etc.)
   - improve drug rehabilitation programs (e.g. increase capacity and capability of rehabilitation centers)
   - improve diagnostic and treatment capability of STD clinics

2. The DOH Sentinel HIV Surveillance System should,
   A. continue to do serological surveillance in large cities
   B. focus more on risky behaviors or activities to help target and evaluate intervention efforts.
      - behavioral surveillance methods must be refined and validated (e.g add testing for syphilis) prior to implementation
   C. set surveillance goals, set policy briefs relating to scientific aspects of the surveillance system, design and review methodologies, and regularly evaluate the achievement of surveillance goals.

Introduction

The objective of HIV Sentinel Serologic Surveillance is to provide early warning of dangerous increases in HIV infection rates so that the DOH National AIDS Prevention and Control Program and its partner government and non-government organizations will be able to intervene to prevent transmission of HIV ***before it spreads*** to infect large numbers of people. If the DOH can identify hot spots where the risk of HIV transmission is high, scarce resources can be targeted where they will have greatest effect.

However, because seroprevalence rates among high risk groups have been around 1 per 1,000, it is difficult and expensive to detect increases in seroprevalence because thousands of people would have to be sampled. In order to save most resources for interventions several strategies have been adopted:

1. ***Systematically sample those at highest risk.*** The Human Immunodeficiency Virus (HIV) usually begins to spread in large cities.[1-3] Since the HIV is transmitted by blood and sexual contact, those with greatest exposure to these risk factors must be included in the surveillance. Systematic surveillance is based in large cities among groups with known high prevalence of risky behavior.

2. ***Calculate sample size using Lot Quality Assurance (LQAS) methods.*** This is a statistical technique that allows us to tell with 95% Confidence if the rate of HIV seropositive is below or above a cutoff level[4] (Appendix A). Cutoffs are calculated to indicate levels where immediate interventions are needed.

3. ***Rely on passive surveillance and periodic surveys to estimate rates in populations with less risky behavior.*** The AIDS Registry gathers results of HIV serology from many sources on different populations all over the Philippines. In 1993, there were 766,836 tests recorded.[5]

This report summarizes the results of the first round of HIV surveillance conducted in Quezon City-sentinel site in NCR and in Metro Cebu last June to September 1993.

Methods

Six groups were included in the surveillance and using the LQAS method, sample sizes were calculated to allow detection of a rate of 1% if 300 subjects could be gathered and a rate of 5% if 100 subjects were gathered. (Appendix B). Blood was collected from each participant for HIV testing. HIV screening tests were done in the Bureau of Research and Laboratories (BRL) for Quezon City and in the Cebu City Health Laboratory for Cebu City. HIV confirmatory tests were done in the Research Institute for Tropical Medicine (RITM). Prior to blood extraction, the participants were made aware of the objectives of surveillance, given assurance that testing was anonymous and confidential, and advised about the meaning of test results and the advantages of knowing their results personally. Post-HIV test counseling was made available to all those who wanted to know their HIV test results. Demographic characteristics and data on risk factors were also collected using a standard questionnaire. For male STDs from Quezon City, only their ages and their blood for HIV testing were collected. Purposive sampling was utilized to sample those at highest risk.

Results

NATIONAL CAPITAL REGION:

HIV seroprevalence: Of the sample size of 299 for female sex workers (FSW) in Quezon City, 1 tested positive for HIV which indicates the HIV seroprevalence in all FSWs may reach 1% or more. No other groups were positive at the threshold level.

Risky Activities:

Female Sex Workers: Ninety-eight freelance and 299 registered sex workers participated. Median age for FLSWs was 22 (range:14-43) years while median age for FSWs was 22 (range:16-43) years. Freelance sex workers reported more sex partners per week (median 3, range 1-14) compared to FSWs (median 2, range 1-21). One hundred thirty-five (45%) FSWs and 28 (28%) FLSWs reported their sex partners never used condom. Two (2%) of FLSWs reported injecting drug use.

Male Sex Worker: One hundred-three male sex workers (MSWs) participated. Median age was 23 (range 16-49) years. Seventy-eight (76%) reported having male sex partners while 91 (88%) reported having female sex partners. Forty-three (55%) of the 78 with male as clients and 60 (68%) with female as clients reported they never used condom. One (1%) reported injecting drug use.

Men who have sex with other men: Two hundred ninety-four MSMs participated. Median age was 27 (range 16-52) years. Two hundred seventy-three (93%) reported they never used condom during sex.

Male STDs: Three hundred twenty-eight blood specimen for HIV testing from male with sexually transmitted diseases (MSTDs) were collected. Median age was 29 (range 17-68) years. No other data were collected.

Injecting drug users: Sixty-five IDUs participated. Sixty-one (94%) were males while 4 (6%) were females. Median age for male IDUs was 24 (range 13-47) years while for female IDUs median age was 18 (range 18-37) years. Both male and female IDUs use injectable drugs 1-7 (median 2) times per week.

All sexually active male IDUs reported they never used condom with their male or female sex partners while 3 (75%) female IDUs reported their sex partners never used condom.

METRO CEBU:

HIV seroprevalence: Because all samples from Metro Cebu were negative for HIV Ab, no serologic *hot spots* were identified.

Risky Activities:

Female Sex Workers: One hundred-nine FLSWs and 310 FSWs participated. Median age for FLSWs was 24 (range 16-48) years while median age for FSWs was 20 (range 14-40) years. Freelance sex workers reported more sex partners per week (median 14, range 1-30) compared to FSWs (median 3, range 1-12). Fifteen (5%) of FCSW and 37 (34%) of FLSW reported their partners never used condom during sex.

Male Sex Worker: One hundred-five MSWs participated. Median age was 18 (range 13-41) years. All reported having male sex partners while 38 (36%) having female sex partners. One hundred four (99%) of those having male clients and 31 (82%) of those with female clients reported they never used condom. Ten (10%) reported injectable drug use.

Men who have sex with other men: Three hundred-two MSMs participated. Median age was 25 (range 14-52) years. Two hundred eighty-three (93%) reported condom was never used during sex. Twenty-four (8%) reported injectable drug use.

***Male STDs*:** One hundred-five MSTDs participated. Median age was 28 (range 15-55) years. Eighty-two (78%) reported they never used condom with female sex partners. Four (4%) reported injectable drug use.

***Injecting drug users*:** Two hundred twenty-three IDUs participated. Two hundred-nine (94%) were males while 14 (6%) were females. Median age for male IDUs was 22 (range 14-41) years while for female IDUs median age was 22 (range 13-48) years. Male IDUs inject drugs 1-42 (median 4) times per week while female IDUs inject 1-28 (median 8) times per week.

Of the male IDUs, 53 (25%) reported having male sex partners while 151 (72%) reported having female as sex partners. Ninety percent (48) of the 53 and 88% (133) of the 151 reported they never used condom during sex. Of the female IDUs, 6 (46%) reported their partner never used condom.

Discussion

The seroprevalence of HIV remains relatively low in all groups tested. This is confirmed by findings from the AIDS registry and the sentinel surveillance pretest round in 1992.[6] The U.S. Naval Research Unit (NAMRU) surveyed 13,704 individuals engaged in the sex industry in the National Capital Region (NCR) and Angeles City from July 1993 to April 1994 and found between 0.03% and 0.5% HIV positivity rate in some cities (Pasay City, Manila, Makati City) of the NCR and 0.4% HIV positivity rate in Angeles City[7].

Unfortunately, in both NCR and Metro Cebu the risky behaviors that facilitate rapid spread of HIV were common, especially unprotected penetrative sex. Unless effective interventions are made, HIV will probably spread to the general population through the sexual route. The rate of injection drug use was alarming since this behavior most rapidly transmits HIV.

All the factors for rapid transmission of HIV are present, as they were in Thailand in 1988 just before rates exploded in injecting drug users and rapidly spread to other parts of the population.[3] If we are to prevent rapid HIV transmission, we must continue our interventions targeting those practicing high risk activities now.

Recommendations

1. The DOH National AIDS/STD program and its partner governmental and non governmental organizations should continue their efforts on reducing risky activities targeting primarily ***sex workers*, MSMs, MSTDs**, and ***injecting drug users*** in large cities such as Quezon City, Pasay City, Cebu City, and Angeles City
   - intensify IEC (e.g hot lines, tri-media campaign) aimed at risk groups
   - promote safe sex practices (e.g. promote consistent and correct condom use, provide condoms, etc.)
   - promote safe injection practices (e.g. access to clean injection equipment)
   - improve drug rehabilitation programs (e.g. increase capacity and capability of rehabilitation centers)
   - improve diagnostic and treatment capabilities of STD clinics

2. The DOH National HIV Sentinel Surveillance should
   A. continue to do serological surveillance in large cities
   B. focus more on risky activities or behaviors to help target and evaluate intervention efforts
      - behavioral surveillance methods must be refined and validated (e.g. add testing for syphilis) prior to implementation
   C. set surveillance goals, set policy relating to scientific aspects of the surveillance system, design and review methodologies, and regularly evaluate the achievement of surveillance goals, and refine estimates of the number of HIV seropositive in the Philippines.

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APPENDIX A

Interpretation of LQAS Estimates

The Objective of the HIV Surveillance is to find *hot spots*, areas where risk of HIV transmission is highest to identify where interventions are most needed. Intervention targeted at hot spots will have the greatest impact at the lowest cost.

Lot Quality Assurance Sampling (LQAS) was developed in industry as a quality control method. For example, if you are the manager of a factory and you might sign a contract to sell 50,000 ball bearings to the CAR Company. CAR is willing to pay a good price but requires that you guarantee that 99% of the ball bearing are perfect: no cracks, no flat spots, etc.

It will cost nearly as much to inspect each bearings it did to make them. If you do this, you will lose money. A better solution is to use LQAS. By knowing the size of the lot (50,000) and the desired quality (99%) perfect, you can calculate how many bearings you would need to sample in order to be sure that the whole lot is at least 99% defect-free. If you randomly select 267 bearings and they are all perfect, you can be 99% sure that at least 99% of the whole lot of 50,000 bearings are not defective. *If even one of the 267 sample bearings is defective, you reject the whole lot because you cannot be sure that the whole lot of 50,000 has less than 1% defectives.*

When we apply LQAS to public health, we consider that each person who is HIV seropositive is like a defective product. We consider the *target population* of people doing a risky activity as a *lot*. We calculate that if we sample 300 people at random and they are all HIV-seronegative, we can say with 95% confidence that the target population has less than 1% seropositives. If even *1 of the sample population* is HIV positive, we cannot be sure that the whole *target population* has a rate less than 1%. So we identify a *hot spot* where intervention is acutely needed. This is the public health equivalent of rejecting a lot.

People are not ball bearings and it is impossible to select a random sample of people indulging in high risk behavior, so we are not strictly following the assumptions for LQAS. However, we believe reporting LQAS results gives the most accurate estimate of the true situation.

What it tells you: Lot Quality Assurance Sampling (LQAS) allows us to tell with 95% confidence if the rate of HIV seropositive is below cutoff level. The first round shows with 95% confidence that the rate of HIV infection among the female sex workers tested in Cebu City is below 1%. In Quezon City, there was a *hot spot* where we cannot say the rate is below the cutoff level of 1% in female sex workers, so intervention is needed to prevent spread of HIV. There are probably other hot spots in the National Capital Region (NCR) that need interventions too.

What it does not tell you: Because only those thought to be at highest risk are sampled, Sentinel HIV Serosurveillance <u>does not</u> tell you the prevalence of infection in the <u>general population</u> or in others who may practice risky behaviors less frequently.

Managing Biases: Every surveillance system has some bias. While bias cannot be eliminated, it can be managed and data can be interpreted so that bias does not distort our understanding of the results.

HIV Sentinel Surveillance is like a fire alarm system. You want your alarm to go off when any room in the house is on fire, you don't want to wait until the average level of smoke and flames in the rooms has reached some level. This is how the surveillance system is designed.

A purposive sampling method was used. Population groups known to practice risky behavior were chosen. Within these groups, individuals practicing more risky were more likely to be chosen. For example, previous studies have shown that sex workers in massage parlors and casas tend to engage in more risky behavior than those in bars[1]. Only after all the massage parlors and casas were sampled would sampling begin in other bars.

HIV Surveillance is *biased towards higher rates*. There is a risk of saying that HIV rates are higher than they really are . The cost of such an error is that we may divert some interventions to an area which is not, in reality, a hot spot.

If HIV rates are in reality high, there is little chance that the surveillance will report that the rate is low. The cost of this type of error is that no intervention will be done in a high risk situation. People will be encouraged to continue dangerous risky behavior because they have been told there is no danger of getting HIV; **there may be grave public health consequences** [2]. Therefore the surveillance system is designed to avoid this type of error.

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APPENDIX B

Identified sentinel groups included in the first round of HIV Surveillance activities - Quezon City and Cebu City

SURVEILLANCE GROUPS	Collection Site	Method of Testing	Target Sample Size
Injecting drug users (IDUs)	Treatment facilities, rehabilitation centers	Voluntary anonymous	300
Male STD Patients (MSTDs)	Social hygiene clinics, private laboratories	Anonymous unlinked	300
Male Sex Workers (MSWs)	Gay bars and sex venues	Voluntary anonymous	100
Men who have sex with other men (MSMs)	Gay bars and sex venues	Voluntary anonymous	300
Female sex workers (registered) (FSWs)	Commercial establishments	Voluntary anonymous	300
Female sex workers (freelance) (FLSW)	Streets of trade	Voluntary anonymous	100

Table 1 Estimated seroprevalence per surveillance group, NCR (Quezon City sentinel site), June 18 - August 13, 1993

Surveillance Groups	N *	HIV (+)	LQAS Results
Sex workers:			
female (registered)	299	1	hot spot
female (free lance)	98	0	below danger level
male	103	0	below danger level
Male with STDs	328	0	below danger level
Men who have sex with other men	294	0	below danger level
Injecting drug users	65	0	below danger level

* LQAS calculated sample size of 100-300 to detect seroprevalence of 1%-5%

Table 2 Estimated seroprevalence per surveillance group, Metro Cebu, June 29 - September 20, 1993

Surveillance Groups	N *	HIV (+)	LQAS Results
Sex workers:			
female (registered)	310	0	below danger level
female (free lance)	109	0	below danger level
male	105	0	below danger level
Male with STDs	105	0	below danger level
Men who have sex with other men	302	0	below danger level
Injecting drug users	223	0	below danger level

* LQAS calculated sample size of 100-300 to detect seroprevalence of 1%-5%

Table 3 Number of male sex partners per week and reported condom use among surveillance groups, NCR (Quezon City Sentinel Site), June 18-August 13, 1993

Surveillance Groups	N	No. of partners		Reported Condom Use (%)		
		median	range	always	sometimes	never
Sex workers:						
female (registered)	299	2	1-21	22%	32%	45%
female (free lance)	97	3	1-14	30%	41%	27%
male	78	2	1-15	18%	27%	55%
Men having sex with other men	294	1	1-15	1%	5%	93%
Injecting drug users	42*					
Male IDUs n = 61	5	3	2-3	-	-	100%
Female IDUs n = 4	4	1	1-2	-	25%	75%

* 42 969%) of male IDUs reported no male sex partners

Table 4 Number of female sex partners per week and reported condom use among surveillance groups, NCR (Quezon City Sentinel Site), June 18-August 13, 1993

Surveillance Groups	N	No. of partners		Reported Condom Use (%)		
		median	range	always	sometimes	never
Sex workers:						
male	91	1	1-7	10%	22%	66%
Injecting drug users	42*					
Male IDUs n = 61	17	2	1-7	-	-	100%

* 42 969%) of male IDUs reported no male sex partners

Table 5 Number of male sex partners per week and reported condom use among surveillance groups, Metro Cebu, June 29 - September 20, 1993

Surveillance Groups	N	No. of partners		Reported Condom Use (%)		
		median	range	always	sometimes	never
Sex workers:						
female (registered)	310	3	1-12	42%	54%	5%
female (free lance)	109	14	1-30	1%	65%	34%
male	105	1	1-3	1%	-	99%
Male with STDs	105	1	1-2	-	-	100%
Men having sex with other men	302	1	1-14	1%	5%	94%
Injecting drug users	41*					
Male IDUs n = 209	53	1	1-5	-	8%	91%
Female IDUs n = 14	13	1	1-5	15%	38%	46%

* 41 (19%) of male IDUs and 1 (7%) female IDU reported no male sex partners

Table 6 Number of female sex partners per week and reported condom use among surveillance groups, Metro Cebu, June 29 - September 20, 1993

Surveillance Groups	N	No. of partners		Reported Condom Use (%)		
		median	range	always	sometimes	never
Sex workers:						
male	38	1	1-3	-	8%	82%
Male with STDs	105	1	1-7	-	22%	78%
Men having sex with other men	45	1	1-4	-	13%	87%
Injecting drug users	42*					
Male IDUs n = 209	151	1	1-7	1%	9%	88%

* 41 (19%) of male IDUs and 1 (7%) female IDU reported no male sex partners

Table 7 Reported injecting drug use among surveillance groups, NCR (Quezon City Sentinel Site), June 18 - August 13, 1993

Surveillance Groups	N	Injecting Drug Use (%)
Sex workers:		
female (free lance)	98	2%
male	105	1%
Men having sex with other men	294	1%

Table 8 Reported injecting drug use among surveillance groups, Metro Cebu, June 29 - September 20, 1993

Surveillance Groups	N	Injecting Drug Use (%)
Sex workers:		
female (registered)	310	2%
female (free lance)	109	13%
male	105	10%
Male with STDs	105	4%
Men having sex with other men	302	8%

⑥ Survey of HIV Risk Behavior Among Female Sex Workers in Pasay City

Survey of HIV Risk Behavior Among Female Sex Workers in Pasay City, Metro-Manila, Philippines April-May 1994

Dr. Judith Iturralde-Tapiador
Field Epidemiology Training Program
Department of Health, Philippines

SLIDE #1
INTRODUCTION:

During April 1994, a survey among female sex workers (FSWs) was conducted in Pasay City by a joint team comprised of representatives of the target audience, members of FETP and Pasay City Health Office. The study was conducted to provide a demographic profile of the FSWs, to identify high risk behaviours to HIV infection and to provide information useful to HIV surveillance.

SLIDE #2
METHODOLOGY:

A descriptive study was undertaken among FSWs in Pasay City. FSW was defined as any female who renders sex for a fee and works in an establishment. The sample size was 300 FSWs paralleling the protocol used in the HIV seroprevalence survey. Purposive sampling and voluntary participation was utilized. Respondents were recruited from night clubs and saunas frequented by foreigners along Roxas Boulevard.

A quantitative survey instrument was developed based on a review of the literature and recent studies among Filipino FSWs. The instrument was pretested by nine (9) trained peer-interviewers and revised accordingly. Five (5) Focus Group Discussions (FGDs) were conducted among FSWs from the same establishments to gather qualitative data in conjunction with the survey.

