Seven out of 10 women interviewees said that they have not used a condom. Forty-two per cent were unwilling to recommend condoms to their partners because they trusted them, they believed in their spouses' capacity to decide for themselves, their spouses were kind and did not engage in sex with prostitutes or with other women. Recommending condoms was viewed as tantamount to encouraging their partners to have sex with others.

Pursuing this line of thought, 50% of the women interviewees saw no risk for STDs to their spouses and 37% saw none from AIDS. And if they should be asked for recommendations for protecting their spouses from these diseases, they would recommend condoms only after abstinence (42%), masturbation (40%) and engaging in sports and recreation (30%). Other suggestions were withdrawal, reading the bible, visiting tourist spots and roaming around (2% each).

A sexuality seminar in the workshop brought to the fore related concerns on relationships. A portion on sharing had the participants revealing their beliefs that sex is something exclusive between the male and the female and that it is an important factor for harmonizing a family. Only a male-female relationship is moral and righteous in the eyes of God and of men. Bisexual and homosexual relationships are unpleasant, abnormal and immoral and that extramarital relationships especially on the part of wives, are very sinful.

Related to this sharing are thoughts on sex education. Some participants said that it was only with marriage and only with their husbands that they had learned about sex. On the other hand, a group of Metro Manila women shared that as early as their teens, they had already learned about sex.

Some points emerge from this portion on sexual history and patterns. One is female concern for monogamy and fidelity in the face of the foreign posting of their partners and their possible sexual relationships there while abroad. Another is that the male respondents themselves distinguish between a wife and a casual sex partner. When abroad they set limits on involvements, seeking out and paying for sex but ultimately returning to wife and family.

4.4. Risk avoidance

The overseas workers in the TRENDS survey registered the highest scores among all groups examined in recognising that something can be done to make oneself resistant to AIDS. The female OCWs were more optimistic than their male counterparts (86% vs. 18%).

The male OCWs in the survey were more emphatic than the other groups that risks could be reduced by avoiding sex with homosexuals, avoiding sex with prostitutes, having one or a regular sex partner and using condoms in sexual encounters.

Also seen as risk reduction measures are having check-ups, being more selective with friends, using vitamins, using medicines or antibiotics, washing genitals before and after sex, and practicing withdrawal.

Fidelity and abstinence were likewise proposed by 61% of the women OCWs and 70% of the seamen at the workshop. The FGD participants agreed and stressed monogamy or limiting to just one sex partner.

To complement their thoughts on the condoms, 66% of the males in the TRENDS survey said that they would use condoms if they were asked by their partners. A full 81% were aware that condoms can prevent venereal diseases.

Among the El Greco interviewees, it is youth that facilitates agreement to use condoms (92% in the case of young adults). The other figures are 76% for middle adults and 33% for late adults.

The educational level of the interviewees also seems to weigh heavily: 82% of seamen who had gone to school would use condoms as against 67% of those without a degree.

More dramatic was the proposal of the FGD participants in order to avoid risks. There was a consensus to isolate the victim and keep him from returning to his work area to stop contamination. They also proposed the legalization of prostitution, mandatory testing, and maintaining high standards of health.

In the case of **women**, 86% of those in the TRENDS survey said that one could make oneself resistant to AIDS by a number of ways: avoiding sex with prostitutes; avoiding sex with homosexuals; having check-ups; having only one sex partner or one regular partner; being more selective with friends; using vitamins; using medicines/antibiotics ; practising withdrawal; washing genitals before and after sex; and using condoms, in their proper order.

It is significant to see that the women overseas workers ranked condoms last. Even among those who have had sex, less than a fifth (16%) have asked their partners to use condoms.

The low rank they gave condoms might be linked to the statements on abstinence. They did not have to protect themselves from sex since they were abstaining from it.

Similarly most of the wives/partners of the seamen would go beyond condoms to practise fidelity to one sex partner (86%) and even to vow abstention from sex (100%).

The same is true to about two-fifths of the married women overseas workers in the TRENDS survey who said that they did not have to change their behavior because of AIDS. Presumably, they were already in monogamous relations with their partners.

There is a large number of the wives of seamen who would promote condoms to lessen the risk of AIDS. About two-thirds (65%) of those who perceived their partners to be at risk to STDs would recommend the use of condoms, and three-fourths (75%) of those who perceived them to be at risk to AIDS would recommend condoms.

4.5. Discussion

The three studies confirm that gaps in knowledge exist as well as some hesitance to reduce risks. In general, the respondents lack full and accurate information (for example on transmission and prevention) which could arm them with the will to prevent AIDS. For instance, ignorance about diagnostic tests for AIDS may restrain one from having one at all.

The women are inclined to adopt protective measures for themselves and their husbands. They express willingness to practise total abstention in the hope that men will match this but feel resigned to their husbands' extramarital flings. This says much about social expectations of women as a spouse works abroad. This is due in some way to gender tracking: men are allowed and even expected to play around while women are reared to feel whole only when married ("I learned of sex only from my husband").

Education and age seem to influence the decision to use condoms and other effective methods for AIDS prevention. Perhaps these factors can be used in programs to influence OCWs, who are relatively young and schooled, in eliminating risks to their health.

There appears to be some support among OCWs for mandatory testing, quarantine and control of prostitution.

Perhaps there may be a groundswell for stronger measures against groups perceived to have loose morals. Policy makers might need to consider these suggestions quite soon.

5. Commercial Sex Workers

Prostitution is supposed to be the world's oldest profession yet it is scourged by the world's newest pandemic - AIDS.

The late President Marcos is quoted to have said that prostitution does not exist in the Philippines because it is not being regulated. "No regulation, no profession," he is said to have answered critics once.

In a legal sort of way the logic is correct since permits are issued to waitresses but not to prostitutes. And it is the Sanitation Code that requires biweekly tests for them, not the Professional Regulation Commission.

It is this sophist way of reasong that fails to ameliorate or even worsens the lot of a very marginalized sector of Philippine society. Why would waitresses need clearances for gonorrhea or shyphilis?

Be that as it may, one could explain AIDS away as a hazard of the trade. To earn a living they must face dangers just as carpenters or drivers do.

But it is ironic that in earning a living prostitutes must lose their lives. In engaging in sexual intercourse for pay, they expose themselves to the leading mode of transmission of AIDS in the Philippines.

This is not a brief for legalizing prostitution, although one must point out that feminists are enriching the discussion by proposing decriminalization as an alternative.

What is relevant now is that AIDS is preventable, and this must happen for the men and women who have a fee-for-service arrangement (a mark of a profession) as commercial sex workers.

Also relevant to the discussion is that generally speaking they would leave this profession if they had a choice. Some of the male sex workers interviewed by TRENDS say that this is just a temporary station in life for them, that they are saving up for college. [22]

Generally too prostitutes would change professions if they had an option.[23] Those diagnosed for HIV infection were forced to circumvent the withdrawal of health permits by operating **sub rosa**, precisely what the law is not supposed to do. But this is because prostitutes have no other marketable skill in the labor market. Some women sex workers may not even understand English, the language of business, and have been documented to ignore posters on risk avoidance that are in English. [24]

Their action has implications for materials development, one being that sex workers will choose those that fit them. And there are as many aspects to this as there are kinds of (or euphemisms for) sex workers: **silahis** (bisexuals), **casa** workers (women prostitutes), callboys, bar girls, massage parlor attendants, receptionists, dancing partners, etc.

As long as there is prostitution, there remains a potential for AIDS transmission. This is the reason why this sector is a priority group for education on prevention.

For this situation analysis the materials available on commercial sex workers (CSWs) range from knowledge-attitude-practice-behavior (KAPB) surveys in Metro Manila to reports on support systems to seropositivity studies. The last category is truly time-bound but they mark the spread of AIDS among CSWs.

5.1 The RITM study (1989)

A health education and intervention program was conducted by RITM from January 1989 to June 1990. Venues were the sites of ongoing surveillance on HIV infection: the Manila Health Department Venereal Diseases Control Clinic and some clinics of Quezon City.

The program aimed to prevent the spread of HIV infection in the Philippines by intervening through education, promoting and distributing condoms, and managing STDs appropriately.

Before this intervention took place a baseline survey was conducted with 250 male and 640 female commercial sex workers (320 female massage parlor attendants and 320 bar/club workers).

The respondents were interviewed with a 21-page semi-structured questionnaire for a demographic/KAP/sexual profile. There was also a four-page medical questionnaire-physical examination form.

Intervention consisted of education, training and counselling programs by, among others, credible peers of the commercial sex workers.

There were also group sessions with a medical team organized to answer questions from sex workers as well as focus group discussions among sex workers and their **mama-sans** (managers).

Condoms from the US Agency for International Development were also distributed to **mama-sans** and to sex workers visiting the Manila VD Clinic for their biweekly check-ups. These condoms were then given by the **mama-sans** to their workers.

Other program components were surveillance, monitoring and treatment of HIV infection and STDs among study groups.

5.1.1. Demographic profile

The mean age of the females was 23.6 years; for the males, 22.9 years.

Over one-half of the females had come from depressed regions of Southern Luzon and Central Visayas. Most of the male commercial sex workers were from Metro Manila and Central Luzon.

Most of the commercial sex workers were unmarried (66% of the female massage attendants, 60% of the female bar/club attendants and 79% of the males).

The females have had more schooling than the males: 91% of the massage attendants and 90% of the bar/club workers had reached high school and below, the highest educational attainment
of the entire group.

5.1.2. Knowledge levels/attitudes

Over one-half (57-70%) had heard of AIDS which was deemed incurable by 38% of the female masseuses, 45% of bar girls, and 50% of the males. That AIDS is sexually transmitted was known by only 16%, 15% and 36% of the respondents, respectively. Most wanted information; 21-37% had discussed the disease with friends but only half felt that a doctor or nurse was a trusted source for AIDS.

The mass media were rated trustworthy by 17% of the masseuses, 29% of the bar girls and 52% of the men.

Less than half of the group (40-48%) said that the clinic was a convenient place to go for information on AIDS.

Majority (67-87%) were aware of the test done for AIDS (blood). Over half knew the correct information about risky practices like sexual transmission, intravenous drug use, etc.

Only a fifth to a fourth felt that AIDs would appear in a year's time. They could cite its most common symptoms: weight loss, skin disease and fatigue.

Persons with AIDS will die, 72-81% of the group said. This is the effect they are aware of and fear most.

If infected, 37% of the bar girls said they would commit suicide. This would also be the course of action of 37% of the masseuses and 29% of the male sex workers.

About 28% of the female massage attendants, 34% of the female car/club workers and 27% of the male respondents would seek medical attention.

5.1.3. Sexual history/patterns

Almost all of the respondents have had prior sexual experience. Their first partner was their boyfriend or girlfriend (49% of the massage parlor attendants, 56% of the bar/club workers and 54% for the males).

Their current sex partners were usually their customers. This is true for 89% of the massage attendants, 88% of the club/car workers and 94% of the males.

Almost all admitted to paid sex. Majority of the females had been pregnant, with over one half ending in abortion.

Vaginal sex was practised by 33% of the bar girls and 61% of the males; anal sex by 5-6% of the females and by 66% of the males.

Almost all have had sexually transmitted diseases at one time or another: 186 of the 320 massage attendants, 187 of the 320 bar/club workers and 113 of the 250 men.

5.1.4. Risk avoidance

Many of the respondents knew of ways to prevent AIDS but not all would necessarily act accordingly. For example 24% of the massage attendants mentioned "avoiding sex with many partners" as a preventive measure but only 9% said they were planning to prevent AIDS in this particular way.

The males were similar in their gap between knowledge and action. Fully 35% were aware that avoiding sex with too many partners can prevent AIDS but only 14% mentioned this as their plan to avoid the disease. In fact they gave only one other plan: the use of condoms (10%). At most only about a third cited condoms as a deterrent to AIDS: 31% of the masseuses, 29% of the bar girls and 10% of the males.