RESULTS:

SLIDE #3
DEMOGRAPHICS:

A total of 304 volunteers were interviewed with 70 (23%) working in sauna establishments and 234 (77%) working in clubs. The median age of FSWs was 22 years with a range of 16-36 years. Eighty-five percent (85%) were single, 64% had attained some secondary education and 13% had some college education. Most of the FSWs identified their occupation as club dancer (54%), followed by receptionist (21%) and sauna attendant (21%). The median age for coital debut of FSWs was 18 years (range 11-27 years) and the median age of initiation to commercial sex was 20 years (range 12-29 years).

SLIDE #4

If we compare FSWs working in saunas and clubs, the major difference is in their level of education attainment. The majority of FSWs from clubs (85%) had some secondary education compared to 45% of sauna girls. Sauna workers also tend to be younger and have a higher percentage of live-in partners than club workers.

SLIDE #5

MAP: Majority of the FSWs came from Regions outside of the National Capital Region (NCR). Seventy-eight percent (78%) of respondents came from Region 8 (Leyte and Samar provinces). About 20% of club FSWs and 78% of sauna FSWs came from this Region.

SLIDE #6

When asked who encouraged them to the job, 57% of FSWs responded that they voluntarily applied for the job; 34% were encouraged by friends and 5% by relatives. Others include neighbors and recruiters. Seventy-seven percent (77%) were aware in advance that sex is involve in the job, while, 23% had no idea, whatsoever, that sex would be involved.

SLIDE #7

The common reasons for entering the trade were to earn easy money for financial help to the extended family (41%), to be independent by earning her own money (28%) and to raise her own child (10%). The FSWs were supporting an average of four (4) dependents. Moreover, 45% of FSWs had children of their own (range: 1-7 children).

Other reasons for entering the trade included peer influence, just for the thrill, protest against family, lack of job qualification, bored at home, pursue further studies, forced by superior, and to find a rich husband.

Seventy-six percent (76%) of the girls reportedly tried to avoid the sex trade but were unsuccessful mainly because they needed money. When asked how they compensated for loss of income when they tried to reduce commercial sex activity, 47% stated that they consumed more drinks (paid by the clients). The number of drinks per night ranged from 2-30 glasses with an average of 5 glasses. Others compensated for loss income by budgeting, using their savings, and other sources of income.

SLIDE #8

Health Profile:

Majority had consultations with STD clinics as shown by the high percentage of FSWs with health cards issued by the City Health Office (93%). Fifty-three percent (53%) had history of STD and 3% (10) of the FSWs have tried injecting prohibited drugs. No one claimed sharing of needles.

SLIDE #9

Forty-seven percent (47%) of FSW respondents perceived themselves to be at risk of acquiring HIV infection while 53% do not perceive themselves to be at risk or have no idea of the risk.

CONDOM USE:
SLIDE #10

Eighty-three percent (83%) of all respondents claimed to use condoms regularly (regular - defined as every sex act). A higher proportion of FSWs from clubs (85%) than from saunas (76%) reported regular condom use. However, when asked whether a condom was used in the last sexual act, only 65% of FSWs from clubs reported actual use compared with 89% of FSWs from sauna.

SLIDE #11

REGULAR CUSTOMERS: Seventy-one percent (71%) of FSWs have regular customer; 38% of regular customers are married men.

Among FSWs with regular customers, the majority (81%) claimed to regularly use condoms with their customary clients. Upon further probing, however, 58% of reported users indicated that they stopped using condoms with their regular customers after the first few sex acts (range 0-10 sex acts). Therefore, the proportion of FSWs actually using condoms regularly with customary clients (70%) is lower than what was originally reported (81%).

BOYFRIENDS: Thirty-eight percent (38%) of FSW respondents have boyfriends; 24% of the boyfriends are married. Less than one-third (31%) of FSWs use condoms regularly with their boyfriends.

SLIDE #12

NON-USE OF CONDOMS: Common responses for why condoms were not used by FSWs included: Boyfriend, customer doesn't want to use, regular customer, customer appears clear, and other reasons such as forgot to bring condom and sex using condom is painful.

When asked to demonstrate the use of condom, 26% of FSWs responded that they did not know how to use a condom.

SLIDE #13

Among those FSWs whose customers refused to use condom, 30% of girls claimed that they went home without performing sex, 25% attempted to convince the customer to wear a condom, 23% performed non-penetrative safer sex acts with the customer, and 22% had sex without condom.

In a situation where the FSW failed to bring a condom, 56% ordered condoms from the roomboy, 23% relied on their customers to supply the condom, and 21% had sex without condom.

SLIDE #14

SOURCE OF CONDOMS: Condoms were purchased/obtained by FSWs mainly from drugstores (28%), STD clinics (26%), establishments (19%), and hotels/motels (19%). Other reported sources included NGOs and supermarkets.

SLIDE #15

LUBRICANTS: The most commonly used lubricant was K-Y Jelly (49%), a water-based product. About 40% of respondents reported use of oil-based lubricants which are contraindicated for use with condoms.

Rupture of condom during sex was reported by 37% of FSWs with an average of 4 ruptures per year (range 1-20 times).

Although the majority of FSWs that use condom believe that they know how to use them correctly (74%), the high proportion using oil-based lubricants with condoms suggests otherwise.

SLIDE #16
SEXUAL PRACTICES

The FSWs had relatively low frequency of commercial sex. The median number of sex acts with customers was 2 per week for club FSWs (range 0-14) and 5 per week for sauna FSWs (range 0-15).

The ratio of foreign to filipino clients was 1:18 for sauna FSWs and 1:1.5 for club FSWs.

SLIDE #17

The most common source of information on the correct use of condom reportedly came from seminar from the CHO, leaflets, peers and customers. Others include private doctors, private seminars and posters.

Practically all FSW respondents (96%) claim they have read instructions on proper use of condoms.

SLIDE #18

Some suggestions by FSWs on how to improve seminars and understanding of condom use were to conduct seminars to interested parties only (26%), participants repeat demonstration on the use of condom (22%), separate females from males (18%), teach personal hygiene to girls (15%). Other suggestions include conduct seminars in the barrios/barangays.

SLIDE #19
SUMMARY FINDINGS

1. The FSW respondents had a median age of 22 years, were single, had some high school education and relatively low frequency of commercial sex (2-5 acts per week).

2. FSWs respondents in sauna are younger, less educated and have more sex partners compared to sex workers in clubs and other types of establishments.

3. More than half of FSW respondents have history of STD infection and 3% reported use of injecting drugs. Less than half of the FSW respondents (47%) perceive themselves to be at risk of HIV infection.

SLIDE #19B

4. FSW respondents in clubs had more foreign partners compared to sauna girls and reported lower rates of condom usage in the last sex act.

5. FSWs have 3 types of sex partners: ordinary customers, regular customers and boyfriends.

6. Majority of FSWs claim to use condoms regularly, however only 70% used condom during the most recent sex act.

SLIDE #19C

7. Knowing the person (and assuming they are uninfected), whether boyfriend or regular customer is a common reason for not using the condom.

8. The majority of FSWs feel that they know how to use condom properly but the relatively high proportion using oil-based lubricants and experiencing rupture of condom during usage suggests otherwise.

9. Seminars at the city health office were the main source of information on STD/HIV/AIDS for FSWs.

RECOMMENDATIONS

SLIDE #20A

1. FSWs need more training in self assessment and reduction of risk, and safer sex negotiation skills.

2. Since knowing the person (and assuming they are uninfected), whether boyfriend or regular customer is a common reason for not using the condom, the problems with this risk assessment strategy must be emphasized in training and in IEC interventions.

SLIDE #20B

3. Since many FSWs experience condom breakage, and since one-in-four reportedly do not know how to use condom, it is clear that FSWs need correct condom use training. Written and pictorial instructions alone may not be enough. Peer education would be one possible strategy.

4. Since sex is often initiated at an early age, educational efforts should be targetted appropriately.

FOR FUTURE STUDIES:

SLIDE #20C

5. To elicit accurate and complete responses from risk groups, peer interviewers should be trained and utilized to gather behavioural data. Honoraria should be provided to peer interviewers and sufficient time should be allowed to involve them in all aspects of the development and pre-testing of the survey instrument.

6. Future studies may need to probe further to identify other risk behaviours and to elicit more qualitative data to supplement the quantitative survey.

7. Similar studies should be undertaken in other urban centers and among other risk groups.

⑦ The Epidemiology of HIV Infection in Metro Manila and Two Former Military Base Areas/U.S. Naval Medical Research Unit No. 2 Detachment

U.S. NAVAL MEDICAL RESEARCH UNIT NO. 2 DETACHMENT MANILA, REPUBLIC OF THE PHILIPPINES

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

OBJECTIVES

- Determine the prevalence of HIV infection in selected target groups

- Evaluate the role of behavioral risk factors for transmission of HIV in the Philippines

- Describe the migratory patterns of selected risk groups

METHODS

Target Groups:

- Female & Male CSWs
- Workers in entertainment-oriented establishments
- Females & Males seeking testing and counselling at AIDS Education and Counselling Centers

METHODS (Con't)

Data Collection:

- Participation in the study strictly voluntary
- Informed consent was obtained from each subject
- Blood was drawn and a 3-page questionnaire administered by trained interviewers at:
    - o Social Hygiene Clinics
    - o Entertainment establishments
    - o AIDS Education and Counselling Centers
- Sera were tested for HIV-1 BY ELISA (Abbott)
- Samples Repeatedly Reactive by ELISA were confirmed by Western Blot (Dupont)
- Those confirmed positive by Western Blot were offered further laboratory and clinical evaluation, were given counselling and introduced to treatment available at San Lazaro Hospital

SURVEILLANCE FOR HIV-1

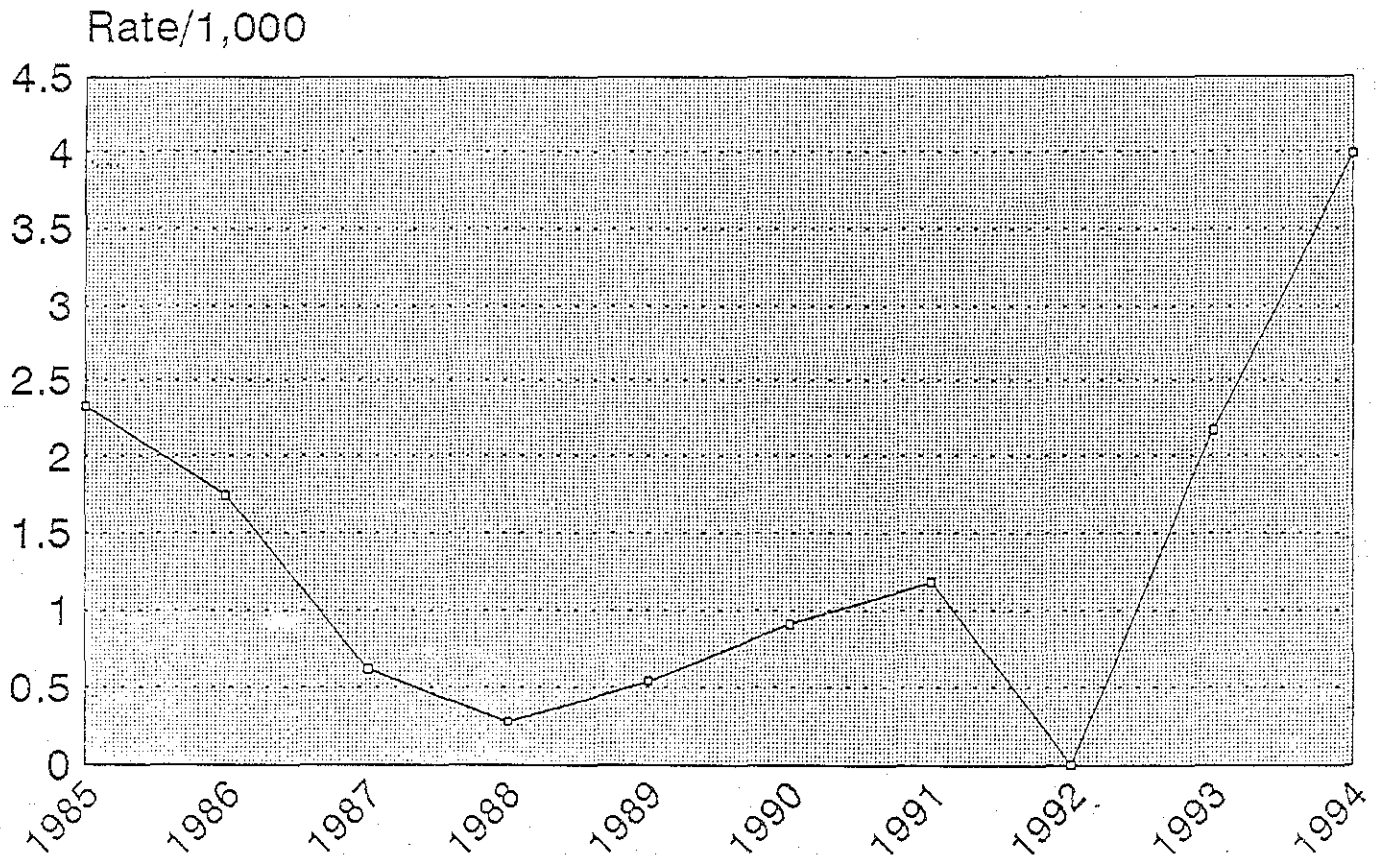
July 21, 1993 - April 25, 1994

City	# Tested		# Positive		Rate (per 1,000)	
	Female	Male	Female	Male	Female	Male
Makati	2983	228	1	0	0.34	0
Marikina	335	0	0		0	
Paranaque	665	14	0	0	0	0
Pasay	1483	0	8		5.39	
Quezon City	3648	804	0	0	0	0
Angeles	1705	10	7	0	4.11	0
Mabalacat	51	1	0	0	0	0
Olongapo	637	36	0	0	0	0
Subic	155	2	0	0	0	0
Remedios Center (Manila	11	65	0	0	0	0
Kabalikat (Manila)	16	34	0	0	0	0
Reach Out (Metro Manila)	0	830		2		2.41
Total	11689	2024	16	2	1.37	0.99

PREVALENCE OF ANTIBODY TO HIV-1

FEMALE CSWs

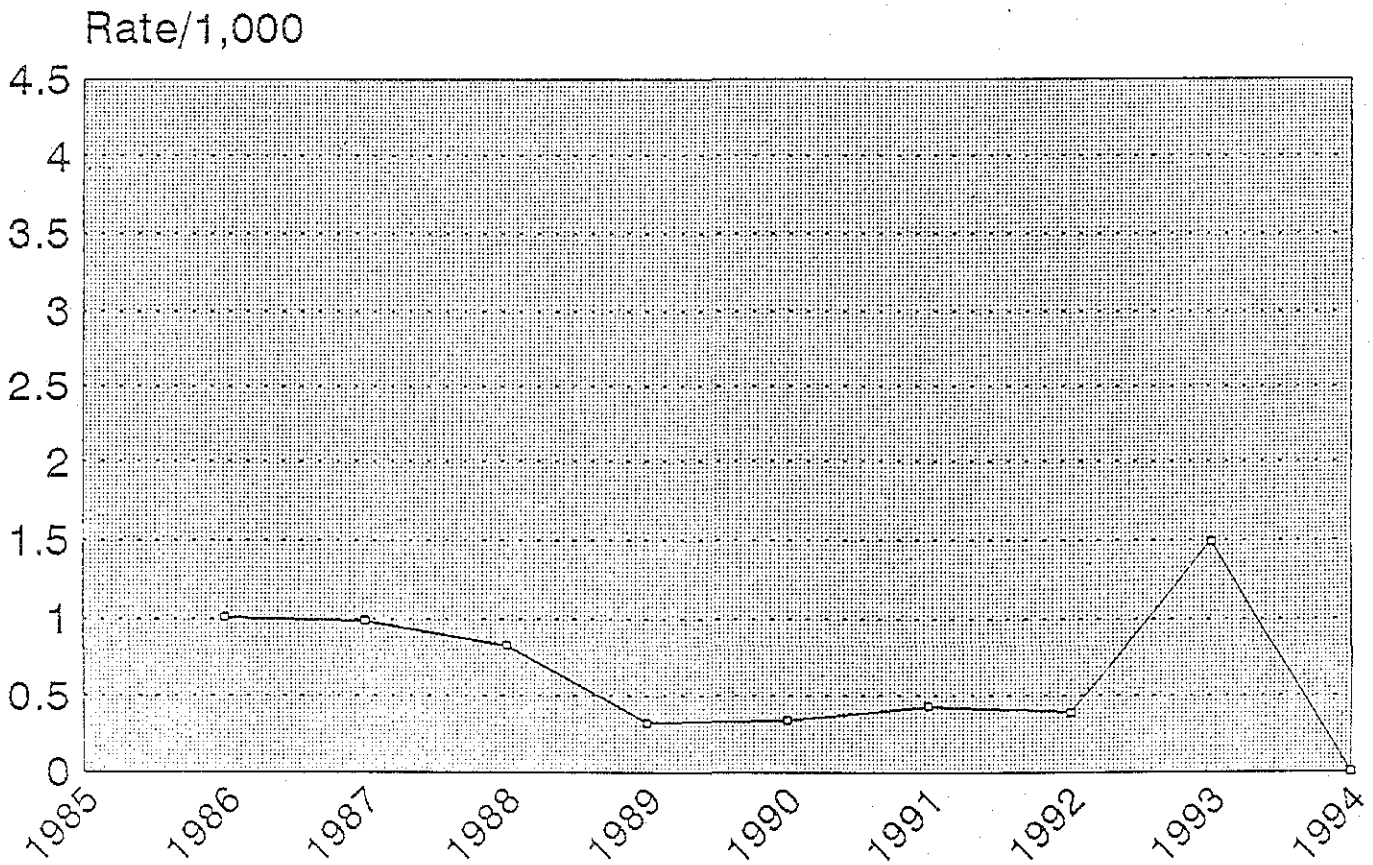
Angeles/Mabalacat



PREVALENCE OF ANTIBODY TO HIV-1

FEMALE CSWs

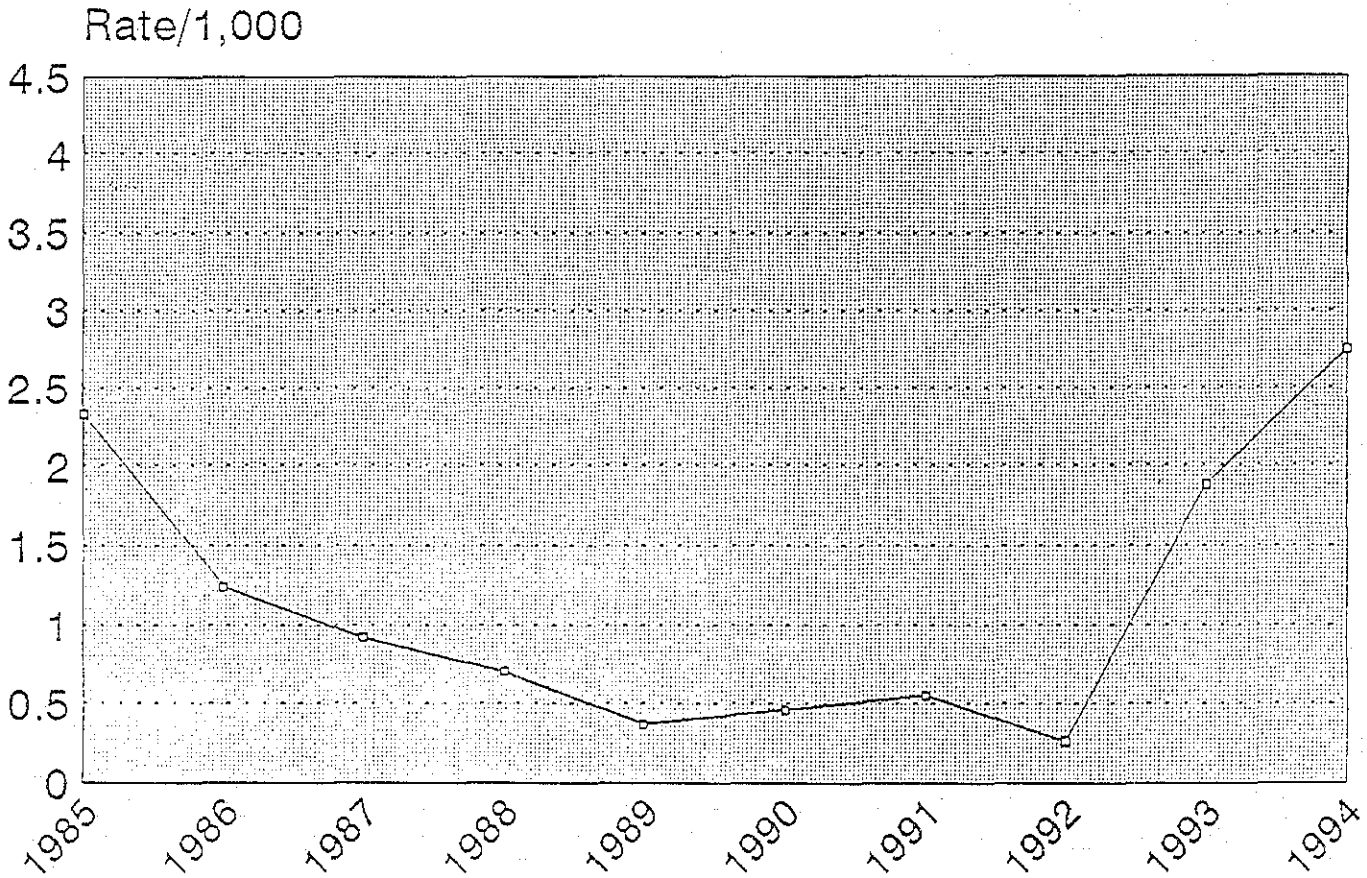
Olongapo/Subic



PREVALENCE OF ANTIBODY TO HIV-1

FEMALE CSWs

Combined Cities



CHARACTERISTICS OF STUDY POPULATION

Females

	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles	Mabalacat	Olongapo	Subic
Mean Age	23.45	23.44	22.56	23.00	23.35	24.14	23.51	25.40	23.25
(Range)	(15-51)	(17-48)	(14-51)	(13-53)	(13-58)	(15-53)	(17-38)	(18-45)	(16-49)
Mean Educational	10.30	8.05	9.27	8.92	9.62	8.27	9.29	8.68	7.73
Level (Range)	(1-18)	(1-14)	(1-17)	(1-18)	(1-19)	(1-14)	(1-12)	(1-14)	(1-12)
Marital Status									
Married	8.9%	6.3%	7.2%	6.8%	9.5%	2.5%	4.1%	3.4%	4.7%
Separated/Annulled	8.1%	12.1%	7.5%	12.6%	7.9%	8.7%	14.3%	7.8%	4.7%
Single	83.1%	81.6%	85.4%	80.6%	82.6%	88.8%	81.6%	88.8%	90.5%

REGION OF ORIGIN

Female Employees of

Entertainment-Oriented Establishments

Number (Percent)

	City of Employment						
Region of Origin	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles/ Mabalacat	Olongapo/ Subic
NCR	1053 (35.5%)	72 (21.8%)	131 (20.3%)	339 (23.3%)	1076 (29.7%)	149 (8.6%)	78 (10.0%)
CAR	19 (0.6%)	1 (0.3%)	1 (0.2%)	7 (0.5%)	15 (0.4%)	6 (0.3%)	9 (1.2%)
1	85 (2.9%)	14 (4.2%)	13 (2.0%)	36 (2.5%)	155 (4.3%)	48 (2.8%)	22 (2.8%)
2	51 (1.7%)	8 (2.4%)	8 (1.2%)	17 (1.2%)	79 (2.2%)	20 (1.2%)	8 (1.0%)
3	257 (8.7%)	38 (11.5%)	57 (8.8%)	102 (7.0%)	452 (12.5%)	636 (36.6%)	363 (46.7%)
4	292 (9.8%)	40 (12.1%)	56 (8.7%)	117 (8.0%)	285 (7.9%)	76 (4.4%)	40 (5.1%)
5	216 (7.3%)	66 (20.0%)	51 (7.9%)	106 (7.3%)	231 (6.4%)	113 (6.5%)	54 (6.9%)
6	227 (7.7%)	15 (4.5%)	50 (7.8%)	147 (10.1%)	279 (7.7%)	124 (7.1%)	36 (4.6%)
7	156 (5.3%)	23 (7.0%)	45 (7.0%)	137 (9.4%)	246 (6.8%)	121 (7.0%)	37 (4.8%)
8	254 (8.6%)	33 (10.0%)	94 (14.6%)	279 (19.2%)	424 (11.7%)	331 (19.0%)	93 (12.0%)
9	49 (1.7%)	4 (1.2%)	9 (1.4%)	27 (1.9%)	47 (1.3%)	19 (1.1%)	9 (1.2%)
10	111 (3.7%)	5 (1.5%)	33 (5.1%)	41 (2.8%)	132 (3.6%)	54 (3.1%)	15 (1.9%)
11	180 (6.1%)	8 (2.4%)	88 (13.6%)	82 (5.6%)	178 (4.9%)	35 (2.0%)	7 (0.9%)
12	16 (0.5%)	3 (0.9%)	9 (1.4%)	17 (1.2%)	25 (0.7%)	7 (0.4%)	6 (0.8%)
	2966	330	645	1454	3624	1739	777

REGION OF ORIGIN

Female Employees of Entertainment-Oriented Establishments

Number (Percent)

Region of Origin	Region of Employment		
	NCR	Region 3	Combined
NCR	2671 (29.6%)	227 (9.0%)	2,898 (25.1%)
CAR	43 (0.5%)	15 (0.6%)	58 (0.5%)
1	303 (3.4%)	70 (2.8%)	373 (3.2%)
2	163 (1.8%)	28 (1.1%)	191 (1.7%)
3	906 (10.0%)	999 (39.7%)	1,905 (16.5%)
4	790 (8.8%)	116 (4.6%)	906 (7.9%)
5	670 (7.4%)	167 (6.6%)	837 (7.3%)
6	718 (8.0%)	160 (6.4%)	878 (7.6%)
7	607 (6.7%)	158 (6.3%)	765 (6.6%)
8	1,084 (12.0%)	424 (16.9%)	1,508 (13.1%)
9	136 (1.5%)	28 (1.1%)	164 (1.4%)
10	322 (3.6%)	69 (2.7%)	391 (3.4%)
11	536 (5.9%)	42 (1.7%)	578 (5.0%)
12	70 (0.8%)	13 (0.5%)	83 (0.7%)
	9019	2516	11535

PROVINCE OF ORIGIN

Female Employees of Entertainment-Oriented Establishments

(Number/Percent)

	Place of Employment		
Rank Order	Metro Manila Cities	Former Base Areas	Combined
1	Metro Manila (2,671/29.6%)	Pampanga (462/18.4%)	Metro Manila (2,898/25.1%)
2	Cebu (487/5.4%)	Zambales (347/13.8%)	Pampanga (709/6.1%)
3	Leyte (479/5.3%)	Metro Manila (227/9.0%)	Leyte (653/5.7%)
4	Negros Occ. (378/4.2%)	Leyte (174/6.9%)	Cebu (621/5.4%)
5	W. Samar (347/3.8%)	Cebu (134/5.3%)	Negros Occ. (479/4.2%)
6	Davao Del Sur (343/3.8%)	W. Samar (120/4.8%)	W. Samar (467/4.0%)
7	Pampanga (247/2.7%)	Negros Occ. (101/4.0%)	Zambales (446/3.9%)
8	Camarines Sur (235/2.6%)	Tarlac (66/2.6%)	Davao Del Sur (374/3.2%)
9	Quezon (216/2.4%)	Camarines Sur (60/2.4%)	Camarines Sur (295/2.6%)
10	Pangasinan (213/2.4%)	N. Samar (57/2.3%)	Pangasinan (258/2.2%)
Total	(5,616/62.3%)	(1,748/69.5%)	(7,200/62.4%)

	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles	Mabalacat	Olongapo	Subic
Mean Age at First Sex	18.75	17.84	18.00	18.21	18.41	18.50	18.71	18.54	17.40
(Range)	(6-31)	(12-26)	(6-28)	(9-29)	(6-36)	(12-32)	(13-28)	(12-35)	(11-25)
N =	2517	296	558	1385	3196	1546	41	572	154
Took Money for First Sex	2.5%	1.7%	2.9%	12.9%	1.5%	16.0%	0	9.9%	8.4%
Never Had Sex	15.7%	11.6%	16.0%	6.6%	12.4%	9.3%	19.6%	10.2%	0.6%
N =	467	39	106	98	454	159	10	65	1
Ever Accept Money for Sex	34.1%	32.9%	36.2%	68.6%	13.7%	70.6%	36.6%	69.9%	69.5%
Mean Age First Accepted Money for Sex	22.5	24.7	21.6	21.2	22.4	22.0	26.5	22.5	21.5
(Range)	(14-42)	(8-48)	(15-35)	(13-38)	(14-38)	(12-38)	(15-35)	(14-45)	(14-33)

HISTORY OF STD OR INJECTABLE DRUG USE

Female Employees of Entertainment-Oriented Establishments

Percent

	City of Employment								
	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles	Mabalacat	Olongapo	Subic
Ever had an STD	11.1	4.0	7.3	32.1	4.8	22.8	10.0	19.4	38.1
Type if known:									
Gonorrhea	2.7	1.0	1.2	9.5	1.3	6.0	2.5	12.4	9.7
Syphilis	0.04	0	0	0.4	0.1	0.1	0	0.5	1.3
Genital Warts	0.3	0.7	0.4	1.2	0.1	0.4	0	0.2	0.7
Genital Ulcers	3.8	0	2.5	13.1	1.0	3.4	0	0.5	0.7
Vaginal Discharge (w/itching pain)	2.4	1.3	0.9	7.7	1.0	1.6	0	1.0	0.7
Injectable Drug Use	0.1	0.3	0	0.07	0.25	0.06	1.96	0	0
(Number)	-3	-1	0	-1	-9	-1	-1	0	0
Injectable Drugs Used	Shabu	Shabu		Shabu	Shabu Cocaine Nubain	Valium	Anesthetic		

TRAVEL OUTSIDE THE PHILIPPINES

City Employed In	Number Reporting Foreign Travel	Percent Reporting Foreign Travel	Total Number of Trips	Mean Number of Trips Per Traveler
Makati	614	20.6%	807	1.31
Marikina	19	5.7%	27	1.42
Paranaque	61	9.2%	68	1.11
Pasay	242	16.3%	273	1.13
Quezon City	549	15.0%	629	1.15
Angeles/Mabalacat	105	6.0%	118	1.12
Olongapo/Subic	39	4.9%	44	1.13

FOREIGN TRAVEL

Most Frequently Named Destinations

(% of Total Trips Abroad)

	#1	#2	#3	#4	#5
Makati	Japan (54.8%)	Hongkong (9.3%)	Saudi Arabia (7.4%)	Singapore (7.0%)	Saipan (5.3%)
Marikina	Japan (59.3%)	Hongkong (14.8%)	Saudi Arabia (7.4%)	Saipan (7.4%)	
Paranaque	Japan (48.5%)	Hongkong (10.3%)	Saudi Arabia (5.9%)	Korea (5.9%)	Cyprus (5.9%)
Pasay	Japan (50.6%)	Hongkong (11.7%)	Saudi Arabia (5.9%)	Singapore (5.5%)	Malaysia (4.4%)
Quezon City	Japan (53.4%)	Hongkong (10.0%)	Saudi Arabia (7.8%)	Saipan (4.8%)	Malaysia (4.4%)
Angeles/Mabalacat	Japan (39.0%)	Hongkong (14.4%)	Saudi Arabia (7.6%)	Singapore (6.8%)	USA (4.2%)
Olongapo/Subic	Japan (29.6%)	Saudi Arabia (11.4%)	Hongkong (9.1%)	Singapore (9.1%)	Cyprus (9.1%)

REPORTED SEX DURING TRAVEL OUTSIDE THE PHILIPPINES

City Employed In	Number Reporting Sex Abroad	Percent of Travelers Reporting Sex Abroad	Number Accepting Money for Sex Abroad	Percent Who Accepted Money for Sex Abroad
Makati	254	41.4%	107	17.4%
Marikina	4	21.1%	2	10.5%
Paranaque	21	34.4%	12	19.7%
Pasay	108	44.6%	59	24.4%
Quezon City	157	28.6%	37	6.7%
Angeles/Mabalacat	41	39.0%	19	18.1%
Olongapo/Subic	12	30.8%	8	20.5%

SEXUAL ACTIVITY DURING PAST YEAR

Female Employees of
Entertainment-Oriented Establishments

City of Employment	Mean number of times had sex per week	Mean number of different sexual partners per week
Makati	2.0	1.3
Marikina	2.0	1.2
Paranaque	1.8	1.2
Pasay	2.4	1.9
Quezon City	1.9	1.1
Angeles	2.1	1.6
Mabalacat	2.2	1.1
Olongapo	1.8	1.4
Subic	1.7	1.2

SEXUAL PRACTICES

Female Employees of
Entertainment-Oriented Establishments

Percent

Makati	Frequently	Occasionally	Rarely	Never
Penis-Vaginal	96.1	2.8	1.2	0
Penis-Oral	3.7	20.7	13.3	62.3
Penis-Rectal	0	0	0.5	99.5
Oral-Vaginal	4.9	31.0	15.2	48.9
Marikina				
Penis-Vaginal	94.0	4.2	1.8	0
Penis-Oral	1.4	9.5	3.2	85.9
Penis-Rectal	0	0	0	100.0
Oral-Vaginal	5.3	15.2	5.3	74.2
Paranaque				
Penis-Vaginal	82.4	10.3	7.2	0.2
Penis-Oral	1.3	9.2	11.2	77.4
Penis-Rectal	0	0.2	0.4	98.5
Oral-Vaginal	5.7	21.3	10.8	61.2

	Frequently	Occasionally	Rarely	Never
Pasay				
Penis-Vaginal	86.9	8.8	4.2	0.1
Penis-Oral	1.6	9.7	6.1	82.6
Penis-Rectal	0	0.1	6.6	99.3
Oral-Vaginal	4.4	28.2	9.1	58.3
Quezon City				
Penis-Vaginal	96.3	2.4	1.3	0.03
Penis-Oral	3.4	13.9	5.8	76.8
Penis-Rectal	0	0	0.2	99.7
Oral-Vaginal	5.4	21.4	6.6	66.6
Angeles City				
Penis-Vaginal	99.7	0.1	0.2	0
Penis-Oral	2.3	12.1	1.3	84.3
Penis-Rectal	0	0	0.1	99.9
Oral-Vaginal	7.0	31.1	2.9	59.0

	Frequently	Occasionally	Rarely	Never
Mabalacat				
Penis-Vaginal	97.3	2.7	0	0
Penis-Oral	0	13.5	0	86.5
Penis-Rectal	0	0	0	100.0
Oral-Vaginal	0	29.7	0	70.3
Olongapo				
Penis-Vaginal	99.8	0.2	0	0
Penis-Oral	2.0	10.5	1.6	85.9
Penis-Rectal	0	0	0	100.0
Oral-Vaginal	7.4	24.3	2.7	65.6
Subic				
Penis-Vaginal	99.3	0.7	0	0
Penis-Oral	0.7	9.3	0.7	89.3
Penis-Rectal	0	0	0	100.0
Oral-Vaginal	4.7	20.7	2.0	72.6

USE OF CONDOMS

Female Employees of Entertainment-Oriented Establishments

Percent

	City of Employment								
	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles	Mabalacat	Olongapo	Subic
Frequency of Reported Use									
Always	11.3	2.0	6.4	25.4	3.2	5.6	0	5.5	4.0
Frequently	13.9	3.0	10.6	21.5	8.2	40.7	15.0	32.2	12.6
Occasionally	10.0	8.1	8.3	15.9	5.7	12.9	7.5	16.7	9.9
Rarely	7.1	3.7	5.4	5.1	4.9	3.9	2.5	5.5	5.3
Never	57.7	83.2	69.3	32.1	78.0	36.8	7.5	40.0	68.2
Reasons for not using a condom:									
He didn't have one	3.1	3.7	5.8	5.3	2.1	1.0	0	1.2	1.9
He doesn't like condoms	51.3	50.8	51.5	52.2	45.0	24.4	22.0	20.3	31.0
I don't like condoms	15.4	7.7	7.9	5.7	16.3	2.7	9.8	2.6	5.2
*Other	30.2	37.8	34.8	36.8	36.6	71.9	68.2	75.9	61.9

*Most common reasons:
- Already using another method of birth control
- Wants to get pregnant
- Steady boyfriend or trusted partner

MOST FREQUENT SEXUAL PARTNERS

Female Employees of Entertainment-Oriented Establishments

Nationality by Region

Percent

	City of Employment						
	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles/ Mabalacat	Olongapo/ Subic
Past Year							
Filipino	49.0	97.8	78.3	34.4	87.1	21.3	51.2
Other Asian	25.1	1.8	18.8	37.6	10.8	3.5	10.6
North American	10.6	0.4	1.1	12.5	1.0	25.4	19.6
European	10.1	0	1.1	8.1	0.4	27.3	10.7
Australia/New Zealand	4.2	0	0.4	6.5	0.1	22.1	6.9
Middle East	0.9	0	0.4	0.8	0.5	0.2	0.2
Prior to 1 Year Ago							
Filipino	75.9	100.0	91.6	53.4	92.2	46.2	72.6
Other Asian	11.8	0	6.7	25.2	6.1	2.2	2.0
North American	6.2	0	0.8	10.6	0.5	31.6	22.6
European	4.0	0	0.5	7.7	0.6	9.0	1.8
Australia/New Zealand	1.8	0	0.3	2.5	0.1	10.8	1.0
Middle East	0.1	0	0	0.4	0.5	0.1	0