Yet it is interesting that they themselves say that close to three-fourths of their customers do comply with a request to use condom: 75% of those of the massage attendants, 74% of the customers of the club workers and 67% of those of the men.

Less than a fifth (5-18%) would stop working or avoid sex altogether to prevent AIDS.

5.2. The TRENDS study (1989)

The 1989 study involved a purposive sampling of 100 male and 100 female sex workers aged 18-34. Most were from the D and E (low and very low income) class groups. Those working outside the tourist belt were excluded because of another ongoing study.

The other sentinel groups in the TRENDS surveys are young adults, overseas workers and men who have sex with men.

5.2.1. Knowledge levels/attitudes

Female sex workers had significantly lower scores in knowledge of transmission and shared more misconceptions about AIDS. For instance, 42% said that one can get AIDS by donating blood and 35% said that it can come from public toilets.

Fully 71% of male sex workers and 69% of the females agreed that little is known of the spread of AIDS.

While 55% of all respondents of TRENDS understood that someone with AIDS may still look healthy, only 29% of male sex workers and 44% of female sex workers knew this. Many said that they could sense if their partner had AIDS (59% of males and 65% of females).

Perceived personal risk for AIDS was highest among the group of sex workers (48% of males and 64% of females, as against an average of 32% for all groups).

That AIDS is easy or somewhat easy to catch is believed by 68% of male sex workers and 74% of females. The male workers scored the lowest here while the female workers scored the highest among all female respondents.

Sex workers scored highest in the perception that AIDS is a western or foreign disease, 53% for males and 64% for females. The average is 45% for all respondents.

Considering that the government requires entertainers to have tests, it is surprising that only 27% of male sex workers and 12% of the females said that they have had an AIDS test.

Only 84% of male sex workers and 77% of female ones were aware of diagnostic tests, compared to the 86% national average. Many (58% and 41%) associated it with blood but had little accurate knowledge beside that.

5.2.2. Sexual history/patterns

Males reported their first sexual encounter with customers at 17 years, the females at 16. Both are lower than the rest of the population of the TRENDS surveys.

Females had males as customers, and these were mostly Filipinos. The males, on the other hand, have had sex at least once with homosexuals (81%), married women (81%), female prostitutes (74%), unmarried women or widows (71%) and bisexuals/married men (59%).

The males said that they entered sex work because they make the best/better money in it than in other jobs (45% as against 40% for the females).

Women sex workers had expressed less negative attitudes about the condom than all female respondents of the TRENDS studies. Yet the sex workers said that they use no condoms in vaginal intercourse with transfer of semen (63%), vaginal intercourse without transfer of semen (37%), giving anal intercourse with transfer of semen (24%), receiving anal intercourse without transfer of semen (20%), receiving anal intercourse with transfer of semen (11%) and giving anal intercourse without transfer of semen (8%).

Some customers refuse to use condoms as reported by 67% of the males and 46% of the females. The sex workers claimed that they could put on condoms without the partner being aware of it. This was declared by 39% of the males and 31% of the females.

As to access, 72% of the males and 61% of the females had to buy them "the last time used"; 14% of the females got the condoms from family planning centers.

5.2.3. Risk avoidance/history

Sex workers scored high in recognizing that something can be done to become resistant to AIDS: 82% of the males and 78% of the females as against 76% for all respondents. But they scored low in awareness of specific methods. Only 54% for instance cited avoiding sex with prostitutes.

The lack of options for women extends into the refusal of customers to use condoms since women (52%) depend largely on pimps and bar owners or managers to negotiate with customers while 73% of the male workers deal directly with them.

Compared with other groups, sex workers have had more experience with condom usage; in fact all claimed to continue to use it after trial (61% for male and 55% for female sex workers).

Sex workers scored the highest among the TRENDS respondents in saying that the condom can prevent venereal disease, is useful for people like them, shows concern for partners and protects one from AIDS (the last at 60% for males and 70% for females).

There are also less attitudinal barriers to condom use except for the religious belief that it is a sin to use condoms.

Very high proportions of sex workers reported behavioral changes (98% for the males and 95% for the females, as against an average of 67% for all respondent groups in the TRENDS surveys).

5.3. The Conaco study (1990)

This survey was commissioned by the World Health Organization as part of four-institution collaboration. It was coordinated by Prof. Ma. Cecilia Gastardo-Conaco of the Department of Psychology, University of the Philippines.

Purposive sampling was used for this particular survey. One way to identify potential respondents was asking the Department of Health for references to hospitality girls who use its social hygiene clinics.

Those who visited these clinics during the fieldwork for this study in Aril 1990 were "passed on" to the interviewers after medical examination.

5.3.1. Demographic profile

A total of 225 hospitality girls were included in the sample. Although their ages ranged from 15 to 42 years old, they were generally young with a mean age of 23.7 years.

Majority had gone to school but 63% had had only some elementary education.

Most had been bar girls, dancers, receptionists and massage parlor attendants with 1.7 years as the mean in the trade. Almost 30% cited poverty as a reason for entering this trade.

5.3.2. Knowledge levels/attitudes

Close to 70% of the respondents had heard of AIDS (150). About 80% of them saw it as a threat to their profession at present and 75% felt it would be worse in the future.

Even if 67% felt that AIDS was rare in the Philippines, 60% said that they might very likely contract it as a hazard of the profession.

Of the 150 hospitality girls who had heard of AIDs, only 5% claimed that they knew a great deal. Three out of five admitted knowing little of it and only 5% claimed total ignorance.

Some 24% confessed they did not know or could not say for sure the possible cause of AIDS. Some gave factors with no scientific basis as causes of AIDS: heterosexual sex, sex with gays, lewd sex, promiscuity, sex with foreigners, blood transfusion, kissing, sharing things with AIDS victims, being near them and internal infection.

These stereotypes also turned up when the respondents were requested to rate the risk in certain behavior like deep kissing with someone with AIDS (29%).

The respondents said that they got information on AIDS from clinic and hospital doctors, who were rated by 70% as trustworthy and reliable sources. Television ranked second in both popularity and reliability. The others were print, radio, friends, neighbors, co-workers, family, etc.

5.3.3. Sexual history/patterns

Majority were shy in talking about sex with a total stranger so that they appeared to be quite reserved.

Only 12% said that they have had sex with customers. In the last four weeks they most often engaged in oral sex (99%), followed by fondling genitals (84%), mouth-to-mouth kissing (77%) and having a man fondle their genitals (62%).

After a sexual encounter the respondents cleansed themselves with a variety of agents: antibiotics, douching, plain water, warm water, suppositories, toothpaste on cotton, etc.

5.3.4. Risk avoidance

The practices for cleansing the reproductive system after a customer are not effective against AIDS. "Can one avoid it by changing behavior?" the hospitality girls were asked. Around 60% answered in the affirmative.

They suggested the following: abstaining from sex, 23%; leaving your present job, 22%; and practising monogamy, 14%. Fewer of the respondents mentioned "doable" deeds like selecting customers well, 10%; using condoms, 7%: avoiding sex with an AIDS-infected person, 7%; having regular check-ups, 3%; avoiding lewd sex, 3%. etc.

The 60% who said one can avoid AIDS by changing behavior were also asked if their friends had done so. About 6% replied in the negative while 25% confirmed it.

Asked if they had themselves done any change in their life, 78% felt a need to change their behavior. They wanted to abstain from sex (27%); practise monogamy (24%); leave their job(17%); be more selective of customers (10%); avoid sex with an AIDS-infected person (7%); use condoms (3%);and maintain a healthy body, practice personal hygiene and use antibiotics.

The respondents knew that condom prevents pregnancies (64%) and STDs (74%). Yet they ranked condom usage as a preferred behavioral change almost at the bottom of alternatives.

Almost everyone (88%) knew where to get a condom but it was only in 1 out of 2 cases that their clients would consent to it.

The respondents believed that the condom is easy to use and is effective against pregnancy and STDs and are accessible and affordable. But they also believed that it causes a man to lose his erection, makes sex less satisfying and offends a regular partner who can then leave.

In the face of the risks, a third (34%) claimed to have changed their behavior. In fact, 92% of these respondents felt that they would be able to change their behavior.

To prevent AIDS, 93% were willing to take a test and around 70% knew where to go for it. Almost all the respondents (93%) said that they would want to know the results and seek medical help if they are found positive (37%).

But 17% said that they would withdraw from society; 12% would commit suicide; 10% would just resign themselves to fate; and 14% said that they would not know what to do.

When asked whether they discussed the risks with their family, 87% of the respondents said they did not.

5.4. Clinic-based studies

These refer to studies that make use of clinical procedures like tests establishing infection of sex workers. Almost all have been done by the Research Institute for Tropical Medicine (RITM) of the Deparment of Health in collaboration with the Bureau of Research and Laboratories (BRL) and the United States Naval Medical Research Unit Number 2 (NAMRU - II).

The studies available for this situation analysis are in different forms: status reports on STDs; documenting progress and outcomes; predicting risk for HIV infection and supporting victims. For this particular situation anlaysis they will be presented by sex.

5.4.1 Women-centered studies

There are three studies that focus on women in the clinical setting.

The first study entitled **Epidemiology of HIV Infections among Prostitutes in the Philippines** followed up two years of testing (1985-1987) for HIV 25,392 prostitutes in 64 cities and towns of the country.[25]

Since 85% of the HIV cases were in Angeles and Olongapo, the investigators decided to do a follow-up. They had planned for two rounds but some of the women missed the second. All in all 2981 women were tested twice.

From those who were tested the investigators got 34 HIV-antibody positive prostitutes and 61 HIV-antibody negative ones as part of a case control study.

All of the cases and controls had engaged in penis-vaginal sex and had foreigners as their most frequent partners. Only 18% frequently used condoms. They were similar in STDs and pelvic examination findings but the cases had more genital warts and CMV and had lymphadenopathy (enlarged inguinal lymph nodes).

The second study sought to test the effectiveness of counseling as a way of motivating prostitutes to reduce the risk of HIV infection by leaving the profession.[26] It was done from February 1986 to November 1988. No areas were specified but presumably in Manila, Angeles and Olongapo, work sites of the authors.

Fifty-four infected prostitutes were detected. Those who could be recontacted were asked to be in a long term study to classify and monitor the clinical/ immunological status of HIV infection.

During their first visit they were interviewed to elicit demographic data and sexual behavior. At the same time they were counseled by trained medical personnel on the meaning of HIV antibody seropositivity, the transmission to sexual partners, the use of condoms, and the need to consider stopping work as prostitutes.

All the volunteers were asked to return every three months for follow-up, evaluation, questionnaire answering and counseling.

For a year and a half, counseling was the only way for the project team to change the clients' sexual behavior until DOH told social hygiene clinics to revoke the licenses of HIV positive women.

The team continued to interview the women after the revocation, following up two groups of 41 HIV-positive but asymptomatic women. One group of 28 received counseling against high-risk behavior while the other group of 13 had their permits revoked at the same time that they were initially counseled to stop engaging in prostitution.

In both groups only twelve stopped. The best approach for this, say the authors, is a combination of ways: offering a reasonable alternative, restricting their current method of livelihood, and counseling.

The third study on women investigated the pregnancies of 54 HIV-1 positive female prostitutes in the age range 18-35.[27]

Interviews took place in September 1990. Twenty-six had a total of 37 pregnancies altogether. Eight were pregnant at the time of the diagnosis of HIV infection. One delivered a premature birth.

Five women had repeat pregnancies; 18 others became pregnant once or twice after HIV diagnosis.

Two of the babies were diagnosed as infected, the first documented case of perinatal transmission, while eight developed non-specific findings suggestive but not diagnostic of HIV infection.

The investigators declared that while it is not clearly indicated that pregnancy exacerbates the course of HIV-1 related diseases in these women, these women could transmit them by perinatal means.