MOST FREQUENT SEXUAL PARTNERS

Female Employees of
Entertainment-Oriented Establishments

Percent

	City of Employment								
	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles	Mabalacat	Olongapo	Subic
Past Year									
Filipino Only	60.4	97.7	82.4	40.0	90.4	31.1	86.1	56.4	82.7
Foreigner Only	22.8	0.4	7.3	47.8	4.1	59.3	5.6	31.3	6.9
Both	16.8	1.9	10.3	12.2	5.5	9.6	8.3	12.3	10.4
Prior to 1 Year Ago									
Filipino Only	77.4	100.0	92.4	55.1	92.8	50.1	90.0	69.1	91.1
Foreigner Only	18.9	0	7.3	43.8	6.0	48.5	10.0	29.4	7.8
Both	3.7	0	0.3	1.1	1.2	1.4	0	1.5	1.1

	Makati	Marikina	Paranaque	Pasay	Quezon City	Angeles	Mabalacat	Clongapo	Subic
Of those with only Filipino partners in part year, what % had foreigner sex partners prior to 1 year ago	1.3	0	0.8	1.7	1.3	1.6	0	2.8	2.5
Of those with only Filipino sex partners prior to 1 year ago, what % had foreigner sex partners in the past year	21.2	2.4	10.1	25.8	4.9	34.2	0	18.1	11.0

CHARACTERISTICS OF HIV POSITIVES

Mean Age at Time of Test (Range)	23.3 (18.35)
Mean Age at First Sexual Intercourse (Range)	18.1 (13-21)
Money Accepted for First Sex	25%
Ever Accepted Money for Sex	93.75%
Mean Age First Accepted Money for Sex (Range)	20.7 (17-32)
Registered with Social Hygiene Clinic	93.75%
City working in at time of Positive Test:	Pasay 8 Angeles 7 Makati 1
Last city worked in:	Manila 8 Boracay 1 None 7

Foreign Travel: 3/18.75%

Travelers who had sex abroad: 100%

SEXUAL ACTIVITY OF HIV POSITIVES

Mean number of times had sex per week	3.4
Mean number of different sexual partners per week	2.8

Frequency of Condom Use:	Percent
Always	0
Frequently	31.25
Occasionally	31.25
Rarely	25.0
Never	12.5

Sexual Partners of HIV Positives:

	No./Percent	
	Past Year	Prior to 1 Year Ago
Filipino Only	1/6.25	1/7.14
Foreigner Only	13/81.25	11/78.5
Both	2/12.5	2/14.29

History of STDs: 12/75%

Injectable Drug Use: 0

Type of Sex	Percent Frequently	Occasionally	Rarely	Never
Penis-Vaginal	100.0	0	0	0
Penis-Oral	12.5	18.75	18.75	50.0
Penis-Rectal	0	0	0	100.0
Oral-Vaginal	25.0	37.5	37.5	25.0

CITY_____ BAR or CENTER_____ NAMRU-2 ID#_____

DEPARTMENT OF HEALTH/NAMRU-2 HIV SURVEILLANCE QUESTIONNAIRE
(FEMALE)

1. HOW OLD ARE YOU? _____

2. WHERE DO YOU COME FROM? (WHERE DID YOU GROW UP?)

CITY (OR TOWN) _____ PROVINCE _____

3. WHERE DO YOU LIVE NOW? CITY (OR TOWN) _____

BARANGAY _____ PROVINCE _____

4. WHAT WAS THE HIGHEST YEAR OF SCHOOLING YOU COMPLETED?

ELEMENTARY	1 2 3 4 5 6	
HIGH SCHOOL	1 2 3 4	(CIRCLE HIGHEST YEAR)
COLLEGE	1 2 3 4	
BEYOND COLLEGE	1 2 3 4	

5. WHAT IS YOUR MARITAL STATUS?

MARRIED ____ *SEPARATED/ANNULLED* ____ *SINGLE (NEVER MARRIED)* ____

6. HOW OLD WERE YOU THE FIRST TIME YOU HAD SEXUAL INTERCOURSE WITH A MALE? ____ DID YOU ACCEPT MONEY FOR THAT SEX? YES ___ NO ___

7. HOW OLD WERE YOU WHEN YOU FIRST ACCEPTED MONEY FOR SEX? _____

8. DO YOU NOW ACCEPT MONEY FOR SEX? YES ___ NO ___

9. BEGINNING WITH THE FIRST TIME, LIST ALL THE CITIES (OR TOWNS) AND PROVINCES (WITH DATES) WHERE YOU ACCEPTED MONEY FOR SEX.

	LOCATION			DATES		TYPE OF WORK	REG/UNREG	
	CITY (OR TOWN)	PROVINCE	BAR	FROM MO/YR	TO MO/YR	(SEE NOTE*)		
A.								
B.								
C.								
D.								
E.								
F.								
G.								
H.								
I.								
J.								

* BAR HOSTESS/ENTERTAINER, DANCER, MASSEUSE, CALL GIRL, STREET WALKER, OR OTHER DESCRIPTIVE TITLE. CHECK IF REGISTERED OR UNREGISTERED.

10. DID YOU EVER LIVE IN WITH A BOYFRIEND OR HAVE REGULAR SEXUAL RELATIONS WITH THE SAME MAN (CUSTOMER OR NON-CUSTOMER) FOR MORE THAN ONE MONTH? IF YES, LIST FOR EACH BOYFRIEND:

	BOYFRIEND'S NATIONALITY	WHERE YOU LIVED TOGETHER CITY (TOWN) PROVINCE	DATES FROM MO/YR TO MO/YR
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			

11. HAVE YOU EVER TRAVELED OUTSIDE THE PHILIPPINES? _____ IF YES, WHAT COUNTRY(S)? _____ WHEN?(MO/YR TO MO/YR) _____

DID YOU HAVE SEX THERE? _____ DID YOU ACCEPT MONEY FOR SEX THERE? _____

12. DURING THE PAST 12 MONTHS:

A. WHAT IS THE USUAL NUMBER OF TIMES YOU HAD SEX EACH WEEK? _____

B. HOW MANY DIFFERENT SEXUAL PARTNERS DID YOU USUALLY HAVE EACH WEEK? _____

C. WHO DID YOU HAVE SEX WITH MOST FREQUENTLY?

(1) RACE
- CAUCASIAN ____
- ASIAN ____
- BLACK ____
- MIDDLE EASTERN ____

(2) NATIONALITY
1. _____
2. _____
3. _____
4. _____
5. _____

13. PRIOR TO ONE YEAR AGO, WHAT RACE(S) _____ AND NATIONALITY(S) _____ DID YOU HAVE SEX WITH MOST FREQUENTLY?

14. HOW OFTEN DO YOU PERFORM THE FOLLOWING TYPES OF SEX?

	FREQUENTLY	OCCASIONALLY	RARELY	NEVER
A. PENIS-VAGINAL				
B. PENIS-ORAL				
C. PENIS-RECTAL				
D. ORAL-VAGINAL				

15. HOW OFTEN DO YOUR SEXUAL PARTNERS USE CONDOMS?

ALWAYS ____ FREQUENTLY ____ OCCASIONALLY ____ RARELY ____ NEVER ____

16. WHEN YOUR SEXUAL PARTNERS DON'T USE A CONDOM, WHAT IS THE MOST COMMON REASON?

DIDN'T HAVE ONE WITH HIM ____ *HE DOESN'T LIKE CONDOMS* ____

I DON'T LIKE CONDOMS ____ OTHER REASON (SPECIFY) _____

_____

17. HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (STD, VENEREAL DISEASE)? ____ IF YES, DID YOU HAVE:

	YES	DATE(S) (MONTH/YEAR)
GONORRHEA	_____	_____
SYPHILIS	_____	_____
GENITAL WARTS	_____	_____
GENITAL ULCERS	_____	_____
VAGINAL DISCHARGE W/ITCHING PAIN	_____	_____
OTHER STD (SPECIFY)	_____	_____

18. DID YOU EVER TAKE INJECTABLE DRUGS NOT PRESCRIBED BY A DOCTOR? ____
IF YES,

WHEN?_____

WHAT DRUG(S)?_____

HOW OFTEN?_____

DATE OF INTERVIEW_____

*INTERVIEWER'S NAME*_____

⑧ Program proposals by RITM/DOH

PROPOSAL FOR A THIRD COUNTRY TRAINING PROGRAM ON THE LABORATORY DIAGNOSIS OF HUMAN IMMUNODEFICIENCY VIRUS INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

Proponent: Department of Health, Research Institute for Tropical Medicine
Alabang, Muntinlupa, Metro Manila, Philippines

Rationale:

Acquired Immune Deficiency Syndrome (AIDS) has, within a short period of time, emerged as a global health problem. AIDS continues to escalate at a very rapid pace and it is estimated that by the year 2000, 30 to 40 million will be infected and about 2/3 of these will be seen in Southeast Asia and the Western Pacific Regions. In Thailand alone, WHO estimates that there will be between 2-3 million HIV infected persons by the year 2000.

Since its first description in 1981, the knowledge of the spectrum of the clinical manifestations of AIDS has greatly broadened. Advances in HIV medicine provide real benefits to patients and the community as well as challenges to health workers to acquire skills needed to detect HIV infection and diagnose opportunistic infections early. To the patient, early diagnosis and intervention with antiretroviral therapy may delay progression of the disease and chemoprophylaxis against opportunistic infections will help them maintain a good quality of life. To the community, early diagnosis and counselling provide excellent opportunity for minimizing HIV transmission and of reducing the impact of HIV.

Sexually transmitted diseases(STDs) continue to be highly prevalent. It has been estimated that 685,000 people are infected with STD pathogens daily and that there are 250 Million new cases yearly. In addition to the problem of control of STDs, we now know that STDs facilitate transmission and increase the risk of acquiring HIV infection. Genital ulcers caused by STDs (e.g. chancroid, herpes, syphylis) have been associated with the greatest risk of acquiring HIV infection. Other STDs which do not cause ulcers may also enhance HIV transmission because they increase the number of white blood cells, which are both targets and sources of HIV in the genital tract. Genital inflammation may cause microscopic cuts that can allow HIV to enter the body. STDs causing vaginal

and urethral inflammation are far more common than genital ulcer diseases and so may be responsible for a larger share in HIV transmisson. Infection with HIV also affects the other STDs. In people with HIV infection, other STDs may be more resistant to treatment and symptoms may last longer. Hence, they are more likely to transmit HIV and increase the pace of the AIDS epidemic.

It is therefore essential that health-care providers are equipped with up-to-date knowledge and skills in the diagnosis of HIV infection, opportunistic infections in AIDS and sexually transmitted diseases.

General Objective:

To provide opportunities for health care providers to enhance their knowledge and develop their technical skills in the diagnosis of HIV infection, opportunistic infections in AIDS and the other sexually transmitted diseases.

Specific Objectives:

By the end of the training course, it is hoped that the participants will be able to:

1. Understand the nature of HIV infection with regards to to the biology of the virus, its effect on the immune system.

2. Understand the HIV/AIDS pandemic, modes of transmission and methods of prevention.

3. Appreciate the clinical picture of patients with AIDS as it correlates with various opportunistic infections and other related diseases.

4. Understand the natural history of sexually transmitted diseases (STDs), the pathogen, sequelae, and transmissibility.

5. Understand the link between STDs and HIV Infection/AIDS.

6. Demonstrate adequate knowledge and competency in performing HIV antibody screening and supplemental tests.

7. Understand the significance and limitations of other methods in HIV diagnosis such as PCR, Antigen datectection and Virus Isolation.

8. Demonstrate adequate knowledge and skills in performing diagnostic procedures necesarry for the detection of different pathogens causing opportunistic infections in AIDS.

9. Demonstrate adequate knowledge and skills in the accurate identification of pathogens associated with sexually transmitted diseases.

10. Demonstrate adequate knowledge and skills in performing antibiotic/anti-TB drug susceptibility tests.

11. Understand and practice biosafety precautions for the handling and testing of blood, body fluids and potentially infectious materials/agents in the laboratory.

12. Understand specific AIDS/STD counselling strategies.

13. Clarify some of the social, ethical and legal issues in AIDS/STD.

Proposed Duration: 30 days
Course Instruction: English
Participants: 16 (8 Foreign, 8 Local)

Qualifications:

Participants should:

1. be at least 2 years laboratory experience in Microbiology.

2. be in AIDS/STD work

3. have a sufficient command of spoken and written English

TITLE OF PROPOSAL:

TRAINORS' WORKSHOP ON THE LABORATORY DIAGNOSIS OF HIV INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

PROPONENT:

DEPARTMENT OF HEALTH RESEARCH INSTITUTE FOR TROPICAL MEDICINE, PHILIPPINES.

RATIONALE:

The growing impact of AIDS and other sexually transmitted diseases (STDs) demands the need for trained laboratory personnel to provide early, accurate and reliable results in the diagnosis of HIV, opportunistic infections among AIDS patients and sexually transmitted diseases. Cognizant of this demand, a training course on the laboratory diagnosis of HIV, opportunistic infections in AIDS and sexually transmitted diseases for laboratory personnel is being proposed. Key to the successful delivery of this training course, faculty and context preparation is paramount. For this reason, this trainors' training workshop is proposed for consideration of the Japanese Government in its committment to the prevention of the spread of AIDS through the enhancement and strengthening of laboratory diagnostic capabilities.

GENERAL OBJECTIVE:

To train trainors for the laboratory diagnosis of HIV infection, opportunistic infections in AIDS and sexually transmitted diseases.

SPECIFIC OBJECTIVES/EXPECTED OUTPUT:

At the end of the workshop, the following should be accomplished:

1. Enhanced knowledge and skills proficiency of the trainors in the performance of laboratory procedures for the diagnosis of HIV infection, opportunistic infections AIDS and other STDs.

2. Increase in the number of qualified trainors in HIV/AIDS and STDs.

3. Standardization of teaching formats.

4. Production of Trainor's Manual/Guide.

DURATION: 2 weeks

PARTICIPANTS: 16 RITM STAFF (Microbiology/Pathology)

TRAINORS' WORKSHOP ON THE LABORATORY DIAGNOSIS OF HIV INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

PROPOSED COURSE CONTENT

SCHEDULE	LEARNING ACTIVITIES	
DAY 1		
8:00-9:00	Orientation to the course Acquaintance Levelling of Expectations	
9:00-10:00	Assessment of Attitudes	
10:00-10:15	Break	
10:15-12:00	Development of communication skills and training plan	
12:00-1:30	Lunch Break	
1:30-5:00	Lecture 1	:AIDS Information: Epidemiology, Biology of HIV, modes of transmission, HIV testing, clinical picture and management, reporting and counselling.
DAY 2		
8:00-9:00	Lecture 2	:Laboratory Safety and Precautions
9:00-10:00	Lecture 3	:Specimen collection, handling, transport and storage
10:00-10:15	Break	
10:15-12:00	Laboratory 1	:HIV Testing (Simple and Rapid Assays)
12:00-1:30	Lunch Break	
1:30-5:00	Laboratory 2	:HIV Testing (Enzymeimmunoassays)

DAY 3

8:00-10:00 Lecture 4 :Laboratory Diagnosis of Opportunistic Bacterial Infections

10:00-10:15 Break

10:15-4:00 Laboratory 3 :HIV Testing (Supplemental tests)

12:00-1:30 Lunch Break

4:00-5:00 Homework 1 :Analysis of training needs/training plan for HIV Testing

DAY 4

8:00-9:00 Discussion of Homework 1

9:00-12:00 Laboratory 4 :Diagnostic procedures for the diagnosis of Mycobacterial in fections AIDS: AFB staining of sputum and tissue; Auramine staining

12:00-1:30 Lunch Break

1:30-5:00 Laboratory 5 :Mycobacterial Culture
Antibiotic Susceptibility Testing

DAY 5

8:00-10:00 Lecture 6 :Laboratory diagnosis of opportunistic fungal infections in AIDS

10:00-10:15 Break

10:15-3:00 Laboratory 6 :Identification of M. TB (Biochmical Tests)
Anti-TB Drug Susceptibility Testing

3:00-3:15 Break

3:15-4:30 Laboratory 7 :Direct identification of Candida and Cryptococcus Candida and Cryptococcus culture

4:30-5:00 Homework 2 :Analysis of training needs/plan for opportunistic bacterial and fungal infections

WEEK 2

DAY 1

8:00-9:00 Discussion of Homework 2

9:00-12:00 Laboratory 8 :Work-up of Candida and Cryptococccus culture

12:00-1:30 Lunch Break

1:30-5:00 Laboratory 9 :Mucicarmine Staining and Identification of Mycobacteria

DAY 2

8:00-10:00 Lecture 7 :Laboratory diagnosis of opportunistic parasitic infections in AIDS

10:00-10:15 Break

10:15-12:00 Laboratory 10 :Direct Identification of Cryptosporidium

12:00-1:30 Lunch Break

1:30-5:00 Laboratory 11 :Serologic Diagnosis of Toxoplasmosis

DAY 3

8:00-10:00 Lecture 8 :Laboratory diagnosis of opportunistic viral infections in AIDS

10:00-10:15 Break

10:15-12:00 Laboratory 12 :Laboratory detection of P. carinii

12:00-1:30 Lunch Break

1:30-4:30 Laboratory 13 :CMV Isolation and Identification Histopathologic identification of CMV

4:30-5:00 Homework 3 :Analysis of training needs/plans on the laboratory diagnosis of parasitic and viral infections

DAY 4

8:00-9:00 Discussion of Homework 3

9:00-10:00 Lecture 9 :Introduction to Sexully Transmitted Diseases

10:00-10:15 Break

10:15-12:00 Lecture 10 :Laboratory Methods in the Diagnosis of Sexually Transmitted Diseases

12:00-1:30 Lunch Break

1:30-5:00 Laboratory 14 :Microscopic Examination of KOH and Saline Mounts
Gram's Stainning and microscopic examination of GC smear
N. gonorrhea culture

DAY 5

8:00-10:00 Laboratory 15 :Work-up of N. gonorrhea culture
Antibiotic Susceptibility Testing for N. gonorrhea

10:00-10:15 Break

10:15-12:00 Laboratory 16 :Serologic Diagnosis of Syphilis (RPR, TPHA, FTA-ABS)

12:00-1:30 Lunch Break

1:30-4:30 Laboratory 17 :HSV Isolation and Identification
Chlamydia Isolation and Identification
Chlamydia Direct Test

4:30-5:00 Homework 4 :Analysis of training needs/plans on the laboratory diagnosis of sexually transmitted diseases

DAY 6

8:00-9:00 Discussion of Homework 4

9:00-12:00 Development of Training Format/Modules

12:00-2:00 Post-Workshop Evaluation
CLOSING CEREMONIES

THIRD COUNTRY TRAINING PROGRAMME ON THE LABORATORY DIAGNOSIS OF HIV INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

WEEK 1

WORKSHOP MODULE ON THE DIAGNOSIS OF HIV INFECTION

WEEK 1	8 : 30 - 9 : 45	10:00 - 11:00	11:00 - 12:00	1:30 - 3:00	3:15 - 5:00
DAY 1	Registrantion & Opening Ceremonies		Course Orientation Administrative Matters	Acquaintance & Moving Survey	Presentation of Country Reports
DAY 2	Presentation of Local situation (Local participants)	Lecture 1 Epidemiology of HIV Infection/AIDS	Lecture 2 Biology of HIV	Lecture 3 Laboratory Safety and Precautions	Lecture 4 HIV Screening Tests: Principles and Methods
DAY 3	Lecture 5 HIV Supplemental Tests: Principles and Methods	Laboratory 1 HIV Screening: Simple and Rapid Tests		Laboratory 2 HIV Screening : Enzymeimmunoassays (Plate and Bead Format)	
DAY 4	Lecture 6 HIV Isolation and PCR: Principle & applications in the diagnosis of HIV	Laboratory 3 HIV Screening: Enzymeimmunoassay (continuation)		Laboratory 4 HIV Supplemental Test: Western Blot	
DAY 5	Lecture 7 Pre- and Post- Test Counselling/Role Sloying	Laboratory 5 HIV Supplemental Test: Lineimmunoassay		Laboratory 6 HIV Supplemental Test: Immunofluorescence Technique	

COFFEE BREAK: 9:45 - 10:00 LUNCH BREAK: 12:00 - 1:30 COFFEE BREAK: 3:00 - 3:15

THIRD COUNTRY TRAINING PROGRAMME ON THE LABORATORY DIAGNOSIS OF HIV INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

WEEK 2

WORKSHOP MODULE ON THE DIAGNOSIS OF OPPORTUNISTIC INFECTION IN AIDS

WEEK 2	8:30 - 9:45	10:00 - 11:00	11:00 - 12:00	1:30 - 3:00	3:15 - 5:00
DAY 1	Lecture 8 Clinical Picture and Management of HIV Infection	Lecture 9 Collection, Handling and Transport of specimens for the diagnosis of Opportunistic Infections	Laboratory 7 Use of PCR in HIV Diagnosis	Laboratory 8 PCR ..continued	Discussion Post Workshop Evaluation
DAY 2	Lecture 10 Mycobacterial Infections	Lecture 11 Laboratory diagnosis of Opportunistic Bacterial Infections	Lecture 12 Antibiotic Susceptibility Testing	Laboratory 9 Mycobacterial Culture (Processing and Inoculation of samples)	
DAY 3	Lecture 13 Rapid Diagnosis of Mycobacterial Infections	Lecture 14 Anti-TB Drug Suscopti-bility Testing	Laboratory 10 Identification of M.TB : AFB Staining(sputum & Tissue preparation) Auramine Staining	Laboratory 11 Identification of M.TB ...continuation of Lab. 10 Use of Biochemical Tests	
DAY 4	Laboratory 12 Diagnosis of Mycobacterial Infections Using PCR (Demonstration)			Laboratory 13 Antibiotic Susceptibility Testing Anti-TB Drug Susceptibility Testing	
DAY 5	Lecture 15 Candidiasis / Lecture 16 Cryptococcal Infectior	Lecture 17 Laboratory Diagnosis of Opportunistic Fungal Infections	Laboratory 14 Reading & Interpretation: Anti-TB Drug and Antibiotic Susceptibility Testings	Laboratory 15 Candida & Cryptococcus culture	Laboratory 16 Direct Examination of Candida & Cryptococcus

COFFEE BREAK: 9:45 - 10:00 LUNCH BREAK: 12:00 - 1:30 COFFEE BREAK: 3:00 - 3:15

THIRD COUNTRY TRAINING PROGRAMME ON THE LABORATORY DIAGNOSIS OF HIV INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

WEEK 3

WORKSHOP MODULE ON THE DIAGNOSIS OF OPPORTUNISTIC INFECTIONS IN AIDS

WEEK 3	8:30 - 9:45		10:00 - 11:00	11:00 - 12:00	1:30 - 3:00	3:15 - 5:00
DAY 1	Lecture 18 Toxo-plasmosis	Lecture 19 Crypto-sporidiosis	Lecture 20 Pneumocystis carinii Pneumonia	Lecture 21 Laboratory Diagnosis of Opportunistic Parasitic Infections	Laboratory 17 Work-up of Candida and Cryptococcus culture	Laboratory 18 Mucicarmine Staining of Cryptococcus Cryptococcal Antigen Detection
DAY 2	Laboratory 19 Microscopic examination of Cryptococcus (continuation of Lab. 18)		Laboratory 20 Direct Identification of Cryptosporidium: 1. Modified AFB Staining 2. IF Technique		Laboratory 21 Serologic Diagnosis of Toxoplasma Infection 1. Latex Agglutination Test 2. Immunofluorescence Technique	
DAY 3	Laboratory 22 Detection of Pneumocystis carinii : Histopathologic and Immunofluorescence Technique			Laboratory 23 (Continuation of Lab. 22): Staining and Microscopic Examination		
DAY 4	Lecture 22 Cytomega-lovirus infection	Lecture 23 Laboratory diagnosis of Opportunis-tic Viral Infections	Laboratory 24 CMV Isolation: Demonstration of Cell Line and Inoculation of specimens	Laboratory 25 Cytopathic Effect of CMV (Demonstration) Identification of CMV using Immunofluorescence Technique	Laboratory 26 Serologic Diagnosis of CMV : IgG/IgM Antibody Detection	Laboratory 27 Histopathologic Identi-fication of CMV Discussion Post Workshop Evaluation
DAY 5	STUDY TOUR (INCLUDES SATURDAY & SUNDAY)					

COFFEE BREAK: 9:45 - 10:00 LUNCH BREAK: 12:00 - 1:30 COFFEE BREAK: 3:00 - 3:15

THIRD COUNTRY TRAINING PROGRAMME ON THE LABORATORY DIAGNOSIS OF HIV INFECTION, OPPORTUNISTIC INFECTIONS IN AIDS AND SEXUALLY TRANSMITTED DISEASES

WEEK 4

WORKSHOP MODULE ON THE DIAGNOSIS OF OPPORTUNSTIC INFECTION IN AIDS

WEEK 4	8:30 - 9:45	10:00 - 11:00		11:00 - 12:00		1:30 - 3:00	3:15 - 5:00
DAY 1	Lecture 1 Introduction to Sexually Transmitted Disesses	Lecture 2 Neisseria gonorrhea	Lecture 3 Syphillis	Lecture 4 Chancroid gonorrhea	Lecture 5 Specimen collection, transport & processing	Laboratory 1 Gram's Staining and Microscopic Examination of GC smear	Laboratory 2 N. gonorrhea Culture
DAY 2	Lecture 6 Herpes Infection	Lecture 7 Chlamydia	Laboratory 3 Chlamydia Isolation (Demonstration) HSV Isolation (Demonstration)			Laboratory 4 Serologic Diagnosis of Syphilis (RPR, TPHA & FTA-ABS)	
DAY 3	Laboratory 5 Work-up of N. gonorrhea culture					Laboratory 6 Observation of HSV Cytopathic Effect Identification of HSV using IF Technique	
DAY 4	Lecture 8 Trichomonas	Lecture 9 Bacterial Vaginosis	Laboratory 7 Microcopic Examination : KOH Mount Wet Mount			Laboratory 8 Staining and Microscopic Examination of Chlamydia Isolates Chlamydia Direct Test	
DAY 5			Discussion Post Workshop Evaluation			CLOSING CEREMONIES (6:30 p.m.)	

COFFEE BREAK: 9:45 - 10:00 LUNCH BREAK: 12:00 - 1:30 COFFEE BREAK: 3:00 - 3:15

⑨ History of Blood Services in the Philippines

I. History of Blood Services in the Philippines

A. Early History of NBP

With an objective of providing safe & adequate blood to people in need, the National Blood Program (NBP) of the Philippine National Red Cross (PNRC) was born on July 17, 1948. Initially established as the Central (Community) Blood Bank, the forerunner of the National Blood Center (NBC), it gradually developed into a network of blood service facilities throughout the whole archipelago.

B. Partnership with PCSO

Running a blood program, however, was not without difficulties. In line with meet ing its objective, the NBP believes that a voluntary blood donor is the safest source of blood and, in order to provide this kind of blood to the myriad of patients in the hospitals, the financial resources have to be maximally stretched to produce an average of 100,000 units of blood annually for the past 11 years.

Thanks to the PCSO whose regular contribution has in one way or another enabled the NBP to purchase the much needed equipments, supplies, & reagents to support the manpower delivering the services & to maintain the blood bank equipments for production of quality blood.

Structure of the PNRC-NBP

The NBP operates nationwide through its network of blood centers (Appendices 1 & 2) which were developed in time to meet the increasingly urgent demand for blood:

N B P

(Regional Blood Centers)

National Blood Center	Eastern Visayas Blood Center	Western Visayas Blood Center	Mindanao Blood Center
*Chapter Blood Center - 25	8	4	11
**Blood Extension Service - 8	3	0	3
***Blood Station - 4	3	0	3

Notes:

* --Complete facilities for:

Recruitment and screening of blood donors

Bleeding of blood donors

Storage and processing of blood

Dispensing of blood

**--Complete facilities for:

Recruitment and screening of blood donors

Bleeding of blood donors

Storage only of blood (processing of blood is done by nearest blood center or by the provincial hospitals)

***--Facilities only for storing and dispensing of blood for emergency use.

II. HIGHLIGHTS IN 1993:

A. Chronology of Events

January - The Philippine National Police started the year with a kick-off Program for Operation Purple at Camp Crame headed by the Director General Umberto Rodriquez who himself led the Mass Blood Donation (MBD). A total fo 103 Police Officers, Trainers and Civilian Staff donated blood.

February - In this month of hearts the NBC with the support of the Administration headed by Chairman Demetrio Quirino Mass Blood Donations at TIP Manila and Quezon City were organized to obtain 507 and 506 units of blood, respectively. The "Operation Dugtong-Buhay" is a yearly activity.

The Blood Galloners Valentine Blood Donation activity at the NBC was also held with 51 donors bled.

March - President Fidel V. Ramos donated his own blood on his birthday. A total of 47 units was collected at Malacanang, Kalayaan Hall.

Ayala Corporation also held its regular annual MBD with 74 donors who are members of the staff, bled on said occasion.

April - This is usually month with the lowest collection. Only 2 MBDs were conducted including the one in Caloocan on the occasion of Mayor Macario Asistio's B-day with 53 donors bled.

May - On the occasion of the opening of the senate, the Personnel and staff held their own MBD at the Senate building. Thirty one (31) members of the staff including Senator Jose Lina joined this heroic activity.

June - Quezon City hall staff organized a MBD on the occasion of Mayor Ismael Mathay's B-day. One hundred seventynine (179) donors were bled, consisting of Central Police District personnel, Barangay Captains and other constituents of Quezon City. The

Philippine Navy also held MBD on the occasion of its Anniversary with the Philippine Navy GHQ having a collection of 116 and Ft. San Felipe have a collection of 85 donors mostly members of the force.

July - Blood donors week, July 11 - 17, was celebrated nationwide. In Metro Manila the event started with a Motorcade at Quirino Grandstand. This was attended by Metro Manila Chapters, several NGOs and Movie personalities. A Series of MBDs was conducted in different private companies. On the Recongnition Day outstanding donors and friends of the NBP were given awards.

The PMA in Baguio City held its MBD with 152 cadets and officers bled on said occasion.

August - The B-day of former Mayor Ramon Bagatsing neted 132 donors held at Manila Chapter.

The B-day celebration of Governor Ynares of Rizal collected 166 donors and this was arranged through Rizal Chapter, PNRC.

On this month Gov. Rosa Rosal and officers of the Galloners Club were also given the opportunity to give the Blood Galloners Vest and framed poster to Pres. Fidel V. Ramos. This poster of the President donating blood is being used for the promotion of Mass Blood Donation.

September - PICC in celebration of their Anniversary involved their group in a MBD which obtained 25 units of blood.

October - Kick-off of ROTC Operation Dugtong-Buhay was held at Fort Bonifaciso. A total of 50 cadets were bled. The Philippine Coastguard also held their MBD at their GHQ with 27 Coast Guards bled.

The Mayor of Ibaan, Batangas also join the increasing number of local government heads in promoting voluntary blood donation and a total of 14 units was collected.

The Bureau of Research and Laboratory also sponsored a MBD at DOH compound with 6 donors donating blood.

November - A MBD conducted by the Philippine Medical Association was held at PMA office and all its Component Society under the leadership of PMA President Dr. Primitivo Chua who celebrated his B-day on November 27. A total of 404 donors were bled for this occasion nationwide.

December - Mayor Alfredo Lim of Manila sponsored a MBD at City Hall to celebrate his birthday. A total of 109 donors were bled on said occasion. The Katipunan ng mga Artistang Pelikulang Pilipino also sponsored a MBD with its President, Mr. Rudy Fernandez, and Philip Salvador leading the donation.

B. Summary of Performance

In 1993, the PNRC collected a total 91, 363 units with distribution as presented in Table 1. The various chapters' contribution have been specified in Tables 2A-2D.

Fig. 1 shows how much blood is collected form 1990 - 1993.

By component preparation, chances of acquiring diseases by blood transfusion is reduced. In 1993, 7.13% of total units collected have been processed. Fig. 2 illustrates the different components prepared by the different blood centers. While preparation of components has been initially done based on demand, it is expected that the future blood transfusion system will be improved so that 1 unit of blood will serve more than 1 patient.

Blood donations may be done inside the blood center or in MBD sites such as schools, halls, public and private offices. (Fig. 3). 82% of the PNRC supply came form donors who took time to visit the blood centers.

Based on requests for blood, information on the number of patients served have been obtained. A total of 47,585 patients have been served who required blood for emergency or non-emergency purpose.

The NBP also served requests for mass blood typing. A total of 69,599 persons have been blood-typed.

To ensure safety of blood, strict screening measures have been instituted such as physical examination and laboratory screening for malaria, syphilis, hepatitis B and HIV. Throughout the year 287 units of blood tested positive for Syphilis, 3,387 units for hepatitis B and 1 for HIV.

Ⅲ. PROBLEMS AND MAJOR RECOMMENDATIONS

The numerous brownouts in early to mid 1993 primarily caused the decrease in collection in the following ways:

1. Some private companies have lessened the number of workers who are prospective blood donors.

2. In order to maximize use of electrictity, some institutions could not afford to allot some time for mass blood donation.

3. With on power to run airconditioning units, the comfort usually provided to donors cannot be assured.

4. The fluctuations in power supply caused need for frequent repairs of equipments which limited collection and processing of blood.

Another major problem is the lack of computer to store all necessary data. At present the NBP has only one computer/printer which is mainly used to store information on blood donors at the NBC for statistical purposes. Most other information are collected manually. The availability of another computer will prevent re-typing of letters containing the same information, for minutes with minor corrections, and of whole reports which simply need to be updated.

The lack of funds has unquestionably limited the output in terms of incapability to purchase supplies as necessary.

IV. PLANS FOR 1994

The 5-year (1993-1997) development plan of the NBP contains the targets for the year 1994. Emphasis shall be placed on the following:

1. intensification of donor recruitment drive.

In order to meet the increasing demand for safe blood, the PNRC seeks to encourage more people to donate blood.

Starting with the NBC, a target of at least 1 MBD per day has been set to ensure a continuous stock of blood. Additional target donors include Staff of the various private firms listed in the "Top 1,000 organization. . ."

2. development of Chapter Blood Centers

HIV infection/AIDS is the latest addition to the list of diseases that may be acquired by blood transfusion. As such it also adds to the cost of processing blood. As of end 1993, only the NBC, 3 RBCs & 42 CBCs are capable of screening blood. In prominent blood centers these HIV-testing cannot be done due to lack of technology, screening for HIV antibodies is doue by the provincial/regional hospital prior to transfusion, if the hospital has the resources.

It is expected that by the end of 1994, 12 more CBCs (with the next highest blood collection in 1993) will be reinforced by training of medical technologists in HIV proficiency.

3. development of Blood Extension Services to Chapter Blood Centers

With continuous support form our donors, the PNRC-NBP hopes to elevate the status of chapters from BES to CBC.

With other targets as indicated in its 5-year development plan from 1993 to 1997 (Appendix 3), the NBP of the PNRC aims to provide an adequate and affordable supply of safe blood and blood products to patients who need them.

4. purchase of computers

This will enable the NBP to collect as much information which can be utilized in evaluating performance and planning future projects.

5. sustainability

Sooner or later, funds may not be available as newer projects/programs may catch the enthusiasm of donors. It is in the best interest of the PNRC, esp. of the NBP, to identify strategies that will enable the program to be self-sustainable.

One strategy that will be piloted this year is the supply of blood to gov't hospitals who shall shoulder the cost of the plastic bag and the processing /handling fee. This system of dealing directly with the hospital ensures that the handling fees are paid compared to the previous situation when PNRC deals with patients relatives, mostly indigents who cannot replace the blood nor pay the handling fees.

ACKNOWLEDGEMENT

With sincere gratitude, the Philippine National Red Cross-National Blood Program wishes to acknowledge the Philippine Charity Sweepstakes Office for its unending support to the provision of this basic humanitarian service. Truly the PCSO has greatly contributed to save a thousand lives because each unit of blood transfused to an ailing patient has caused a revival.