5.4.2. Men and women

One of the first to be done on sex workers was the 1985-1987 study on 2,065 workers in bars, discos, massage parlors and sauna baths of Manila, Quezon City and Mandaluyong.[28]

The study determined HIV infection prevalence as well as practices that put these respondents, known to have multiple sex partners, at risk.

There were 1,770 females and 295 males who almost always were exposed to non-Filipino sexual partners. Three females were found seropositive.

The prevalence rate for the entire group was a low 0.14% which according to the authors correlates with figures for similar population groups studied by another research group in the Philippines.

To summarize the findings, males more frequently admitted receptive anal sex (25 against 0 for females) but females had a greater number of sexual partners, mostly foreign, and longer employment in sex-oriented establishments. The data suggest that the female group had risk behaviors which made them more likely to get the HIV infection.

Condom use was low: never for 42 out of 295 males and 452 for the 1,770 females; occasionally for 251 men and 1,250 women; and regularly for 2 men and 45 females.

The second study worked with the test results of 1,357 sex workers to find out the prevalence of STDs in 936 females and 421 males visiting the Manila Health Department Venereal Disease Control Clinic and a few other establishments in Quezon City that are covered by the RITM AIDS Research.[29]

The prevalence of STDs was higher among the females (484 or 52%) than the males (42 or 10%).

Among the females, 554 infections were discovered, the most common being **Neisseria gonorrhea** (136 or 15%) followed by **Chlamydia Trachomatis** (124 or 13%). They had other pathogens. One was confirmed positive for HIV infection.

The males were diagnosed for gonorrhea (12 or 3%), **Chlamydia Trachomatis** (12 or 3%), genital warts (11 or 2.6%) and syphilis (6 or 1%).

The authors point out that women have a high rate of STDs despite their taking antimicrobials, indicating a need for a plan to manage STDs in order to control the spread of HIV.

Another study available is a nationwide one on three viruses HIV, Hepatitis B, and **Treponema Palladum.** The study reports tests conducted on 97,976 hospitality girls from 13 regional areas of the Philippines. Of these, 75,861 examinations were done in the areas where there was a concentration of foreigners. These areas were in: Olongapo/Subic, Zambales; Angeles/Mabalacat, Pampanga; and San Fernando, La Union. There were actually 58 or 0.07% antibody positive between May 1, 1985 to June 30, 1989.[30]

In Manila, RITM found 7 or 0.083% HIV antibody positive out of 8,447 examinations done on hospitality girls up to June 30, 1989. Three, or 0.23% homosexuals out of 1,262 tests were reported HIV antibody positive.

Warning on how fast AIDS has gained a foothold in the country, the authors stressed that one should not relax one's guard even if no seropositive cases had been detected in areas outside the concentration of foreigners, in professional blood donors, and among Filipino military personnel in Subic, the few vagrants, and drug addicts being rehabilitated. Unregistered hospitality girls, streetwalkers and night vagrants had not been tested.

Foreigners or male Filipino nationals who have lived abroad where AIDS is prevalent can infect people. A seropositive Filipino can engage in unprotected sex outside or even within his/her usual work area. Homosexuals are now infected. Only a few workers can be monitored since small businessess have fluid situations of employment. Condoms are hardly used, as proven by the high rate of gonorrhea in places where it is supposed to be well-controlled. Hepatitis, a sexually transmitted disease, is still prevalent. Controlling it means using the same measures against AIDS or any other STD as pointed out by the authors.

In conclusion, it must be pointed out that while commercial sex workers are popularly perceived as the main carriers of AIDS, this is not entirely true. Anyone who is infected is a carrier whether he/she knows it or not.

5.5. Discussion

CSWs form the population segment most exposed to HIV infection through the heterosexual mode of transmission. Most know of this danger and would like to change professions as soon as they earn enough capital for some small business. Society must facilitate this move.

On another plane there are dangers to female sex workers who have a greater number of sex partners, hold misconceptions about AIDS, suffer from STDs and experience pregnancies even when positive for HIV. These circumstances exemplify the greater burdens our women have to bear in our society.

This reality can be taken as a cue for motivators, counselors and IEC materials developers on approaching women sex workers differently from their male counterparts.

One message to women sex workers is on the use of condoms for avoiding AIDS or pregnancy (or sometimes both). Female CSWs have manifested low levels of condom use for risk avoidance. They must be persuaded to insist on a "no-condom, no sex" policy even at the sacrifice of giving up part of their income. It is imperative that they be taught how to discipline themselves and be assertive.

Despite claims of success at control, sexually transmitted diseases remain prevalent among different groups of our population in many areas of the country.

This points to the need for vigor in also eliminating STDs. Fortunately the same measures to control AIDS hold for other STDs as well. This should be a key point in interpersonal as well as mass campaigns.

Evidently there is a need to do much more to service our CSWs, especially the women, on risk avoidance. It is not enough that hospitality girls register at a social hygiene clinic, have biweekly check-ups, and lose their pink cards if found positive for HIV. The danger exists that they may dodge follow-up by going underground as unregistered streetwalkers and stay beyond the reach of programs aimed at improving their welfare.

1 − 2 Government Program on AIDS

II. GOVERNMENT PROGRAMS ON AIDS

In the Philippines AIDS may not be a "homegrown" disease and the first case was recognized much later than in other countries, but the Government of the Philippines is aware that the pandemic threatens the health of the Filipinos as well as national development. This has prompted the leadership to adopt a policy of joining worldwide efforts for AIDS prevention and control.

1. Overview

1.1. Historical background[1]

A year after the first case of AIDS was diagnosed in 1984, the Department of Health initiated serosurveillance through the Research Institute for Tropical Medicine (RITM) and the Bureau of Research and Laboratory (BRL) in collaboration with the United States Naval Research Unit-2 (US NAMRU-2).

In February 1987 the Government established under the Office of the Under Secretary for Public Health, the National AIDS Prevention and Control Committee, which was replaced in August 1988 by a National Advisory Committee when the DOH Executive Committee approved the National Medium-Term Plan for the Prevention and Control of AIDS in the Philippines (1989-1993).

The Plan initially got technical assistance from the United States Agency for International Development (USAID) and in March 1988 from the World Health Organization Global Programme on AIDS with a technical consultant on planning.

On August 10, 1988 the National AIDS Prevention and Control Programme (NAPCP) was officially launched.

A National Advisory Committee for AIDS Control was created to give advice on policy and to regularly evaluate the implementation of the programme. A National AIDS Programme Management Committee was also created to implement the NAPCP.

The Plan was first implemented by the administration of Health Secretary Alfredo R. Bengzon who, among other things, spearheaded the holding in Manila of the First International Conference on AIDS in Asia in November 1987. The Plan was revised in 1990 to meet the increasing number of HIV infection and AIDS cases in the country.

The Plan gained more prominence when Health Secretary Juan M. Flavier was appointed by newly-elected President Fidel Ramos in 1992. The Secretary placed the AIDS Unit under a newly-created office headed by an assistant secretary-level official, Dr. Carmencita Reodica. The Office of Special Concerns fast-tracks the implementation of the priority concerns of AIDS, maternal and child health, family planning, nutrition and dental services. Sec. Flavier also included under the AIDS program of the Department the prevention and control of sexually transmitted diseases (STDs).

The program gets guidance from a high-level DOH-wide National Advisory Committee on AIDS Control and by a policy advisory body, the Philippine National AIDS Council (PNAC).

1.2. Policy statements

In September 1988 twelve policy recommendations were ratified by the National Advisory Committee for AIDS Control and Prevention and approved by Health Secretary Bengzon on January 4, 1989.

The following policy statements have been the terms of reference of all anti-AIDS activities of the country:

1. Prevention and control of HIV infection/ AIDS shall be the priority of the National AIDS Control Programme.

2. AIDS education shall be integrated in existing school curricula of elementary, high school and college levels; implementation shall be the responsibility of the Department of Education, Culture and Sports.

3. Communication campaigns on HIV infection/AIDS shall be part of an information delivery system integrated into closely related programs.

4. To prevent HIV transmission, protective measures such as condom usage shall be promoted among persons with high-risk sexual behavior. These protective measures shall be made available and widely accessible.

5. All blood donors and blood for transfusion shall be screened for HIV.

6. No mandatory testing shall be required except for those persons already being tested under existing law. Persons who engage in high-risk behavior shall be encouraged to undergo voluntary testing. Informed consent for pre-testing shall be required and post-testing counselling shall be made available.

7. Information on the testing, counselling and care of individuals shall remain confidential.

8. For surveillance purposes, statistics on the incidence of infection shall be maintained by the Department of Health.

9. Infected or sick individuals shall be referred for appropriate counselling and care. As a matter of public policy, no person shall be subjected to quarantine or isolation.

10. Health and social assistance shall be provided to infected and sick individuals by government and non-governmental organizations.

11. Tourists shall not be required to undergo testing for HIV infection unless there are medical indications for testing.

12. Visa applicants who have undergone previous testing will be required to disclose the results of such tests upon visa applications.

1.3. Objectives

There are three long-term objectives of the AIDS control program of the Philippines: to reduce HIV transmission, to reduce morbidity and mortality associated with HIV infection, and to reduce the impact of HIV and AIDS on the individual, the family and the community.

The medium-term objectives of the program are:

1. To continue to monitor the epidemic through the incidence of infection among identified sentinel groups and the general population;

2. To institute HIV screening of all blood administered through the government's health care system;

3. To promote health education to encourage safe behavior among vulnerable groups as well as the general population;

4. To promote the use of condoms among those who practice high-risk behaviors;

5. To develop and propose to government specific guidelines for the screening of all blood products used within the non-government private sector, including private hospitals;

6. To enforce appropriate sterilization practices for skin-piercing instruments, including syringes and needles;

7. To reduce the impact of HIV infection on individuals, groups and society.

1.4. Strategies

To achieve its objectives, the Program has five strategies: prevention of sexual transmission, prevention of transmission through blood, prevention of transmission through injection and skin-piercing practices, prevention of perinatal transmission, and reduction of the impact of HIV infection on individuals, groups and society.

1.5. Program structure

Figure 1 shows the interrelationships and linkages within committees for the AIDS program of the country.

As mentioned earlier, the NAPCP is implemented by the National AIDS Programme Management Committee which is chaired by the Programme Manager and composed of designated members from these offices: the RITM, the Bureau of Research and Laboratories (BRL), the Communicable Disease Control Service (CDCS), San Lazaro Hospital (SLH), the Public Information and Health Education Service (PIHES), the Health Intelligence Service (HIS), the Health Manpower Development and Training Services (HMDTS), the National Quarantine Office (NQS) and Regional Health Offices (RHOs).

The AIDS Unit coordinates and monitors the implementation of the NAPCP. Its Program manager, seven doctors and 12 staff members are based at the DOH Central Office.

There are regional AIDS coordinators in the 14 geographic health regions of the country. Each health region has at least one regional hospital, one regional health laboratory and one regional training center.

Giving advisory services and regularly evaluating the NAPCP is the National Advisory Committee chaired by the assistant secretary for special concerns and composed of the heads of RITM, BRL, San Lazaro Hospital, CDCS, HMDT, HIS, and the National AIDS Program Manager.

The Philippine National AIDS Council (PNAC) gives policy advice. It was created by Pres. Ramos through Executive Order No. 39, Series of 1992, on Dec. 1 to coincide with the declaration of National AIDS Awareness Month and with the observance of World AIDS Day.

The PNAC is the country's multi-sectoral response to the AIDS epidemic. Its top-level members were inducted into office on July 6, 1993 by Pres. Ramos. They represent the DOH, the National Economic and Development Authority (NEDA), the Department of Justice (DOJ), the Department of the Interior and Local Governments (DILG), the Department of Education, Culture and Sports (DECS), the Department of Tourism (DOT), the Department of Social Welfare and Development (DSWD), the Department of Foreign Affairs (DFA), the Department of Budget and Management (DBM), the Senate Committee on Health and five NGOs: Kabalikat ng Pamilyang Pilipino, the Library Foundation, Health Action Information Network (HAIN), Women's Health Care Foundation (WHCF) and Institute for Social Studies and Action (ISSA). A technical working group meets regularly.

2. Programs, Projects and Activities

For the effective implementation of the NAPCP, five areas of concern are classified as program components: surveillance; information, education and communication (IEC); laboratory services; clinical management and care; and program.[2]

The NAPCP News calls IEC "information, communication and health education" and clinical management and care "care of people with HIV and AIDS."

2.1. Information, communication, health education/Advocacy

In the context of the National AIDS Program Management Committee within DOH, this particular program component is coordinated by the Public Information and Health Education Services, popularly called PIHES.

Other DOH offices involved in IEC-related activities are the AIDS Unit, the RITM and the New Tropical Medicine Research Foundation of RITM.

The initial efforts for mass media campaigns on HIV/AIDS were conducted in Metro Manila. The first was held in 1990 for the general public with messages on radio, television and print correcting myths on HIV/AIDS, especially on transmission modes. The second was launched on Valentines' Day of 1992; it asked young adults to "postpone sex and use protection, if they engage in sex." Both campaigns directed attention to the telephone hotline counseling services of the Remedios AIDS Information Center (RAIC).

In July 1992, a blueprint for IEC activities was produced as the first activity under the USAID-supported AIDS Surveillance and Education Project (ASEP).[3]

The communication strategy advocates two key thrusts of IEC program delivery: mass media communication with the general community and targeting specific audiences identified through consultations as key groups.

These key groups are: policy-makers, politicians, health professionals, religious leaders, media practitioners, teachers, health care workers, overseas contract workers, entertainers, commercial sex workers, and men who have sex with men and their sexual partners.

The communication strategy discusses each group in terms of general participation for inclusion; specific objectives; key message concepts; approaches to achieve objectives and materials development. The strategy also aims to expand IEC interventions to regional centers in Baguio, Cebu and Davao cities.

For those who are not traditional recipients of DOH IEC interventions, the Department works with other government and non-government organizations dealing with them.

2.1.1. Illustrative examples of IEC activities undertaken

For World AIDS Day 1993 PIHES made a bilingual collection of reminders and messages aimed to raise awareness about AIDS.

Fully illustrated the 16-page document had a foreword from Health Sec. Juan M. Flavier asking "friends in broadcast media and partners in health" to help program a build-up, observance and wrap-up from November 22 to December 6.

"Wear red," media men read from the spiels and talking points of PIHES which were components of what the NAPCP called "the biggest awareness program in celebration of World AIDS Day in which different sectors contributed in their own way through parades, fora, talk shows, concerts and advocacy meetings."[4]

Wearing red, Sec. Flavier led a multi-sectoral rally that ended with a concert in Makati, the nation's Wall Street, where musicians showed their solidarity with 5,000 AIDS activists. Programs were held in 25 other cities of the Philippines.[5]

Continuing the practice of launching AIDS-related activities, the AIDS Unit released "Ten Talking Points on AIDS" on Valentine's Day. The pamphlet modifies the poster of the WHO-Western Pacific Regional Office " Ten Talking Points on AIDS for World AIDS Day" and also advertises the RAIC Hotline as a source of confidential information. Reproduced by a number of Regional Health Offices and by a community service organization in Manila, the material accommodates details for telephone hotlines and services.[6]

Other IEC activities initiated by the AIDS Unit are the publication of two issues of **NAPCP News** in 1993, the development of a three-page insert on AIDS in the section on sexually-transmitted diseases that forms part of the family-oriented primary health guide entitled **Household Teaching Manual**, the printing in 1993 of IEC materials on safer sex, and the distribution of videotapes on STDs.

As the AIDS Unit was producing materials and conducting media campaigns for the general public and young adults, it was also conducting information campaigns at the DOH Central Office to help employees give accurate data on AIDS and HIV.

Other DOH agencies had activities for other audiences also. From 1989 to 1990 RITM had a health education/intervention program among male and female sex workers registered in certain social hygiene clinics of Metro Manila. As part of this collaboration with Kabalikat ng Pamilyang Pilipino, posters, pamphlets and comics were given out to 320 female massage parlor attendants and 320 bar/club workers and 250 male sex workers.[7]

Again for commercial sex workers, this time in Mandaluyong, RITM has been developing since last year (1993) a model AIDS/STD counseling and education module.

In 1993 it gave lectures on HIV/AIDS to overseas contract workers sent out by 15 manning agencies. These lectures at the pre-departure orientation seminars (PDOS) were videotaped and are now being played back at the waiting area for departing passengers.

In addition RITM held workshops for the management of the recruiting firms and developed a brochure for the OCWs, **Maligayang Paglalakbay! Alamin ang Totoo sa AIDS.**

RITM has also completed an experiment on four strategies for educating health workers. After a baseline survey, the workers received pamphlets and posters and underwent lectures and role playing. The last one appeared to be the most powerful for attitude and behavior change towards AIDS patients.

The most sweeping intervention is arguably the development and pilot testing of AIDS materials for the Education sector.[8]

Last year the NAPCP produced a prototype module which was pre-tested by the Department of Education, Culture and Sports (DECS) on elementary and high school teachers.

In school year 1992-1993 the New Tropical Medicine Research Foundation of RITM pre-tested modules in selected public high schools in Metro Manila.[9] Likewise, a module called **Immune System Approach** was pre-tested in three private high schools after adaptation by Kabalikat from one pre-tested in a number of Catholic countries.

As of 1992 HIV/AIDS education is integrated in medical, nursing and midwifery courses and in 1993 in dental and medical technology. Workshops and information kits have been initiated for medical and dental students by the Health Action Information Network (HAIN).

2.1.2. Advocacy activities

Advocacy is not mentioned as a separate component from IEC by the AIDS-oriented agencies of the government although a 1993 document from NAPCP reports on "continuous meetings with different agencies (civic, NGOs, religious, etc.) to strengthen the implementation of the NAPCP."

One of the most concrete results of these continuous meetings is World AIDS Day, when a cross-section of the populace marched in support of people living with the disease.

Another is the International Candlelight Memorial held every May 23 to remember those who have died of AIDS and to support those who are living with AIDS and HIV.[10]

Advocacy can also take place outside of special events. The AIDS Unit for instance does advocacy on behalf of the NAPCP at the highest advisory level possible, the National AIDS Council, where it serves as technical secretariat.

The National STD Prevention and Control Program which has been integrated with the NAPCP it had close collaboration in 1993 with the revitalized Philippine Society of Venereologists, a link it plans to strengthen in 1994. It will do the same with other government offices and local government units.[11]

RITM reports ongoing participation since it was founded in 1985 in local and international talk shows on radio, television and press conferences.

Advocacy may also take place with NGOs outside Metro Manila. In 1993 NAPCP encouraged the initiative of Davao-based Talikala Inc. in convening 12 NGOs in the City Health Office for information-sharing and forming a new alliance for information, support and funds.[12]

In March 1993 strong links between NAPCP and the drug abuse control program in Cebu were urged by participants of a consultative meeting on injecting drug use and HIV in Cebu.

Another major target of advocacy is the officialdom of local government who must now fund a major part of health services by virtue of devolution. NAPCP staff has not hesitated to prepare briefing sheets and meet with these executives on AIDS-related issues and funding support.

As for the Church, certain members of its hierarchy and lay groups have questioned certain NAPCP strategies. They have been answered by the Program that responsible adolescent sexuality means abstinence and not the promiscuity feared to come from the availability of condoms and lessons on AIDS.[13]

Legislative advocacy is increasingly becoming necessary in view of at least 15 bills on AIDS filed or refiled in 1993. Among them is Senate Bill 275 which would establish an AIDS Center under the Department of Health authored by Sen. Leticia Shahani. Its counterpart is House Bill 6974 of Rep. Hilarion Ramiro, Jr.

Rep. Ramiro has in addition filed H.B. 9752 for an independent commission to study the causes of AIDS and to propose measures that would prevent its spread.

A more controversial bill requires all aliens and **balikbayans** to submit to an AIDS test as a condition for entry to and/or continued stay in the country. This is H.B. 2844 of Rep. Luz Bakunawa. This is also the intent of Senators Francisco Tatad and Ernesto Herrera in SB 1087: to deport HIV-positive foreigners and bar them from the country. The same bill would separate prisoners with AIDS from their inmates and establish special communities for HIV-positive persons.

Rep. Antonio Diaz of Zambales province has filed HB 8077 that would create an AIDS Prevention and Control Division under DOH. A controversial provision is the establishment of STD-controlled areas in places for sexual trade where commercial sex workers can get work permits only if they test regularly for HIV. Like Rep. Ramiro, Rep. Diaz wants the selective testing of tourists and **balikbayans** believed to be carriers of the virus.

Rep. Carmencita Reyes' HB 5256 sees STD testing as a precondition to admission to and retention in college.

2.3. Training

In as much as there is no seperate provision for advocacy as a program component of the NAPCP, training is not a part of the component of program management but it may be referred to as "capability building."

According to a year-end report of the NAPCP, the Program holds continuous training of health workers in clinical care, diagnosis, counseling, blood handling and other STD/AIDS-related services.[14]

The Service which handles training is shortened as HEMADETS, or Health Manpower Development and Training Services. It has devised a training module for public health workers to equip them with basic facts about AIDS.

HEMADETS capability-building efforts concentrate on field personnel from the regional health offices (RHOs) down to barangay health centers (BHCs). It holds at least two or three courses per region yearly.[15]

Specifically, HEMADETS has trained one batch of medical social workers on basic AIDS information, one group of dentists who can supplement the existing core of field trainors (the coordinators of RHO technical divisions), field health workers on infection control in the context of injecting drug users, and NGO workers as well as DOH staff on advanced counseling methods.

BRL, RITM and San Lazaro Hospital are also training health workers on AIDS. The last two help the DOH conduct training courses in clinical care and management of HIV/AIDS.

RITM has courses for physicians, nurses, social workers, medical technologists and counselors (usually from the private sector) on topics like HIV proficiency testing.

At RITM there are also courses for the clinical staff of regional hospitals and medical centers on the multi-disciplinary approach to the care and management of AIDS patients.

The institute has produced a manual entitled **What health care personnel should know about AIDS.** The 15 pages of text are in English and fully illustrated with drawings.

According to Dr. Aplasca, OIC of the RITM AIDS Research Group, RITM conducts third-country training on HIV testing. Funded by the Japanese International Cooperation Agency (JICA), participants have come for the last two years from Thailand, HongKong, Papua New Guinea, Fiji, Indonesia and China.

The Immersion Program of San Lazaro Hospital is a two-week course for clinicians and nurses on care and management of AIDS patients as well as counseling them and their relatives. The program builds on the training at Prince Albert Hospital in Australia which was attended by the Director of the AIDS Pavilion and other medical doctors.

BRL sets the standards for blood banks, clinical laboratories and HIV testing laboratories. This includes training and accrediting medical technologists from public hospitals and the Philippine National Red Cross on HIV proficiency testing, serum pooling, quality assurance, hematology, biosafety, pathology and phlebotomy.[16]

BRL likewise provides laboratory management courses, refresher courses for technicians who may not correctly identify viruses after a series of tests, one-on-one consultancies, training of trainors, outreach workshops in regional hospitals and medical centers, and inputs to surveillance training courses for trainors.

Since 1992 the AIDS Unit has been holding training courses for regional AIDS coordinators on program management. The syllabus includes basic information on AIDS; two weeks of immersion in first-hand coordination of health education/communication, policy development, media relations and other aspects of Program management; and a consultative workshop to monitor and evaluate regional efforts in AIDS prevention and to plan the operational strategy for the following year.