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FREE STANDING BLOOD BANK

ANNUAL REPORT OF ACCOMPLISHMENTS

January 1 to December 31, 1993

1. Tybe of Blood Bank

[ ] PNRC [ ] PRIVATE FREE STANDING

2. No. of Donors	Screened	Rejected
2.1. Requested	10,391	1,735
2.2. Referral		
2.3. Reserved		
Total		

3. No. of Blood Bled	O	A	B	AB	Total	Rh(-)
3.1. Paid Donors						
3.2. Voluntary Donors	3,764	2,194	2,210	488	8,656	20

4. No. of Blood Units Obtained from

4.1. PNRC Blood Bank	
4.2. Government Hospital Blood Bank	
4.3. Private Hospital Blood Bank	
4.4. Free Standing Blood Bank	

5. No. of Units Prepared		O	A	B	AB	Total	Rh(-)
5.1. Whole Blood		2,180	1,162	1,240	309	4,891	20
5.2. Packed Red Cell		619	397	374	72	1,462	
5.3. Plasma		52	22	39	2	115	
5.4. Platelet Conc.		257	136	124	27	544	
	CRYO	212	143	150	17	522	
5.5. Others	FFP	438	311	283	61	1,093	
	WRBC	6	23			29	

6. No. of Units Tranfused:

	O	A	B	AB	Total	Rh(-)
6.1. Whole Blood						
6.2. Packed Red Cell						
6.3. Plasma						
6.4. Platelet Conc.						
6.5. Others						

7. No. of Units Not Used:

7.1. Expired	52
7.2. Contaminated (Bacteria)	
7.3. HIV (Positive)	0
7.4. HBV (Positive)	661
7.5. VDRL/RPR (Positive)	45
7.6. Others	

8. No. of Donors

	Tested	Positive
8.1. VDRL/RPR	8,313	45
8.2. Malaria		
8.3. HBV	8,313	661
8.4. HIV	8,313	0

9. No. of Units of Blood

	Tested	Positive
9.1. VDRL/RPR	8,121	45
9.2. Malaria		
9.3. HBV	8,121	661
9.4. HIV	8,141	0

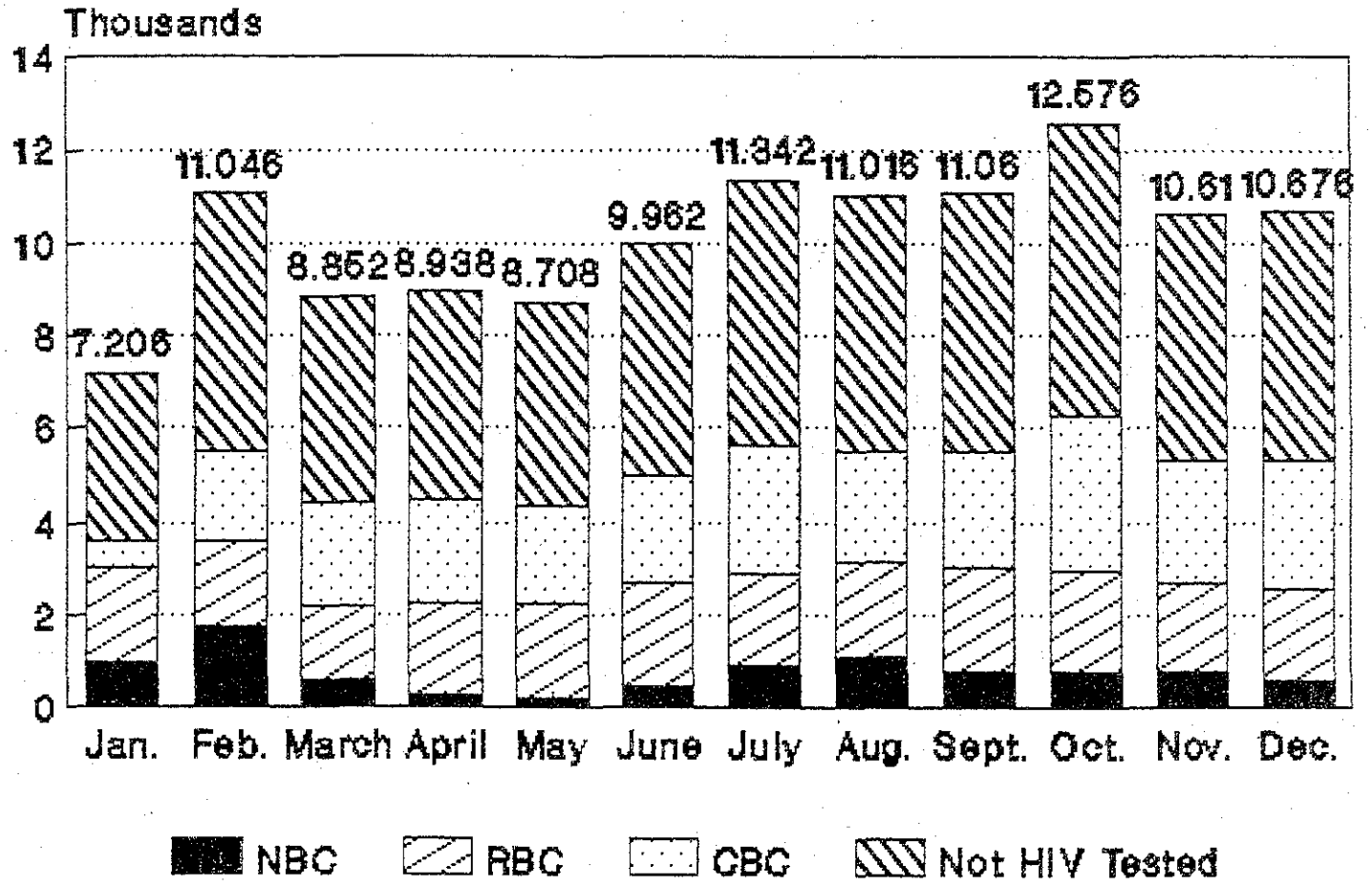
10. NO. of Units of Blood with Tranfusion Reaction: _____

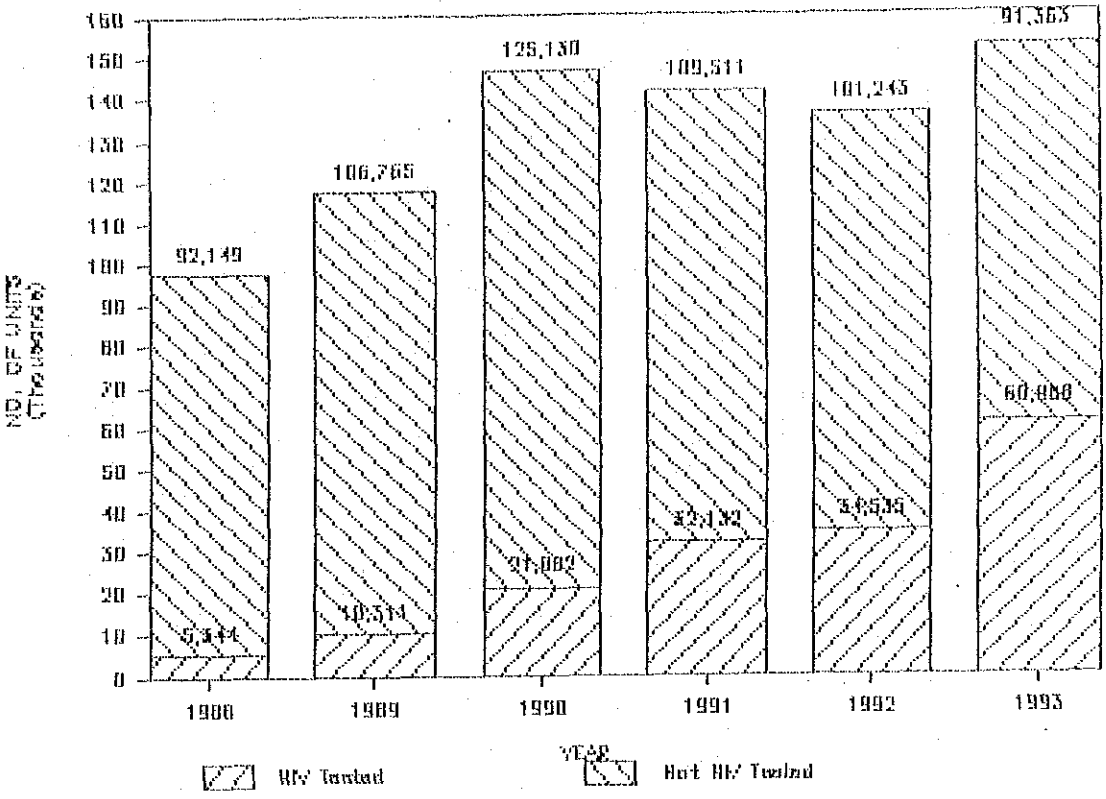
Prepared by:

/roc _____

Noted by: _____

1993 MONTHLY BLOOD COLLECTION OF PNRC
HIV-Testing Centers



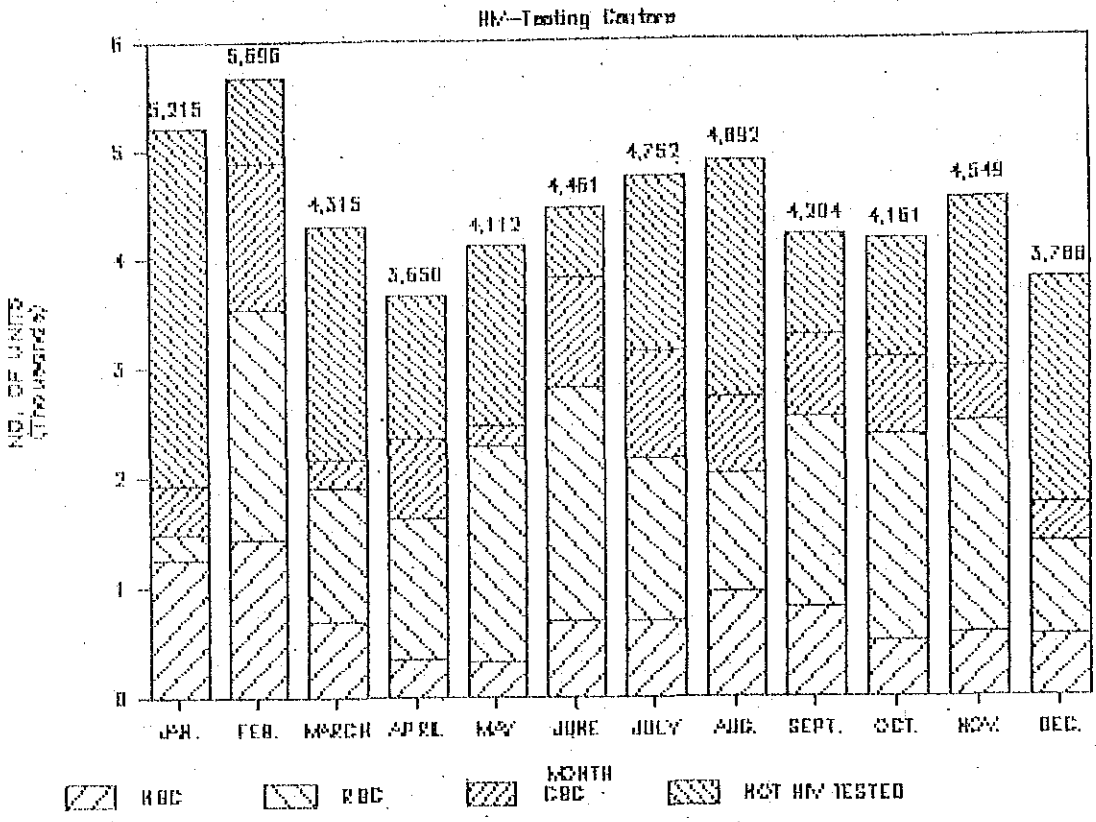


In 1993, the Philippine National Red Cross was able to screen 67% of its blood supply for HIV.

Only 20 Red Cross Blood Centers performed screening tests for HIV.

1. *National Blood Center*
2. *Western visayas Regional Blood Center*
3. *Eastern visayas Regional Blood Center*
4. *Mindanao Regional Blood Center*
5. *Davao City Chapter Blood Center*
6. *Tacloban Chapter Blood Center*
7. *Rizal Chapter Blood Center*
8. *Quezon City Chapter Blood Center*
9. *Bacolod Chapter Blood Center*
10. *Laoag City Chapter Blood Center*
11. *Digos Chapter Blood Center*
12. *Capiz Chapter Blood Center*
13. *General Santos City Chapter Blood Center*
14. *Olongapo City Chapter Blood Center*
15. *Tagum Chapter Blood Center*
16. *Zamboanga City Chapter Blood Center*
17. *Masbate Chapter Blood Center*
18. *Laguna Chapter Blood Center*
19. *Ormoc Chapter Blood Center*
20. *Pagadian City Chapter Blood Center*

1992 MONTHLY BLOOD COLLECTION OF PNRC



HIV91

MONTHLY DIST. OF HIV-TESTED BLOOD

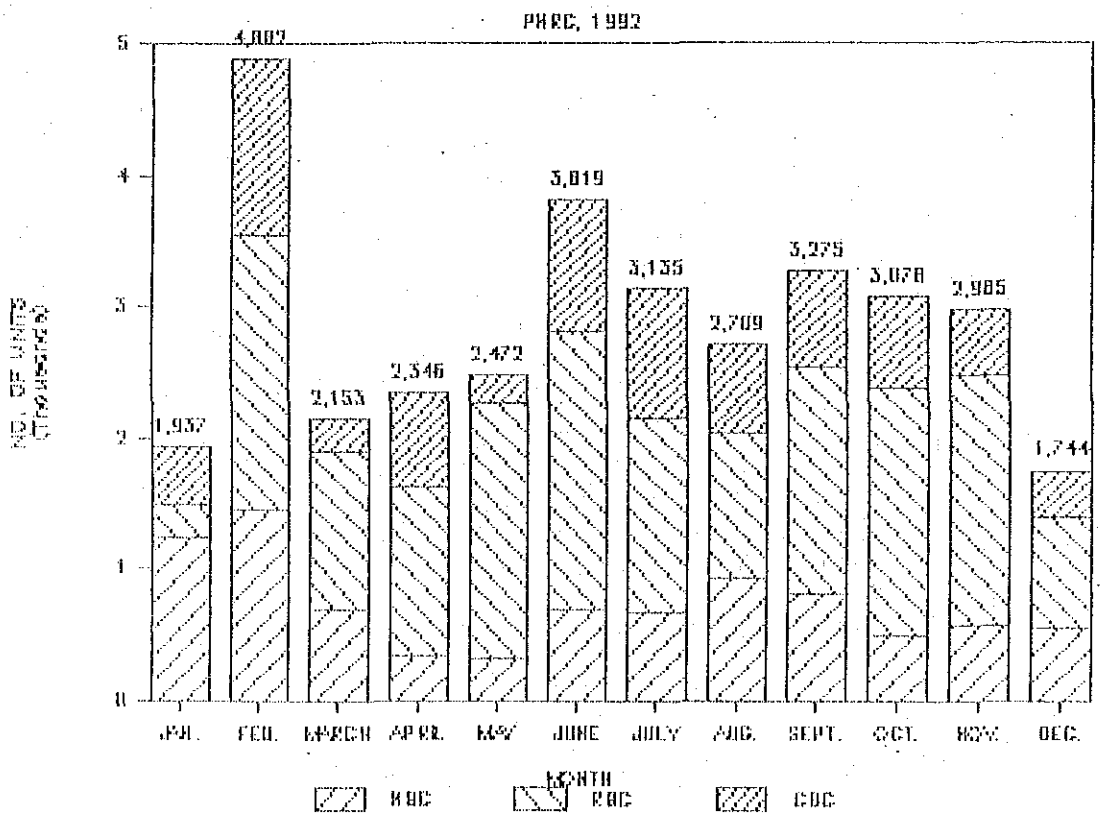


Fig. 1 Units of Blood Collected

(1990 - 1993)

Fig. 2 Blood Components Prepared

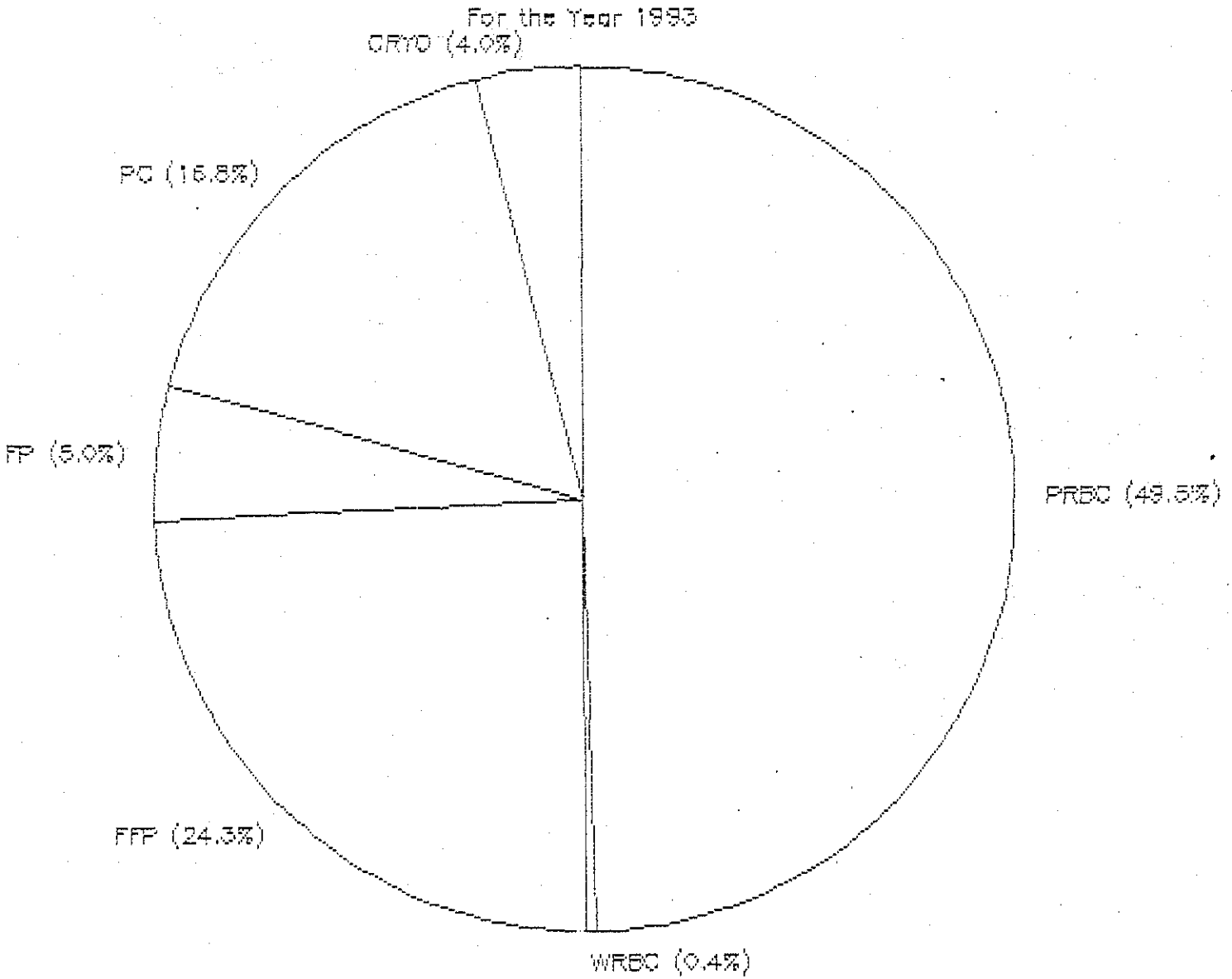
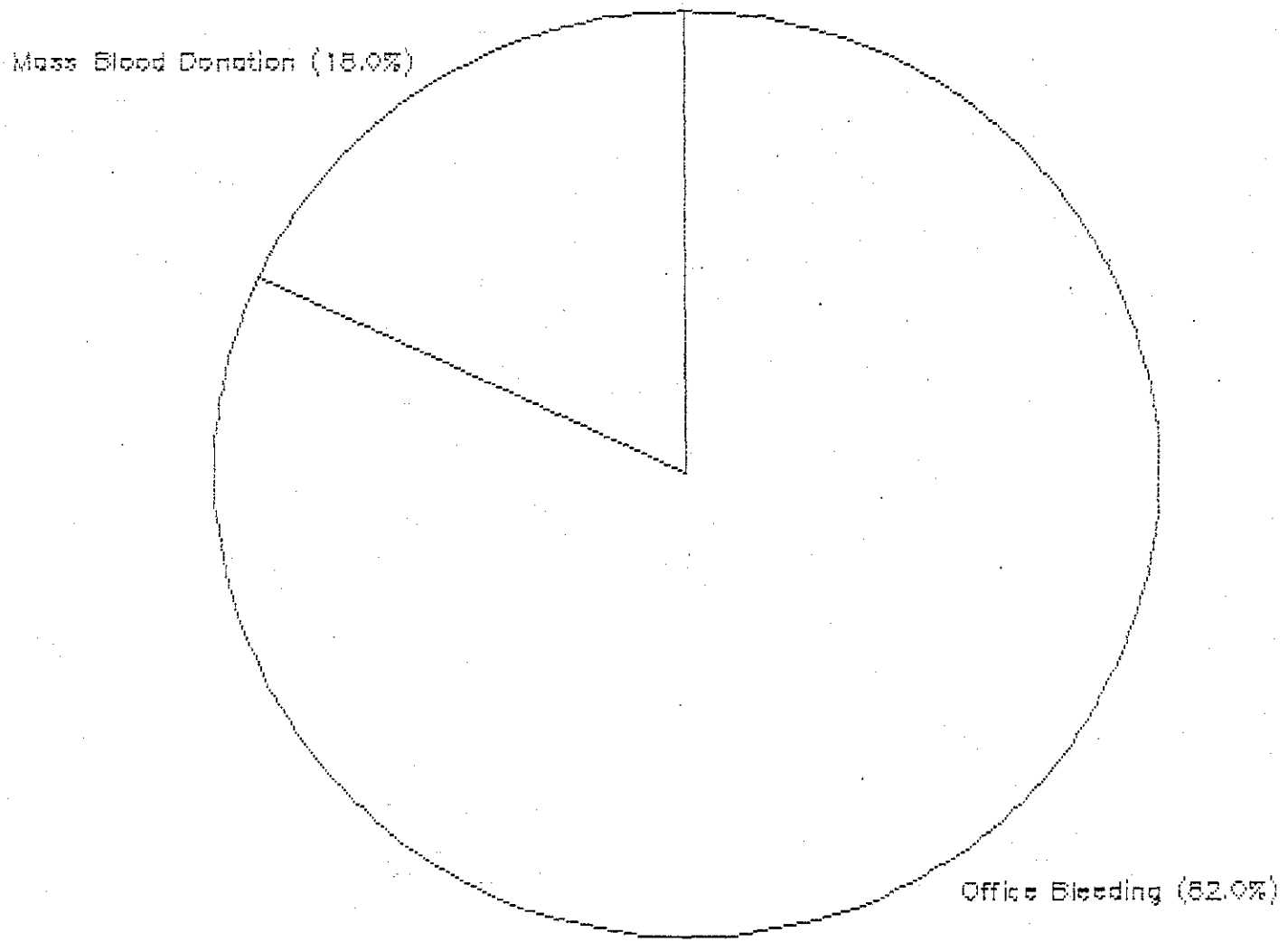