Similarly, some of the staff members of the NAPCP and RITM have attended or read papers at international conferences. Others have observation tours of successful programs abroad. RITM clinicians and administrators were provided study grants and hospital-based immersions in Australia and the United States. Selected staff members of the BRL have also trained abroad on HIV testing.

2.4. Clinical management and care

It is a policy of the National AIDS Prevention and Control Program that government and non-government organizations should give HIV-infected and sick individuals optimal care, health and social assistance as well as refer them to appropriate counseling.

2.4.1. Hospital facilities

There are two governemnt hospitals for people living with HIV and AIDS: San Lazaro Hospital (SLH) and RITM. Both have been admitting patients since 1986.

It will be recalled that San Lazaro is the National Reference Hospital for Clinical Care and RITM as the National Reference Center for HIV offers clinical care, counseling and laboratory services.[17]

The two are supplemented by private hospitals like Makati Medical Center, American Hospital (founded in Tondo during the American occupation of the country, hence the name), Chinese General Hospital and Saint Luke's Medical Center.

According to Dr. Edna Santiago, director of the San Lazaro's facility for AIDS, any private hospital may accept AIDS cases as long as it has trained medical staff, universal procedures for infection control, and adequate systems for those who easily fall ill from airborne bacteria or droplets due to their infection.

From Dr. Santiago's experience it is generally access that determines if a patient will stay at either San Lazaro or to RITM.

Economic status and personal tastes may make a difference in that San Lazaro may be too crowded for well-off patients, hence they are directed to the Pay Ward or to RITM for private rooms.

The AIDS Ward has admitted 109 patients since it began, says Dr. Santiago who added that to the best of her knowledge, RITM has had 116 patients although the 1990 annual report of RITM lists only 49 admissions of patients with HIV infection and AIDS.

There are two types of patients at both government facilities: asymptomatic and symptomatic. Upon admission they are offered laboratory services that include HIV screening, T4 count, complete blood count, urinalysis, stool examination, sputum test, vaginal smear, liver profile every three months for those on anti-TB drugs, chest X-ray every six months and tongue biopsy for those who manifest oral hairy leukoplakia.[18]

The asymptomatics show no signs of AIDS even when diagnosed as HIV-positive, but they are encouraged to get medications and undergo laboratory work-up (including dental folow-up for oral hygiene) every three months for disease monitoring.

Symptomatic patients have to be confined for opportunistic diseases which, in the case of Filipinos, has been identified by studies at RITM to be tuberculosis. San Lazaro allows the rooming-in of children to maintain family unity but those patients with positive results for sputum are advised to use masks.

Once findings for opportunistic diseases turn negative the patients may be discharged. But according to Dr. Santiago, they soon return ill with, say, simple diarrhea (*usually self-limiting in healthy individuals but dehydrating for those with "compromised" immune systems*).

Food, medicines, laboratory examinations, rooms and clinical care are provided free at both facilities. For 1994 the budget of PhP 1.5 million at the AIDS Ward includes supplies and medicines like AZT. There are no figures available for RITM.

The AIDS Ward has access to the Laboratory of San Lazaro and the equipment of NAMRU-2. A detachment of this United States government agency is housed in the hospital compound, thus the Ward can use its floucytometer, the only one in the country, to measure CD4.

With the phase-out of NAMRU in July 1994, the Ward will have to ask RITM to do manual counts of these cells which indicate the progress of AIDS within a person.

2.4.2. Guidelines for hospital care

RITM and San Lazaro follow rules spelled out by the Department of Health. One such document is the **Handbook on HIV/AIDS** which was developed for all hospitals. Another is the **Protocol for Managing AIDS Patients** which was made by RITM. A third has just been drafted by the Hospital Operations and Management Technical Working Group (TWG) on the Management of HIV/AIDS Patients in Hospitals.

Created by Department Order No. 67-K s. 1994, the TWG is made up of representatives from the Hospital Operations and Management Services (HOMS), the STD/AIDS Unit, the San Lazaro Hospital and RITM.

The members recently wrote a document called **Initial Guidelines on OPD Consultation and/or Hospitalization of HIV/AIDS Patients.**

The premise is that all sectors of society, including hospitals, should help prevent and control the worldwide emergency of the pandemic which has not spared the country.

Towards this end the TWG proposes the formation of a HIV/AIDS Core Team (HACT) to be composed of a doctor, a nurse, a medical social worker and a medical technologist, all of whom must have had specified training on HIV/AIDS.

In the document, the TWG specifies the individual functions of each team member and formulates procedures on admission, out- patient care, counseling, team training, prevention and control of HIV transmission in hospitals, general infection control, sterilization and infection control and lastly, accidents due to exposure to blood, body fluids and tissues.

2.4.3. Social support

AIDS prevention and control is the concern of everyone in the community. This is because when an individual contracts AIDS, it affects his family, friends and eventually society itself.

Thus, the emphasis at the AIDS Ward is a family atmosphere. Patients call the nursing staff **Ate** (elder sister) and the maintenance **Kuya** (elder brother); fry rice for breakfast to approximate home cooking; barbecue pork or fish on improvised stoves for **ulam** (viands) to supplement hospital food; and pool their money to buy family-size bottles of soft drinks for everyone during **merienda** or snack time.

Passes are treasured to be able to meet loved ones or see movies or buy new clothes - but the patients hurry back to relate adventures to those who stayed behind.

Last Christmas patients sold Christmas cards to and through NGOs and government offices, shared the proceeds but set some money aside for a revolving fund to buy materials for handicrafts.

Dr. Santiago believes that this gives them something to look forward to in the same way that some of the women want to be pregnant: to have a reason for living. Women now form 89% of admissions at the AIDS Ward.

At San Lazaro, organized groups are volunteering time, money and efforts to help AIDS victims. The Cabinet Ladies Foundation have taught them how to make Christmas cards and doilies. Dr. Santiago remembers Ms. Lovely Romulo, spouse of the Senator, seated next to a patient, addressing her on a first-name basis, and making a glass coaster together with her. The sense of closeness deepened with the Christmas party that soon followed the "classes."

Members of the same foundation plan to build a hall where asymptomatic cases can have alternative livelihood projects. The First Lady, Mrs. Amelita Ramos, was guest of honor at the ground-breaking ceremonies.

In addition, some DOH employees spend their own money to supplement the diet of patients with milk, cereals and other items. At times they might favor one particular person, at other times they might trust Dr. Santiago or the staff to allot to a total stranger the carbohydrate-rich food bought with the much- awaited productivity bonus from the national government.

Since 1991 the RITM has been assisting HIV-infected patients in a number of ways. One is through livelihood projects. The other is the development of a counseling and education module for 325 commercial sex workers in 32 establishments in Mandaluyong.[19]

RITM is also studying the socio-economic impact of AIDS in the Philippines.[20] In this context the OIC of the AIDS Research Group pointed in an interview that social scientists should form part of the team together with economists and doctors. Behavioral modification, she said, is not a single process but an emotion-based reenforcement of information.

NAPCP implemented in 1993 projects for the welfare of HIV-positive cases and AIDS victims. For instance it developed a home care program with funds made available by WHO, held a workshop by community-based social support services for people with AIDS or HIV, and planned one on handling HIV/AIDS patients, relatives and friends.

There have been efforts beyond Manila. A city mayor has employed a number of HIV carriers as clerks. Social hygiene clinics have done the same for HIV-positive women.[21]

2.5. Surveillance

Epidemiological surveillance aims to assess the status of HIV / AIDS infection in the community, particularly its distribution within selected population groups and regions, to monitor the trend of infection in the groups and its shift to other groups and regions, and to guide decision-makers on interventions with specific groups and individuals.

In January 1987 AIDS was made a reportable and notifiable disease. All health facilities whether government or private must report any case of AIDS to the nearest government health officer.

The next year the National AIDS Registry was created and a National AIDS Registrar appointed to keep an official and confidential register of persons infected with AIDS. Quarterly statistics update the government as well as WHO on the incidence of AIDS in the country.

But the Registry is a passive way of getting information since reports have to filter in before cases can be officially entered in it.[22] Other ways of getting a picture of infections are serosurveys, checking records from blood banks on HIV screening, voluntary testing and partner notification, and sentinel surveillance.

2.5.1. Serosurveys

The serum is the liquid part of the blood. It can be tested for HIV antibody at nine of the 12 model social hygiene clinics of the National STD Prevention and Control Program. The test is not mandatory simply because a client has been found positive for STD.

The twelve model clinics can do the basic STD laboratory examinations as well as syphilis and gonorrhea. Four serve as regional centers: those in Regions I, III, VII and the National Capital Region. All 12 are also venues for training health providers.

In 1994 the National STD Program was integrated with the AIDS program by an administrative order. The goal of the STD Program is to promote wholesome family and community welfare through the prevention and control of STDs in the Philippines.

Clinics are sources of passive surveillance reports. A current activity is to develop or improve the reporting and recording system for surveillance.

2.5.2. Blood tests

Blood donations are routinely screened for HIV. Records from blood banks can form part of epidemiological assessment. At present there are 269 registered blood banks.

A field survey of blood banks in the country began last year. Ending this January, the survey has become controversial showing that of the 136 visited, donor bleeding was low (5-10 per day); screening for four mandated diseases (HIV, malaria, syphilis and hepatitis) can be done in only 24% of the blood banks studied; HIV screening can be done in only 37%; and two samples tested were positive for HIV, and 13 for hepatitis B.[23]

The study recommended short-term as well as medium and long-term measures, including immediate improvements in regulations and procedures especially for donor screening, blood screening and monitoring and waste disposal; immediate phase-out of free-standing outlets; discussions on better and safer blood distribution schemes; and immediate creation of hospital blood transfusion committees.

Sero-surveys are also done by NAMRU-2, the latter mostly in Olongapo, Angeles and Metro Manila - in coordination with BRL and RITM. RITM reports of work among male and female sex workers in Manila, Quezon City, Makati, and Mandaluyong; among returning OCWs together with the AIDS Register; blood donors of the Philippine National Red Cross; and prenatal patients with Fabella Hospital.

Some surveillance has also been done at places of employment of commercial sex workers, in tourist areas like Manila, Quezon City, Angeles and Olongapo; in all regions; in all the municipalities and cities in Metro Manila and in Olongapo and Angeles.

2.5.3. Testing for HIV

All laboratories of regional hospitals and medical centers can test for HIV and screen blood supply for HIV infection. Together with private laboratories, a total of 169 can do the HIV testing.[24]

Confirmatory testing of positive initial screening is done by RITM for private laboratories and BRL for the government.

Both evaluate diagnostic kits before these can be licensed by the Bureau of Food and Drugs (BFAD) for distribution.

RITM as National Reference Center for HIV Testing performs special HIV tests like P24 antigen, CD counts and viral serology; holds proficiency workshops for medical technologists of private laboratories to be accredited; determines the cost-effectiveness of pooled sera and blood collected by filter paper for HIV testing; evaluates the testing practices of laboratories in Metro Manila and of blood banks throughout the country; and participates in international quality assessment programs.

For its part, BRL licenses, supervises, regulates and monitors the 169 HIV testing laboratories, 269 blood banks and 2,000 clinical laboratories of the primary, secondary and tertiary categories; trains, retrains, licenses and accredits pathologists and/or medical technologists for HIV proficiency testing, serum pooling and hepatitis B; calibrates machines; contributes to quality assessment programs; and checks standard reagents.[25]

Any HIV testing laboratory can test for HIV as long as it is accredited by BRL, has a medical technologist trained and licensed to do it, and has a supervising pathologist.

2.5.4. Voluntary testing

Anyone who feels endangered by his or her own at-risk activities (or that of his partner) can avail of testing facilities at a variety of sites: STD clinics, antenatal clinics, selected hospitals of infectious diseases, narcotics drug treatment centers and lately, offices of NGOs working in AIDS.[26]

The testing is confidential and preceded by counseling. There is a post-testing counseling. Clients are encouraged to tell their partners and to encourage them to undergo the same tests.