Fig. 3 Distribution of Blood

Collection according to sites



THE PHILIPPINE NATIONAL RED CROSS
NATIONAL BLOOD PROGRAM

National Blood Center*	Port Area, Manila
Regional Blood Center*	Location
1. Eastern Visayas Blood Center	Cebu City
2. Western Visayas Blood Center	Iloilio City
3. Mindanao Blood Center	Cagayan de Oro City
Chapter Blood Center*	
1. Aurora	Aurora, Quezon
2. Agusan del Norte	Butuan City
3. Aklan	Kalibo, Aklan
4. Albay-Legaspi City	Legaspi City
5. Antique	San Jose
6. Baguio	Baguio City
7. Basilan	Isabela
8. Bataan	Balanga
9. Benguet	La Trinidad
10. Bulacan	Malolos
11. Cagayan	Tugeugarao
12. Camarines Norte	Daet
13. Camarines Sur	Naga
14. Capiz	Roxas City
15. Cotabato	Cotabato City
16. Davao	Tagum
17. Davao City	Davao City
18. Davao del Sur	Digos
19. Davao Oriental	Mati
20. General Santos City	Gen. Santos City
21. Iligan City	Iligan City
22. Ilocos Norte	Laoag City
23. Isabela	Ilagan
24. Laguna	Sta. Cruz
25. Leyte	Tacloban City
26. Masbate	Masbate
27. Misamis Occidental	Oroquieta City
28. Negros Occidental	Bacolod City
29. Negro Oriental	Dumaguete City
30. Nueva Ecija	Cabanatuan City
31. Nueva Vizcaya	Bayombong
32. Olongapo	Olongapo City
33. Ormoc City	Ormoc City
34. Ozamis City	Ozamis City
35. Palawan-Puerto Princesa	Puerto Princesa
36. Palawan-Roxas	Roxas
37. Pampanga-Angeles	San Fernando
38. Pangasinan-Dagupan	Dagupan City
39. Quezon City	Quezon City
40. Quezon-Lopez	Lopez
41. Quezon-Lucena	Lucena City
42. Rizal	Pasig
43. Surigao del Norte	Surigao City
44. South Cotabato	Koronadal
45. Surigao del Sur	Tandag
46. Tarlac	Tarlac
47. Zamboanga City	Zamboanga City
48. Zamboanga del Sur	Pagadian City

Blood Extension Service**

1.	Bohol	Tagbilaran
2.	Bukidnon	Malaybalay
3.	Cavite	Cavite
4.	Catanduanes	Virac
5.	Gingoog	Gingoog
6.	Ilocos Sur	Vigan
7.	Kalinga-Apayao	Tabuk
8.	Lanao del Norte	Tubod
9.	Mindoro Oriental	Calapan
10.	San Pablo City	San Pablo City
11.	Siquijor	Siquijor
12.	Sorsogon	Sorsogon
13.	Southern Leyte	Maasin
14.	Zambales	Iba

Blood Stations***

1.	Abra	Bangued
2.	Agusan del Sur	Prosperidad
3.	La Union	San Fernando
4.	Lanao del Sur	Marawi City
5.	Mindoro Occidental	San Jose
6.	Northern Samar	Catarman
7.	Romblon	Romblon
8.	Sulu	Jolo
9.	Western Samar	Catbalogan
10.	Zamboanga del Norte	Dipolog City

*--Complete facilities for:

Recruitment and screening of blood donors
Bleeding of blood donors
Storage and processing of blood
Dispensing of blood

**--Complete facilities for:

Recruitment and screening of blood donors
Bleeding of blood donors
Storage only of blood (processing of blood is done by nearest blood center or by the provincial hospitals)

***--Facilities only for storing and dispensing of blood for emergency use.

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Table 1. Distribution of Blood Collection Accdg. to Regional Blood Centers

Regional Blood Centers	UNITS COLLECTED					
	Office Bleeding		Mass Blood Donation		Total	
	Units	Amt. in cc.	Units	Amt. in cc.	Units	Amt. in cc.
National Blood Center	12,927	4,436,135	8,606	2,926,005	21,533	7,362,140
Cebu Blood Center	12,980	5,828,150	977	264,945	13,957	6,093,095
Iloilo Blood Center	14,507	6,317,640	1,937	786,695	16,444	7,104,335
Mindanao Blood Center	34,494	13,126,600	4,935	1,338,650	39,429	14,465,250
TOTAL	74,908	29,708,525	16,455	5,316,295	91,363	35,024,820

Table 2. Distribution of Blood Collection Accdg. to Chapters

CONSOLIDATED ANNUAL REPORT 1993

2A. NATIONAL BLOOD CENTER

Chapters	UNITS COLLECTED					
	Office Bleeding		Mass Blood Donation		Total	
	Units	Amt. in cc.	Units	Amt. in cc.	Units	Amt. in cc.
1. Abra	3	750	21	5,250	24	6,000
2. Albay	132	46,400	38	9,500	170	55,900
3. Aurora	0	0	0	0	0	0
4. Baguio	157	45,300	339	88,300	496	133,600
5. Bataan	1,334	559,500	116	50,250	1,450	609,750
6. Batanes	0	0	0	0	0	0
7. Batangas	9	2,250	0	0	9	2,250
8. Benguet	55	20,500	0	0	55	20,500
9. Bulacan	0	0	0	0	0	0
10. Cagayan	0	0	0	0	0	0
11. Caloocan City	0	0	203	74,550	203	74,550
12. Camarines Norte	883	334,350	211	75,150	1,094	409,500
13. Camarines Sur	182	57,500	18	4,500	200	62,000
14. Catanduanes	78	43,000	8	2,000	86	45,000
15. Cavite	61	15,250	281	83,250	342	98,500
16. Ilocos Norte	2,279	569,750	170	42,500	2,449	612,250
17. Ilocos Sur	25	6,100	19	4,750	44	10,850
18. Isabela	88	31,750	76	22,750	164	54,500
19. Kalinga-Apayao	82	23,500	0	0	82	23,500
20. Laguna	29	9,250	211	67,550	240	76,800
21. La Union	0	0	26	6,500	26	6,500
22. Manila	1,062	397,900	1,573	530,145	2,635	928,045
23. Marinduque	0	0	36	9,000	36	9,000
24. Masbate	433	193,750	42	16,000	475	209,750
25. Mindoro Occ.	198	49,500	55	12,250	253	61,750
26. Mindoro Or.	17	4,450	0	0	17	4,450
27. Mt. Province	0	0	0	0	0	0
28. Nueva Ecija	614	209,000	39	9,750	653	218,750
29. Nueva Vizcaya	91	33,800	0	0	91	33,800
30. Olongapo City	744	225,550	51	12,750	795	238,300
31. Palawan	1,565	561,375	137	45,650	1,702	607,925
32. Pampanga	1	250	63	15,750	64	16,000
33. Pangasinan	77	27,850	62	16,700	139	44,550
34. Pasay City	0	0	355	102,950	355	102,950
35. Quezon City	481	207,850	2,002	783,800	2,483	991,650
36. Quezon-Lucena	338	86,250	113	28,250	451	114,500
37. Quirino	0	0	0	0	0	0
38. Rizal	1,043	403,900	2,267	782,160	3,310	1,186,060
39. Romblon	0	0	0	0	0	0
40. San Pablo City	45	22,500	0	0	45	22,500
41. Sorsogon	86	38,750	22	9,250	108	48,000
42. Sulu	50	17,950	0	0	50	17,950
43. Tarlac	197	67,400	52	14,800	249	82,200
44. Zambales	488	122,960	0	0	488	122,960
45. Ifugao	0	0	0	0	0	0
TOTAL	12,927	4,436,135	8,606	2,926,005	21,533	7,362,140

2B. EASTERN VISAYAS BLOOD CENTER

Chapters	UNITS COLLECTED					
	Office Bleeding		Mass Blood Donation		Total	
	Units	Amt. in cc.	Units	Amt. in cc.	Units	Amt. in cc.
1. Agusan Norte	218	88,250	35	9,000	253	97,250
2. Agusan Sur	17	4,250	17	4,250	34	8,500
3. Bohol	675	215,500	154	38,500	829	254,000
4. Cebu	4,183	2,059,450	601	153,250	4,784	2,212,700
5. Leyte	2,637	1,303,600	65	23,000	2,702	1,326,600
Ormoc	1,369	315,850	31	7,195	1,400	323,045
6. Leyte Sur	693	365,000	0	0	693	365,000
7. Negros Or.	1,676	778,000	32	14,250	1,708	792,250
8. Northern Samar	34	11,350	0	0	34	11,350
9. Ozamis City	671	314,000	20	6,000	691	320,000
10. Surigao Norte	162	70,200	6	1,500	168	71,700
11. Surigao Sur	107	49,200	0	0	107	49,200
12. Western Samar	0	0	0	0	0	0
13. Eastern Samar	0	0	0	0	0	0
14. Misamis Occ.	536	253,000	16	8,000	552	261,000
15. Tangub City	2	500	0	0	2	500
TOTAL	12,980	5,828,150	977	264,945	13,957	6,093,095

2C. WESTERN VISAYAS BLOOD CENTER

Chapters	UNITS COLLECTED					
	Office Bleeding		Mass Blood Donation		Total	
	Units	Amt. in cc.	Units	Amt. in cc.	Units	Amt. in cc.
1. Antique	1,237	602,300	35	8,950	1,272	611,250
2. Aklan	293	143,900	13	3,900	306	147,800
3. Capiz	911	396,250	19	5,000	930	401,250
4. Iloilo City	9,444	4,020,390	1,541	635,695	10,985	4,656,085
5. Negros Occ.	2,622	1,154,800	329	133,150	2,951	1,287,950
TOTAL	14,507	6,317,640	1,937	786,695	16,444	7,104,335

⑩ Work and Financial Plan (First draft), The Establishment of A Blood Transfusion Services Network in the DOH

WORK AND FINANCIAL PLAN

I. PROJECT TITLE: THE ESTABLISHMENT OF A BLOOD TRANSFUSION SERVICE NETWORK WITHIN THE DEPARTMENT OF HEALTH

II. RATIONALE:

Blood transfusion is one of the important tools in the management of the sick and the injured. Without blood, many surgical procedures cannot be safely performed and many disease conditions such as leukemia and aplastic anemia cannot be effectively treated. Blood transfusion is needed in the care of patients with various other conditions like liver failure, end stage kidney disease, post partum hemorrhage and acute bleeding following trauma. Blood transfusion is therefore an integral part of the health delivery system and for this matter, no hospital can be effective without it.

It is estimated that around 600,000 to 650,000 units of blood are needed annually nationwide. The blood bank statistical reports submitted to the Bureau of Research and Laboratories (BRL) show that in 1992, only 449,583 units of blood were collected. This means that approximately 25% of the estimated needs of the country are not met and that so many patients may have died because of unavailablity of blood.

Of the blood units collected in 1992, 57.7% were supplied by the free-standing or commercial blood banks; 23.4% by the Philippine National Red Cross; 12.3% by goverment hospital-basesd blood banks; and 6.6% by private hospital-based blood banks. Analysis as to the type of blood donors show that 70% the blood needs of the country come from the professional paid donors. Worldwide ekperience has shown that the paid donation system leads to increased risk of disease transmission such as HIV, hepatitis, syphilis and malaria due to inability to obtain accurate medical history from these donors.

It is this problem of shortage of blood and the health risks that the paid donation system is creating that necessitate the establishment of this project that will promote and implement the voluntary non-remunerative blood donation system in DOH retained hospitals. It shall serve as a pilot project towards the establishment of an organized National Blood Transfusion Service Network that will address the need for adequacy and self-sufficiency in safe blood and blood products for the whole country.

III. PROJECT OBJECTIVES:

GENERAL OBJECTIVE: To establish a Blood Transfusion Service Network that will provide DOH retained hospitals an adequate supply of safe and affordable blood at all times *through a system of non-remunerative blood donation.*

SPECIFIC OBJECTIVES:

1. To establish a Blood Center in each of the 7 Head Zones that will integrate and coordinate all efforts of the DOH hospitals towards achieving self-sufficiency in safe blood and blood products within the regions.

2. To increase the number of volunteer non-remunerated blood donors through collaborative efforts of the different sectors of the society.

3. To upgrade the facilities of the DOH hospital blood banks in support of the project.

4. To provide training of medical and paramedical personnel for internal maketing of the project.

5. To generate multi-sectoral and inter-disciplinary support for a NATIONAL BLOOD TRANSFUSION SERVICE NETWORK through the organization of the FIRST NATIONAL BLOOD CONGRESS.

6. To establish the Zonal Blood Center as a training and referral center for the devolved provincial and district hospital blood banks.

IV. PROJECT STRATEGIES

4.1. Project Administration

4.1.1. Central Administrative Agency-will be set up at the National Kidney Institute

4.1.2. Activities

4.1.2.1. Training and Education

4.1.2.2. Purchase and Distribution of laboratory supplies

4.1.2.3. Monitoring and evaluation

4.2. Blood Center

4.2.1. The Blood Center for each of the 7 Head Zones will be chosen from amongst the existing DOH hospitals/regional laboratories.

4.2.2. The Zonal Blood Center will be called the UNIFIED SAFE BLOOD SERVICES CENTER OF

4.2.3. The Zonal Blood Center will be equipped with equipments and supplies that will enable it to prepare blood components for hospitals not able to perform such services. Resource sharing will be implemented.

4.2.4. Boold bank facilities of all participating DOH hospitals will be linked with Zonal Blood Center in a network that will maximize utilization of blood resources.

4.2.5. There shall be no transaction between patients and the Zonal Blood Center. All requests for blood/blood products must be sent directly to Center by the hospital blood banks.

4.3. Donor recruitment

4.3.1. There shall be an organized and sustained public education for the promotion of voluntary blood donation.

4.3.2. Each participating hospital should set up hospital-based blood programs such as pre-deposit, blood replancement, and autologous transfusion programs.

4.3.3. A blood insurance scheme, the BLOOD ASSURANCE PLAN, will be implemented to increase the number of blood donors.

4.3.4. The various civic and religious organizations will be asked to help in donor recruitment through the "ADOPT A HOSPITAL BLOOD BANK" program.

4.3.5. Blood donor recruitment will be done in a professional and systematic manner to avoid the harmful competition for donors.

4.3.6. A mass blood typing campaign will be undertaken through the launching of "DUGONG PINOY, TYPE KITA" during the Blood Donors Week celebration.

4.4. Blood Supply

4.4.1. To effect a smooth transition towards a completely voluntary blood donation system and so as not to endanger the lives of the patients, hospital maybe allowed to secure blood from the commercial blood banks only to a certain degree as dictated by the urgency of the situation. Screening and processing however, will be done by the hospital or the Zonal blood center.

4.4.2. Blood collection facilities will be established in all participating hospitals.

4.4.3. Mobile blood collection activities shall be organized in baranggays, schools, business establishments, churches, military camps and other strategic areas in the head zone regions.

4.5. Blood processing, distribution and utilization

4.5.1. There shall be no transactions between patients and the Zonal Blood Center. All orders for blood and blood products must be sent directly to the Center by the hospitals' blood banks.

4.5.2. Cold chain facilities shall be made available for the proper transport of blood and blood products.

4.5.3. All blood transfusions shall be medically indicated and shall utilize blood component therapy as permitted by the hospital facilities.

4.5.4. Each participating hospital shall have a BLOOD TRANSFUSION COMMITTEE which will monitor the proper usage of blood and at the same time assist in the implementation of the project.

4.6. Professional education

4.6.1. Lectures and seminars on donor recruitment, appropriate use of blood, component therapy preparation and others will be conducted by the Phil. Blood Coordinating Council in close coordination with the other professional organizations like PAMET, PNA, PSHBT, PSP.

4.7. Financial consideration

4.6.1. A service-fee shall be charged for every blood product issued in order to provide operational funds for the Blood Centers and the blood banks. The service-fee should cover all the expenses entailed in collecting and processing the blood including professional serveces. This service-fee should not be construed as sale of blood.

4.6.2. The service-fee for blood and blood products shall be made uniform for all participating hospitals. It should be affordable and within the reach of the greater majority of the people. The costs of cross-matching and other additional tests will be charged separately by hospital blood banks.

V. PROJECT MONITORING AND EVALUATION

5.1. Reports on the quantity of blood products collected and processed by the Zonal Blood Center and the hospital blood banks shall be collected and submitted every month to the office of the Project Manager.

5.2. Reports regarding the donor recruitment activities and number of volunteer blood donour must be submitted every month to the office of the Project Manager .

5.3. A monthly report on the status of the project will be submitted to the Office of the Secretary by the Project Manager.