2.5.5. Sentinel surveillance

Sentinel surveillance is considered to be the best way to use limited means for assessing seroprevalence in selected groups and then for monitoring changes over time.

The method avoids the participation of too many members of just one or two groups of the population.

In the case of the Philippines it is workers at entertainment establishments, overseas contract workers for certain Middle East countries, and commercial blood donors who are tested most often.

While data from these groups show that HIV infection is indeed present in the Philippines, the information is not a reliable gauge of actual prevalence. The same entertainment worker may be counted each time she reports for a test while too few other population groups may be submitting themselves for screening for a true picture to emerge.

For these reasons a systematic surveillance system is needed. The DOH installed one such system in 1991 with technical assistance from two experts on the epidemiology and monitoring of HIV/AIDS infection.

Basically the system uses key groups for HIV testing from strategically selected sites. The prevalence rates among these groups allow inferences that the disease has or has not spread through the entire population. There is no need to test many people at the same time, only when certain thresholds are reached do other groups undergo tests.

There are disadvantages, though, one being the impossibility of tracing seropositive individuals when identity is "de-linked" from blood samples to help maintain confidentiality.

Cost-effectiveness was the key word for the 1991 sentinel surveillance plan. Again cost-effectiveness is the rationale for the surveillance component of the **AIDS Surveillance and Education Project (ASEP)** that began in 1992.

The project seeks to overcome under-reporting of the extent of HIV and give NAPCP more reliable data for more accurate targetting of interventions.

The surveillance component is directed by a small permanent staff within DOH. Blood specimen and minimal information are collected without the need for sophisticated computers or technology at pre-determined sites. No additional laboratories are needed to perform or monitor testing for HIV anti-bodies.

This surveillance component can accurately *identify* groups and geographic regions at risk rather than HIV-positive people. But outside ASEP the DOH agencies like BRL, RITM and nine of the 130 social hygiene clinics will continue to screen individuals.

The FETP has the overall responsibility for managing the surveillance system at both central and local levels.

It has already selected central-level staff, coordinated with BRL and RITM on laboratory support and testing, piloted procedures and protocols in Baguio and Cebu, implemented the first round in Quezon City and Cebu, held a national conference on the results, and trained teams for the second round.[27]

HIV testing will be carried out among high-risk groups every six months, first in six sites and eventually in 30, all strategically located throughout the country.[28]

To maximize the possibility of identifying infected individuals, sentinel groups and sites are chosen with precision. A consensus was reached on groups: homosexual males, returning overseas contract workers, commercial sex workers (male and female) and males being treated for STDs.

Local surveillance units identify and reach a sample size of 300 per risk group (100 for freelance sex workers) per sentinel site for blood extraction.

Regional laboratories of BRL will test these blood samples by serum pooling with the Particle Agglutination Test. RITM will do confirmatory testing of HIV-positive samples using the Western Blot.

Among one or more of the high-risk sentinel groups, there must be a threshold prevalence of 3-5% before the system includes the secondary-risk groups of intravenous drug users, pregnant women attending prenatal care clinics or health units, spouses of OCWs and partners of commercial sex workers.

By the end of 1994 it is expected that the system will be in place in 14 regional urban areas with the highest concentration of individuals at risk of HIV infection.

Reagents and other commodities are to be made available. There will be an external reference laboratory throughout the project.

FETP will collect and analyze data through EPI/INFP software, make semi-annual reports and insure appropriate collection and disposal of materials used in surveillance.

3. Budget and Funding Agencies

In 1993 the budget needed to fully implement NAPCP was PhP 208 million (US$ 8.35 million).[29]

By component this was divided into laboratory services (54% of the total budget), clinical care and management (25%), health education/communication (17%), and surveillance (2%).

As of September only 40% or US$ 3.35 million had been used, coming from the United States Agency for International Development (60%), the Philippine Government (18%), the Australian International Development Assistance Bureau (12%) and the World Health Organization (10%).

It could not be established from the Philippine country report that forms the basis of the above figures if the funds refer to AIDS-related work by both government agencies and NGOs.

More specific data as of March 28, 1994 give figures for the AIDS and STD control and Prevention Programs after their integration was mandated by a Department Order issued in 1993.

In particular the figures are for activities funded by the Philippine Government and WHO; both appropriated a combined figure of PhP 23,602,025.[30]

Of this amount, PhP 18,636,076 were released but only PhP 11,812,636 were utilized.

For social mobilization/IEC a total of PhP 8,703,317 was used, which was 74% of the amount for the combined programs.

Supplies and materials for direct service delivery comprised the second most-funded item (PhP 1,828,973 or 15%).

The third largest amount went to program training, PhP 1,167,760 or 10% of the utilized amount.

Next in rank was monitoring and evaluation which received PhP 720,039 or 6% of the funds used.

Consultancy services got the fifth largest amount, PhP 606,200 (5%).

The sixth most-funded area was administration (MOE) which had about 4% of the funds used (PhP 423,173).

Ranking next was personal services in the course of direct service delivery (PhP 337,235 or 3% of the amount utilized from Philippine Government and WHO monies).

Rounding up the funding were those for a national conference (PhP 308,675), administrative personnel services (PhP 297,824), capital outlay (PhP 264,000) and disease surveillance (PhP 188,400). These sums were part of the funds utilized for 1993 under the WHO-Government of the Philippines partnership.

There are no comparable figures for RITM or the AIDS-related programs of the BRL. For 1990 RITM got six research grants of PhP 6,923,149.8 from three agencies. No other data are available.[31]

1 − 3 Non−Government Organizations

III. NON-GOVERNMENT ORGANIZATIONS'PROGRAMS ON AIDS

This section presents the results of interviews and literature search on AIDS-related activities of the following non-government organizations (NGOs) in the Philippines:

1. DKT International (Philippine Social Marketing Program)
2. Family Planning Organization of the Philippines (FPOP)
3. Foundation for Adolescent Development (FAD)
4. Health Action International Network (HAIN)
5. Institute for Maternal and Child Health (IMCH)
6. Institute for Social Studies and Action (ISSA)
7. Kabalikat ng Pamilyang Pilipino, Inc. (Kabalikat)
8. Population Services Pilipinas Inc. (PSPI)
9. Philippine NGO Council for Population, Health and Welfare (PNGOC)
10. ReachOut AIDS Education Foundation (ReachOut)
11. Remedios AIDS Foundation, Inc. (Remedios)
12. Third World Movement against Exploitation of Women (TW-MAE-W)
13. WomanHealth Philippines, Inc. (WomanHealth)

The documentation of NGO programs began with the choice of NGO-interviewees from the 38 member-organizations of the HIV/AIDS network (see Figure II). The Philippine Population Association (PPA) was also referred to other agencies in the course of data gathering.

PPA collected a large variety of materials: annual reports, regular publications, press releases, abstracts or actual reports of studies, briefing kits, comic books, leaflets, stickers, posters, brochures and product samples.

From a review of these materials and from the results of interviews, programs and activities were classified and analyzed.

1.1. Information, communication, health education and advocacy

The NGOs in this situation analysis use media for a variety of reasons: tell the general population about certain activities, promote and sustain a desirable behavior among specific groups, influence action and policy on AIDS-related issues.

To achieve these an NGO may use the face-to-face approach, speak before groups of people or multiply its reach through the mass media. In the third approach an NGO issues a publication, co-produces a program or outrightly buys time and space for a commercial as part of a multi-faceted campaign on a service or a concept.

The reverse occurs when a media organization covers an activity or invites officials of an NGO to speak on an occasion related to AIDS or airs the production of an NGO.

1.1.1. Illustrative examples of media-initiated IEC activities

Although this is a section on non-government activities, it would be ill-advised to ignore the assistance of media organizations in promoting AIDS-related issues.

Health-media reporters have done much to keep AIDS alive in the public eye. Newspapers for instance broke the news that certain blood bank samples are contaminated with HIV.

The writers of some magazines also cover the AIDS-related programs of NGOs. For World AIDS Day last year (1993) **Philippine Panorama** - the Sunday supplement of one of the country's most widely- circulated English language newspaper - featured PSPI, the local affiliate of Marie Stopes International.

As for television channels, Ch. 9 covered the street play of PSPI entitled **"Kaalamang 343"**. Ch. 2 aired **"Poisoned Blood"**, the award-winning documentary by ReachOut executive director Jomar Fleras. After the showing, the number of callers increased for the telephone counselling service of ReachOut. In the first ever simulcast launching of an AIDS video in 1993, all the channels aired an MTV by ReachOut in which local celebrities discussed AIDS.

As for talk shows on radio, DWIZ gives free air time to **Radyo Woman Watch,** a project of Women's Media Circle Foundation that devotes one day to women's health. On television - **Tell the People,** a late-night public affairs program on Ch. 9, discussed World AIDS Day 1993 on Nov. 25 with Sec. Flavier as one of the guests. This was one of the few times that media assistance and coverage were documented.

For variety shows, Ch. 7's Friday top-rating **Vilma!** has had Sec. Flavier as co-host for the World AIDS Day special of movie star, Miss Vilma Santos. She is wife to Congressman Ralph Recto of Batangas who has introduced or co-authored legislation on AIDS. She played the lead in the biography of Dolzura Cortez, the first Filipina to come out in the open about having AIDS. The film earned much for its producer but raised questions from women and AIDS-related NGOs about accuracy and truthfulness.

1.1.2. Illustrative examples of NGO-initiated IEC activities

An NGO can inform the general public of its activities by producing a regular publication its resources may allow. This is the case for seven of the thirteen NGOs studied: DKT, FPOP, HAIN, IMCH, ISSA, PNGOC and Remedios. Their organs carry news, feature articles and special reports on AIDS.

Activities related to the broadcast media are the airing of video productions by ReachOut, the co-hosting by ISSA of the health segment of **Radyo WomanWatch** on DWIZ and the use of commercials to promote condoms as part of a multi-media approach. ReachOut was founded by playwrights and videographers whose involvement with the issue of AIDS has led to a serious documentary like **Poisoned Blood** as well as to a music video like A+ with its "enter-educate" (or entertainment-education) approach for young adults.

Poisoned Blood focuses on the economics and politics of AIDS; analyzes feminism against the spread of the disease in the Philippines; discusses issues like Spanish and American rule of the country, folk Catholicism and the impact of military bases; and ends with the analysis that the real issue is not AIDS but discrimination, apathy, ignorance, superstition, fatalism and the feminization of poverty.

With WomanHealth, ReachOut is co-producing a same-titled video on the social impact of AIDS on women in the Philippines that will focus on the history of the Filipina, her present role and status, the impact of the disease on women, and existing AIDS programs for them. These two NGOs began working together in 1991 on the proposal for this video. Since then they launched with Kabalikat, the DOH and WHO-GPA the lst International AIDS Video and Poster Festival on March 22-27, 1993 at the Cultural Center of the Philippines.

1.1.3. Special media

Together with the established media of print, radio, television and video, the NGOs in this study have also used special media to promote the concept subtly but effectively.

Classified as special media are brochures, leaflets, pamphlets, posters, comic books, streamers, T-shirts, stickers, hand-outs, billboards, identification cards and stage plays.

PSPI used special media to promote its project AIDSCHECK which won an Anvil Award in 1993 from the prestigious Public Relations Society of the Philippines. The brand name AIDSCHECK appeared on condom packages, stickers, posters of action star Gardo Verzosa saying " **Kaya natin ang AIDS. Mag-condom lagi.**" (We can stop AIDS. Always use condoms), T-shirts and identification cards of former trainees who had banded together in **The Circle of Counsellors.**

The play **Kaalamang 343** was conceptualized, staged and remains co-produced by the Circle of Counselors. It uses local talents among the volunteers to educate viewers of the street play (**kaalaman** means knowledge) on the "ABC" body fluids that transmit HIV, the four means of transmission, and the three options for avoiding infection. "A is for abstinence, B is for Be Faithful and C is for Condoms," Sec. Flavier has said countless times on radio and television. The play is followed by a question-and-answer portion.

AIDSCHECK condoms were promoted face-to-face in "classes" for homosexuals and commercial sex workers of Pasay City, area of operations of PSPI, and by the members of the Circle as a fund-raising project for its community services.

Special media have also popularized the telephone and face-to-face counselling services of ReachOut and Remedios. There are posters, stickers and hand-outs. Two multi-media campaigns in 1990 and 1992 publicized them in Metro Manila as the sources of confidential information on AIDS.

Other materials have publicized the short-term services offered by Remedios and ReachOut on free HIV testing. ReachOut used handbills and word-of-mouth; its staff would go to gay bars and inform homosexuals that the service was available on week-ends and after office hours.

In much the same way, Remedios advertised the service with small prints-outs that were hand-distributed and discreetly posted on its office premises along Remedios street.

1.2. The social marketing of condoms

Traditional as well as special media have been used by DKT and Kabalikat in the social marketing of condoms, defined as the use of commercial marketing for high-efficiency low-cost delivery of vital social needs.

DKT can sell Trust Brand at three pieces for PhP 4.00 to the mass market and high-risk groups because of subsidies from private donors for 20 NGOs engaged in social marketing throughout the world. DKT also had to change its authority to sell only at pharmacies and medical outlets to almost any venue. This had to be cleared with the Bureau of Food and Drugs. The said condoms come from Malaysia.

DKT International succeeded in putting Trust Condoms in the public's mind by selling the brand in drug stores as well as in commercial venues: supermarkets, neighborhood stores, bars, motels, discos, etc. It was the first time for condoms to be marketed this way. Much of the success comes from the multi-media approach.

DKT introduced Trust brand in 1990 after a series of focus group discussion on the name. It now promotes the brand through a play, the radio, tabloids, 300 comic books, 50,000 education pamphlets, and monthly copies of Latex News on internal matters and events of interest to the AIDS community of both NGOs and government agencies. Massive samples of 5,000 - 10,000 a month are given away. DKT officials and a mascot identified with the brand are present at special events. A marketing network and cash vansare found in major cities of the country.

The three-act play **Kondom Kapers**, financed by DKT, lasts for 45 minutes and aims to desensitize its audiences with humorous situations involving a couple and the mascot Super Trust who fights HIV infections.

The central message (Use condoms and be safe.) is reinforced by illustrations and text on the condom pocket as **Mga Payo ni Super Trust** (Advice from Super Trust). Other give-aways include plastic fans, coasters, plastic bags, etc. These are given after the play is staged. The play is followed by a question-and-answer portion handled by medical officers and demonstration on proper condom use that always elicits interest among audiences in schools, headquarters of civic-minded associations, military camps, barangay centers, etc.

In 1992 DKT pioneered in dial-a-condom sales in the Makati area of its offices. The firm was criticized for using telephone operators to receive orders and a fleet of motorcycle drivers to deliver them within its territory, but this resulted in increased sales and requests for interviews about the strategy by both Philippine-based and foreign media. The innovation had to be terminated because of the difficulty in meeting the demand.

The strategy of social marketing has been studied by students of the University of the Philippines, Ateneo Graduate School of Business, De La Salle University and Silliman University in Dumaguete, Negros Oriental.

The scheme has likewise been presented abroad before business associations and trade bodies.

In June 1992 a survey among 400 active condom users in Metro Manila showed Trust to be the fastest moving brand in the area. By a margin of 2 to 1, the brand was ahead of the competition in brand recall, brand most often purchased and most recently bought by the 100 married men, 100 married women, 100 sexually active adult males and 100 female prostitutes in 18 middle-income to lower-income areas.[1]

DKT blurs the line between selling a product and selling a concept in using standard public relations and advertising partners as well as networking for social concerns for condoms.

Another NGO that has used social marketing is Kabalikat. It has used radio commercials that advocates the use of latex condoms because it decreases the spread of AIDS during intercourse with an infected person.[2]

Through the social marketing campaign launched last year, Kabalikat would like to show that NGOs can be proactive in the campaign against AIDS.

The campaign is a partnership with Philusa Corporation that aims to increase public awareness about HIV transmission, to increase public awareness about how the condom can prevent HIV transmission, to encourage the use of condoms as protection from HIV, and to make high-quality, affordable condoms readily available to the Filipino people for their use in preventing AIDS.

The campaign sells Sensation condoms, the thinnest latex condom made in the United States and meets the standards of the WHO for a condom against AIDS.

Each pocket has detailed instructions on correct use. The brand is distributed in drugstores throughout the country but for this social marketing campaign, Philusa has invited inquiries from retailers.

Radio commercials containing the message **"Maniguro. Make it safe"** remind the the target audiences (married and unmarried men, teen-agers, contract workers going abroad, etc.) not to let their dreams to be shattered by AIDS by using condoms.

Kabalikat, like DKT also uses another medium, stage plays, for the promotion of condom use. It has pretested **Luksang Pula**, on representatives of target audiences to check if the message of transmission, prevention and illnesses associated with AIDS is correctly perceived when interwoven with the storyline of streetchildren in the tourist belt of Metro Manila.

The play was developed after a series of workshops with the clients of Kabalikat's drop-in center in Malate.

2. Networking and Coordination

The first effort to bind agencies together in family planning was in 1987 when the Philippine NGO Council for Population, Health and Welfare (PNGOC) was founded. Since then some members have formed networks for HIV/AIDS while retaining membership within the Council - even as PNGOC itself now advocates for AIDS.

2.1. The HIV/AIDS Network

The HIV/AIDS Network started in 1992 but was formalized at a meeting of 24 NGOs on Feb. 19-21, 1993 at the National Training Center in Los Banos, Laguna.[3]

As of January 1994 there are 38 members and all but two are included in this situation analysis (IMCH and PNGOC are not members). HAIN is presently the network's secretariat.[4]

The network envisions empowered communities to prevent the transmission of HIV and reduce the impact of AIDS.

The network sees its mission to be promoting the growth, viability and effective response of groups to HIV/AIDS and upholding active solidarity among members.

Members have identified three main areas of work: capability building, advocacy and networking.

A concrete case of networking is the production by ReachOut and WomanHealth of a video entitled **The Social Impact of AIDS on Women in the Philippines**. Funded by the Protestant Association for Cooperation and Development, it will show the history of the Filipino woman, her present role and status, the impact of AIDS on women, and AIDS programs for women.

The two NGOs had collaborated in the First International AIDS Video and Poster Festival on March 22-27, 1993 where tape- viewing sessions were followed by discussions led by WomanHealth, Kabalikat, WHO and San Lazaro Hospital.

A third case of collaboration is the series of workshops given to clients of Kabalikat's drop-in center by the Children's Laboratory for Drama in Education. Months of training and planning have culminated in **Luksang Pula**, a play on a commercial sex worker who spurns her boyfriend for a man who infects her with HIV.

2.2. Marching for Life Coalition

The Marching for Life Coalition was formed when ISSA held a meeting on February 2, 1993 about a rally of anti-choice groups.

The NGOs formed a coalition and issued a position paper on February 12, a day before the anti-choice rally.

As of July 1993 the coalition had 38 members from the ranks of family planning, population, human rights, youth, labor, women, urban poor, religious bodies and the HIV/AIDS sector.

Eight of the agencies in this situation analysis are members. The secretariat is ISSA which, like HAIN and Kabalikat, is a member of the Philippine National AIDS Council (PNAC).

The vision of the coalition is the nationwide recognition and respect for the rights of every Filipino to dignity and justice. It's mission is advocacy for policies and programs that uphold beliefs, aspirations and thoughts on reproductive health especially in responsible sexuality, family planning and HIV/AIDS.

2.3. Kaagapay

A long-lasting result of the counseling workshop where ISSA participated (see first part of section on IEC and advocacy) is the organization of Kaagapay Support Group, Inc.

Held in July 1992, the workshop was sponsored by Remedios. It had as guest speaker the late Dolzura Cortez, the first Filipina to come out as a person living with AIDS (PWA). She captured the hearts of the Cebu workshoppers who made a commitment to support and care for PWAs as well as people living with HIV (PHIVs).

Since then Kaagapay has had two elections of officers, various fund-raising activities, visits to San Lazaro Hospital for afternoons with PHIVs as part of National AIDS Awareness Month in December 1993, and stronger links with this hospital as a part of the network for people.

Eighteen members are currently active. Remedios serves as the secretariat.

2.4. The PNGOC

A symposium in 1987 on the fifth billionth baby born led to the formation of the first network of health agencies in the country.

Today the coalition has 38 members. All but four (HAIN, Remedios, ReachOut and TW-MAE-W) of the NGOs in this situation analysis are members of PNGOC.

The PNGOC has activities in lobbying, capability building, resource mobilization, networking and innovating on legally accepted strategies. It presents the point of view of members to policy makers and legislators, and publishes a quarterly called **Link**.

A concrete activity is distributing contraceptive supplies to member agencies. PNGOC served as a conduit of pills and condoms marketed by member organization DKT until the Management Information System for Logistics was set up by DOH. Today NGOs are among the beneficiaries of this system.

2.5. Other Linkages

Coordination has linked the NGOs with many sectors.

One is the **media** which cover activities like seminars and street plays and occasionally air NGO-produced documentaries.

A second sector is **local government**. In Pasay City the vice-mayor commemorated World AIDS Day 1992 by inaugurating a billboard with the AIDSCHECK slogan of PSPI: "Kaya natin ang AIDS mag-condom palagi."[5]

It is with Councilor Justo C. Justo's Pasay City AIDSWatch and Information Drive (PAWID) that DKT coordinated AIDS prevention efforts through **Kondom Kapers** showings and the dissemination of condoms and information on HIV.

Coordination with **business** has also been explored by Kabalikat in a survey of 14 NGOs from Hongkong, Indonesia, Malaysia, Thailand, Singapore and the Philippines.[6] The NGOs are all in AIDS education and almost all give counseling. These NGOs intend to work with the business sector primarily for funding.

In reality, at least one Philippine NGO, the ReachOut AIDS Education, has private businessmen on its board of trustees including restauranteur Mr. Larry Cruz and society leader Ms. Bea Zobel. They regularly meet on their own and grace milestones of this NGO.

NGOs also coordinate with**grassroots**. HAIN works with a network of people's organizations in health.[7]

Coordination is also taking place with **international solidarity groups.** ISSA works with the International Women's Health Coalition to develop the area of urban poor women in Barangay Veterans Village. Remedios also operates with representatives of Malaysia's Pink Triangle, African National Congress Women's League and East Cape Council of Churches.[8]

Donor agencies are rightfully important to NGOs. In the case of PSPI, participants of a WHO Regional AIDS Management Conference had a field visit to a nightclub where the women had put up a poster with the help of PSPI staff: "Support us in preventing AIDS—let our women put condoms on you." Japanese and Taiwanese participants offered to translate the notice for their countrymen, an activity duly documented.

In the case of TW-MAE-W, Sr. Soledad Perpinan was appointed by Dr. Jonathan Mann of the WHO-GPA to a temporary consultancy in the Geneva offices which meant visits to AIDS programs in several African Countries.

The full range of coordination and networking has facilitated advocacy and resource sharing among the NGOs. It is expected that this will increase when AIDS cases rise and require even more management skills.

3. Training

The function of training in this particular case is primarily education for AIDS prevention. NGOs hold plays, demonstration-return demonstrations, motivational lectures and workshops for the general public, those at risk, service givers, motivators, counselors and other groups.

Only a few cases of skills training were recorded in materials reviewed for this situation analysis. Even fewer were seen in terms of laboratory procedures even if Kabalikat tests condoms for breakage/strength and four NGOs offer pap smear and similar services for family planning and maternal health. (FPOP, IMCH, ISSA and PSPI). Quite a number of skills training, though, are projected under a USAID surveillance-education project.[9]

ASEP supports training activities for target groups. There are also funds for international training on education and communication techniques used in AIDS prevention programs as well as for attendance at international symposia and workshops on AIDS.