VI. PROJECT TARGETS

		Year 1	Year 2
1.	No. of blood units collected	115,000	154,000
2.	% Voluntary blood donation	75%	100%
3.	% Blood Component Utilization	30%	50%
4.	FIRST NATIONAL BLOOD CONGRESS	July 14 - 15, 1994	

ZONE ASSIGNMENTS

	1994 ESTIMATE BLOOD USAGE
ZONE A (Regions 1 & 3)	18,000 (12%)
ILOCOS REGIONAL HOSPITAL	
MARIANO MARCOS MEMORIAL HOSPITAL	
JOSE LINGAD MEMORIAL GENERAL HOSPITAL *	
PJ GARCIA MEMORIAL HOSPITAL	
ZONE B (Region 2 & CAR)	8,000 (5%)
CAGAYAN VALLEY REGIONAL HOSPITAL	
BAGUIO GENERAL HOSPITAL & MEDICAL CENTER	
ZONE C1	85,000 (55%)
NATIONAL CAPITAL REGION	
ZONE C2 (Region 4 & 5)	6,000 (4%)
BATANGAS REGIONAL HOSPITAL	
BICOL REGIDNAL HOSPITAL *	
ZONE D (Regions 6,7,8)	16,000 (10%)
WESTERN VIZAYAS MEDICAL CENTER	

GOV. C. GALLARES MEMORIAL HOSPITAL

VICENTE SOTTO MEMORIAL MEDICAL CENTER *

EASTERN VIZAYAS MEDICAL CENTER

ZONE E1 (Regions 9, 10, 11)	16,000	(10%)

ZAMBOANGA REGIONAL HOSPITAL

NORTHERN MINDANAO REGIONAL HOSPITAL

DAVAO MEDICAL CENTER

(Davao Regional Laboratory) *

ZONE E2 (Region 12 & ARMM)	5,000	(4%)

COTOBATO REGIONAL HOSPITAL *

* Zonal Blood Center

A C T I V I T I E S

PARTICULARS	TIME FRAME

I. CENTRAL OFFICE (NATIONAL KIDNEY INSTITUTE)

A. RECRUITMENT OF PROFESSIONAL SERVICES

1. 2 FT MT'S PER REGION
2. 2 FT NURSES-DONOR ORGANIZERS PER ZONE
3. 1 HEMATOLOGIST/PATHOLOGIST PER ZONE

B. ASSESSMENT OF CAPABILITIES OF HOSPITALS/BLOOD BANKS

NCR - HGB
LUZON - GR
VIZ/MIN - AP

C. TRAINING

1. MED TECHS
2. Nurses- Donor Organizers
3. PHYSICIANS

D. FIRST NATIONAL BLOOD CONGRESS — JULY 14-15, 1994

E. "ADOPT A HOSPITAL BLOOD BANK"

F. STRATEGIC BLOOD COLLECTION CENTERS

Greenhills

Makati

Quezon City

G. "Dugong Pinoy, Type Kita" JULY 11-17, 1994

A C T V I T I E S

II. ZONAL BLOOD CENTER

A. RECRUITMENT OF PROFESSIONAL SERVICES

B. SEND PEOPLE FOR TRAINING

C. ORGANIZE HOSPITAL TRANSFUSION COMMITTEE
IN EACH OF THE PARTICIPATING HOSPITALS

D. SCHEDULE ON-SITE TRAINING/SEMINAR OF MED TECHS ,
NURSES, PHYSICIANS

E. DONOR RECRUITMENT PLAN FOR THE ZONE
MASS BLOOD LETTING q week

F. PREPARE / RECEIVE RIV'S

G. RECEIVE / DISTRIBUTE SUPPLIES

H. MONTHLY REPORTS

III. HOSPITALS

A. ESTABLISH HOSPITAL - BASED BLOOD PROGRAMS
BLOOD REPLACEMENT
PRE-DEPOSIT
AUTOLOGOUS
BLOOD ASSURANCE PLAN

B. PROFESSIONAL EDUCATION OF THE HOUSE STAFF

C. Monthly reports

D. Prepare RIVs

E. Receive supplies

NATIONAL CAPITAL REGION BLOOD SERVICES

I. Eastern Zone

A. Zonal Blood Center - National Kidney Institute
East Avenue Medical Center

B. Approximate Blood Usage - 45,000 units a year

C. Participating Hospitals

1. Phil. Heart Center
2. Lung Center of the Phils.
3. Phil. Children Medical Center
4. National Orthopedic Center
5. National Children Hospital
6. Quirino Memorial Medical Center
7. E. Rodriguez District Hospital
8. National Center for Mental Health

II. Western Zone

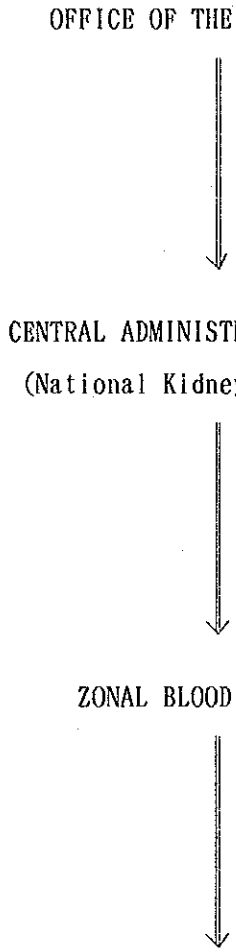
A. Zonal Blood Center - Phil. National Red Cross Blood Center
Jose Reyes Memorial Medical Center

B. Approximate Blood Usage - 40,000 units a year

C. Participating Hospitals

1. Jose Fabella Hospital
2. San Lazaro Hospital
3. Tondo Medical Center

4. RITM
5. Rizal Medical Center
6. Las Pinas District Hospital
7. Valenzuela District Hospital

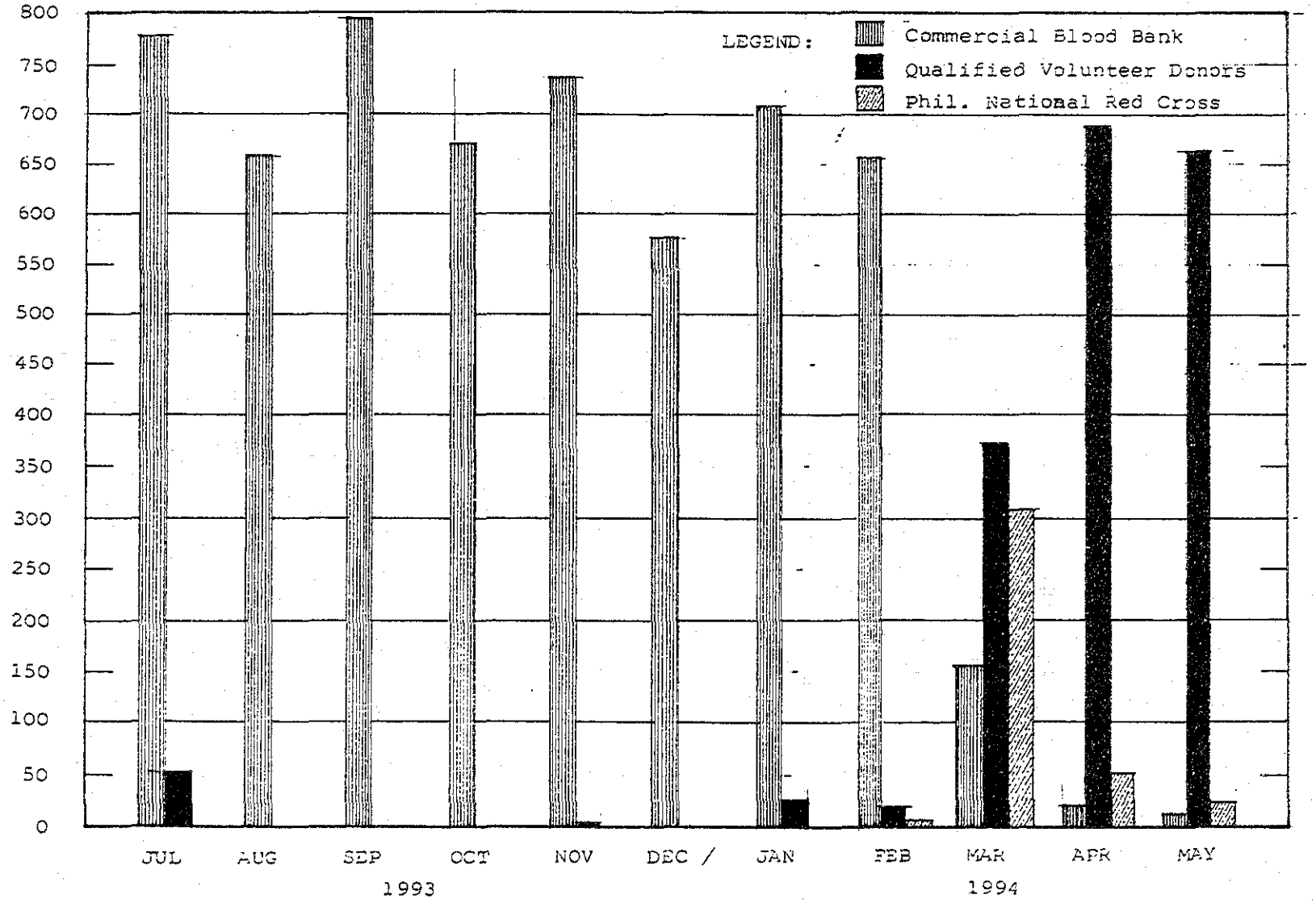

OFFICE OF THE SECRETARY
CENTRAL ADMINISTRATIVE OFFICE
(National Kidney Institute)
ZONAL BLOOD CENTER
HOSPITAL BLOOD BANKS

⑪ Statistical data on the DOH Blood Program

MONTHLY BLOOD BAGS COLLECTED FROM VOLUNTARY DONORS, 1994

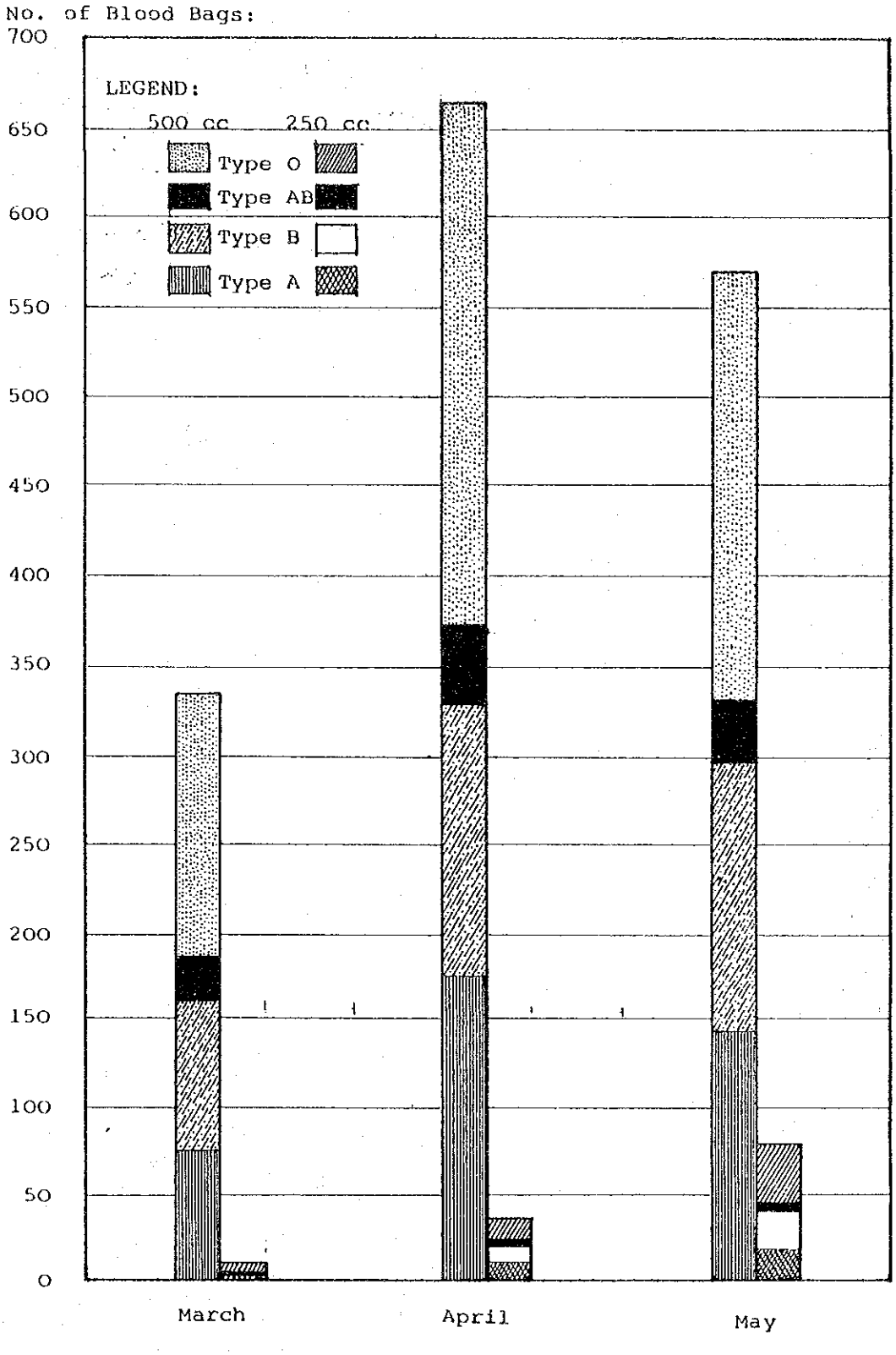
		MARCH	APRIL	MAY	TOTAL
TYPE A	500 cc	75	174	143	392
	250 cc	1	9	17	27
TYPE B	500 cc	85	156	154	395
	250 cc	0	10	24	34
TYPE AB	500 cc	26	43	35	104
	250 cc	2	4	4	10
TYPE O	500 cc	150	292	238	680
	250 cc	6	14	35	55

COMPARISON OF BLOOD UNITS OBTAINED FROM COMMERCIAL
BLOOD BANKS, VOLUNTARY DONORS & PNRC, JULY 1993-MAY 1994
DR. JOSE FABELLA MEMORIAL HOSPITAL



BLOOD BAGS COLLECTED FROM

VOLUNTARY DONORS, 1994



Republic of the Philippines
Department of Health
DAVAO MEDICAL CENTER/REGIONAL INTEGRATED LABORATORY
Accredited HIV Testing Laboratory - License No. 93-240

Name: NAMOC, RAMIL *Date:* June 13, 1994

Age: 23 *Sex:* M *Status:* Single *Nationality:* Filipino

Address: c/o Reyna Shipping

Screening Test for HIV:

Method	Lot No.	Result
PARTICLE AGGLUTINATION (Serodia)	BP 31224	NEGATIVE

OSCAR P. GRAGEDA, M.D., FPSP, APCP
Pathologist

ANGELENE T. BALAYON, RMT.
Medical Technologist

Lab. No.: 0140
Immunology Form 2

TESTING FOR ANTIBODY (HIV)
Monthly Report
Month MAY Year 1994

Date June 10, 1994

Name of HIV Testing Laboratory/Blood Bank DAVAO MEDICAL CENTER/REGIONAL INTEGRATED LABORATORY

Address J.P. LAUREL AVE., DAVAO CITY

Accreditation Number 93-240

SOURCES OF CATEGORY	NUMBER
1. Blood Donors	
1.1 Voluntary Donors	10
1.2 Paid Donors	
2. Blood Units for Transfusion	949
3. Military	2
4. Overseas Worker	
4.1 Land Based	
4.2 Seafarers	10
5. Hospitality Girls	
6. Health Care Workers	
6.1 Hospital Staff	
6.2 Non-Hospital Staff	
7. IV Drug Abusers	
8. Homosexuals/Heterosexuals	
9. Students	
10. Diagnostic Request	
11. General Population	
Inmates of:	
11.1 Prison/Jail	
11.2 Mental Hospital	
11.3 Orphanages	
12. Others (specify) Employment	6
Immigationn	3
TOTAL NUMBER OF PERSON TESTED	980
Total Number of Tests Done (Including Repeat Tests)	995
Total Number of Tests Run/Work (Including Controls)	294
Total Number of Seropositive Cases	None
Number of Samples referred to: BRL	
RITM	
Others (specify institution or agency referred to)	
Total Number of Seropositive Cases (Identify as to Item I)	
Total Number of Cases Reported to the AIDS Registry, *IHS*, DOH	
Identify as to Item I and Indicate Age of patient Sex	

Screening Test Done: EIA /___/ PA /X/

Number of Reagent Kits used 5.5 kits Lot number/s BP 31224

Name of Reagent Kit Serodia Manufacturer Fujirebio, Inc.

Expiry Date December 1994

Confirmatory Test Done: WB /___/ IF /___/ RIPA /___/
(if any)

Name of Reagent Kits used _____ Lot number/s _____

Name of Reagent Kit _____ Manufacturer _____

Expiry Date _____

Please attache xerox copies of invoices of HIV reagent kits (indicate lot number and expiration date) purchased during month.

Prepared By:

ANGELENE T. BALAYON, RMT.
Medical Technologist
(signature over printed name)
Certificate No. 075

Checked By:

OSCAR P. GRAGEDA, M.D., FPSP, APCP
Pathologist
(signature over printed name)

Date Reported June 10, 1994

Date Received _____

Received By _____

LIST OF PREVENTION INDICATORS (PI)

29 October 1993

PI 1 : KNOWLEDGE OF PREVENTIVE PRACTICES

No of people citing at least two acceptable ways of protection from HIV-infection
population aged 15-49 reporting

PI 2: CONDOM AVAILABILITY (Central level)

Total No of condoms available for distribution during the preceding 12 months
population aged 15-49

PI 3: CONDOM AVAILABILITY (Peripheral level)

No of people who can acquire a condom
population aged 15-49

PI 4: REPORTED NON REGULAR SEXUAL PARTNERS

No of people aged 15-49 who report having had at least one sex partner other than their regular sex partner(s) in the last 12 months
Total No of people aged 15-49 who report having been sexually active in the last 12 months

PI 5: REPORTED CONDOM USE IN THE MOST RECENT SEXUAL INTERCOURSE OF RISK

No of people aged 15-49 reporting the use of a condom during the most recent act of sexual intercourse with a non-regular sex partner
Total No of people aged 15-49 who report sexual intercourse with a non-regular sex partner in the last 12 months

PI 6: STD CASE MANAGEMENT

No of individuals presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards)
No of individuals presenting with STD in health facilities

PI 7: STD CASE MANAGEMENT

No of individuals presenting with an STD or for STD care in health facilities who received basic advice on condom and on partner notification
No of individuals presenting with an STD or for STD care in health facilities

PI 9: STD INCIDENCE, MEN

No of reported episodes of urethritis in men aged 15-49 in the last 12 months
No of men aged 15-49 surveyed

Under development

PI 8: STD PREVALENCE, WOMEN

No of pregnant women aged 15-24 with positive serology for syphilis
Total No of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened

PI 10: HIV PREVALENCE, WOMEN

No of pregnant women aged 15-24 seropositive for HIV
Total No of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened

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