Sub-grantee NGOs are being trained in administrative procedures, initial proposal development, monitoring and evaluation and other needed skills.

Their chief trainor is the NGO/community advisor of the project who is assisting the lead NGO in working with sub-grantees.

Figures made available for this situation analysis show that USAID has allotted US $70,000 for training activities over five years: $650,000 in local currency of Philippine pesos and $100,000 in foreign exchange.

It is hoped that these direct grants will give NGO workers in IEC the basic and advanced skills as well as the broad perspective to discharge the twofold objectives of the education components of ASEP: firstly, to encourage target groups to avoid engaging in behavior that put individuals at risk of contracting or spreading AIDS and secondly, to change existing behavior to lessen transmission of the HIV virus.

3.1. Training on condom use: plays

Watching plays is a painless way of learning that, used properly, condoms effectively prevent the transmission of the HIV virus. This is the premise of DKT's **Kondom Kapers** and PSPI's **Kaalaman 343.**[10] With humor, dream sequencies and mascots, both plays educate viewers on the nature of AIDS, ways to transmit it, and means to prevent transmission. Viewers are then invited to raise questions, doubts and fears at an open forum where trained staff or medical officers answer queries, show the correct way of putting on condoms, provoke laughter by the use of actual models of penises, but use this rapport to check how audience members would do the procedure.

DKT then distributes sample packets with drawings on the right way of using condoms. Depending on the audience - students, businessmen, the military, women's groups, village association members - this approach may vary.[11]

3.2. Training on safer sex and condom use: workshops

A more structured way of training groups on condom use and safer sex is the workshop.

HAIN has held workshops on AIDS prevention for sex workers as well as students. The former had 30 male sex workers who "cruise" in rundown shopping center of Manila.[12]

Focusing on biomedical and psychosocial aspects, HAIN also developed an IEC kit as well as a booklet on safer sex and asked participants to start a diary on their sexual activities so that they themselves would discern the need to reflect on their lives. But since some did not record everyday, this innovation could not be checked for effectiveness.

On the whole, however, the workshop improved knowledge levels on AIDS, initiated peer education and strengthened the resolve of participants to reduce risk-taking.

As for students, HAIN held seminars from November to December 1991 for 480 medical and nursing students in six Metro Manila universities.

There were information kits to help participants tell peers or patients about AIDS. News clippings and scientific articles are mailed as updates.

Pre- and post-workshops assessment showed that the project raised levels of knowledge on AIDS, checked misconceptions as well as attitudes on AIDS-related issues, and changed the lifestyles of some participants. The project is being replicated among midwifery, dental and medical technology students.[13]

As for ISSA, it has held workshops for 53 recruits of the manning agency El-Greco Tsoukis and their wives/regular partners, with separate sessions for 25 women participants in Metro Manila, 20 in Batangas and 14 in La Union, home provinces of most of their spouses.

After sessions on transmission modes and prevention through safer sex and condoms, some participants exchanged views on AIDS-related issues but pre-workshop interviews and activity processing showed that they need more educational programs on AIDS.

ISSA also had kits: for the seamen belt bags with readings on HIV/AIDS, 30 pieces of latex condoms and diary/journal meant to be sent back to ISSA; and for the women, cosmetic bags with readings, 15 pieces of condoms and stationery sets to encourage letter-writing to their spouses on safer sex.

As part of Project AIDSCHECK, PSPI had study groups for commercial sex workers spread out over twelve sessions in the late afternoon or early evening. There the staff showed the proper use of condoms, invited participants to practice on the same model of a penis to their delight, and checked learning gains by pre- and post-lecture evaluations.

PSPI reports that this adjustments to working hours enabled 242 women to attend 58 sessions lasting 296 hours and 12 club owner/managers to have four sessions lasting 48 hours.

Soon the participants were visiting PSPIs Marie Stopes clinics for STD tests, contraceptive information and services and joining a motivators' group formed by 25 homosexuals in the initial batch of trainees. All in all 65 homosexuals had 42 sessions lasting 384 hours.

For its part ReachOut holds seminars on safer sex using a module whose design was funded by the American Foundation for AIDS Research.[14]

3.3. Integration of information on AIDS with other concerns

A number of agencies report integrating *safer sex and other information* on AIDS with their activities for family planning, maternal and child health, reproductive health and women's rights.

The FAD puts AIDS education within lectures, interviews for baseline data and medical missions on family planning and maternal and child care.[15]

FPOP Central office medical doctors, clinic staff, volunteers and youth counselors tell patients, telephone callers and peer groups of AIDS in the context of family planning and safer sex. FPOP entertains requests for lectures on these topics as another venue for information and training.[16]

IMCH blends AIDS education with counseling and information-giving on safer sex, family planning and contraceptive. The setting may be a one-on-one session with a client or a mother's class in communities served by its 189 clinics nationwide.[17]

ISSA has weekly outreach clinics in the YWCA Quezon City Chapter building where field staff can teach safer sex and AIDS prevention to women waiting for their turn for consultations with volunteer doctors. Another venue for training is the community assemblies arranged by women volunteers in the pilot area of Barangay Veterans Village.[18]

Within weekly lectures for women prostitutes who stay for six months at Bethany Growth Home to learn a new trade, TW-MAE-W incorporates information on AIDS. There is one session on STDs which is handled by the AIDS education officer. This NGO used to teach sex workers resting in their drop-in center how to use condoms until the Catholic church ruled against them.[19]

WomanHealth has a pilot project in an urban poor community in Bagbag, Novaliches where women health volunteers have had workshops run by WomanHealth officers and staff on sexuality, the reproductive system and health rights.[20]

3.4. Direct training

FPOP provides its clinical staff skills training on AIDS and refers to a special chapter in the **Quality Assurance Manual, Essential Clinical Standards for Contraceptive Service Delivery for IPPF Family Planning Association's in East and South East Asia and Oceania Region.**

The chapter describes STDs, their symptoms and types, and how to avoid them, test for them, treat both partners, and check for pregnancy before treating a female client. The chapter also defines HIV and AIDS, their stages of development and transmission and delves on the link between sexual activity and HIV infection, infection control in the clinic, counseling and confidentiality especially for self-identified clients, contraception for infected ones, and types of hepatitis and their transmission.

IMCH incorporates infection control measures in family planning courses for its manpower as well as service providers of other agencies: integrated basic/comprehensive family planning for physicians, nurses and midwives; refresher courses in family planning; preceptors' courses for basic/comprehensive family planning; interpersonal communication skills; training of trainers; management of family planning programs at the clinic level; management supervisory skills workshops; and quality of care workshops.

In addition IMCH staff get updates on AIDS and STDs from lectures by visiting colleagues from the Margaret Sanger Center, lead agency/conduit for UNFPA-funds for 95 clinics nationwide.

For its part Kabalikat trains province-based NGOs like the FPOP Davao chapter. It also produced comics and brochures for the RITM education and intervention programs for sex workers; a component of intervention was training.

ReachOut can train various groups through safer sex seminars and theater workshops. The module for theater was designed by the Bulwagang Gantimpala drama group.

ReachOut has a peer -led project in Philippine Christian University, Adamson University, Feati University, Far Eastern University, Philippine Normal University, and the Diliman and Manila campuses of the University of the Philippines.

In each of these seven schools the education and empowerrment project aims to prevent the spread of HIV infection by training peer intervenors to work with members of five sorrorities and five fraternities. Workshop modules and brochures come from surveys and in-depth interviews on AIDS-related issues.[21]

Both ReachOut and Remedios train counselors for their hotline service.

For its part Remedios gives skills-building seminars to members of the HIV/AIDS network on topics like public speaking and the development of IEC materials, and makes available to other NGOs its facilities for training and other activities even as its staff lectures before various groups.[22]

4. Services and Facilities

In the context of the twelve agencies, this section covers services and information on contraception, STD, HIV and AIDS; referrals; HIV testing; drop-in centers; support groups; and resource centers.

4.1. Services and information

Services include pregnancy testing, pap smears, gram stains and wet mounts at FPOP and IMCH; regular outreach clinics of ISSA and FAD; family medicine and well baby clinics of PSPI, IMCH and FPOP's network of nine community health care centers (CHCCs) funded by UNFPA which can make referrals for extensive testing;[23] and the women-oriented clinics mounted by WomanHealth on special occasions like March 8, International Women's Day.

All the NGOs offer information on contraceptive and STD services in the spirit of informed choice as well as referrals when warranted.

Voluntary and confidential testing on HIV is given by ReachOut and Remedios in coordination with DOH and sponsors/donors. Counselling before and after the test is expected to be given, as is referral for confirmatory and hospital facilities.

TW-MAE-W clients go to San Lazaro Hospital for their regular STD tests and for HIV testing as necessary. The coordinator of this NGO, Sr. Mary Soledad Perpinan avers that its task is to take care of HIV-positive clients in a sympathetic way that dignifies the death of a person with his or her coping skills.

4.2 Support systems: *drop-in centers and support groups*

For commercial sex workers there are drop-in centers operated by Kabalikat and TW-MAE-W.

The latter is called "Belen" after the birthplace of the Christ Child in Bethlehem. Generally unmarked and sometimes with no telephones these houses are located in Manila, Quezon City, Batangas and Subic.

Kabalikat has a drop-in center in the redlight and tourist belt district of Manila. At the corner of Adriatico and Herran streets, it houses streetchildren, sex workers, drug abusers and other marginalized sectors.

When HIV positive cases become fullblown AIDS, sufferers can be confined at three government facilities: San Lazaro Hospital, RITM and the City Hospital of Manila.

For its part WT-MAE-W houses cases at its Bethany Transition Center in Marikina. It finds funds for their medical needs until it must call on San Lazaro Hospital as a last resort.

ReachOut supports AIDS patients at San Lazaro by visitations every Wednesday and starts off their families on income-generating opportunities ("buy and sell").

According to an interview with Dr. Joann Castro, head of counselling, ReachOut strives for normal functioning by the patient, his or her family and their support.

Thus ReachOut has marketed the greeting cards made by its clients or even purchased these as their supply. Dr. Castro advocates projects built on the medical condition of the patient, human rights, and gender ethics. In an interview its head, Mr. Jomar Fleras, made a strong appeal for respect for individual rights regardless of sexual preferences.

4.3 Resource Centers

A variety of assistance and facilities are available for the general public and for NGOs themselves.

ReachOut offers a Speakers Bureau and a resource library of AIDS publications, videotapes, posters and slides.

Resource centers vary in computerization levels but are part of the services of HAIN, ISSA, Kabalikat, ReachOut, Remedios, TW-MAE-W and WomanHealth.

Mini-libraries can be found at FPOP's provincial clinics, youth centers and community health care centers.

Remedios has regular viewing hours of videotapes where staff can facilitate post-viewing discussions.

ReachOut offers bookings of AIDS-related materials. Examples are **Divine Miss M.**, the first Filipino play about AIDS and a winnner of a Carlos Palanca Memorial Award for Playwriting; **Poisoned Blood**, the first video on the socio-economic political ramifications of AIDS in the Philippines; A+, the first Philippine-made AIDS education video for young adults; AIDS theater workshops for students; and over 100 AIDS posters and videos that can be exhibited.

5. Research and Development

Activities in this sector include focus group discussions, surveys, in-depth interviews, syntheses of studies and project documentation, monitoring and evaluation.

The researchers might be agency personnel themselves, professional bodies, university-based institutions or students.

The agency personnel and professional bodies conduct primary research as inputs to IEC activities, face-to-face counseling, training design and project activities.

The following agencies have reported research activities on their own: FAD, HAIN, ISSA, Kabalikat, PSPI and ReachOut.

NGOs conduct pre- and post-project surveys to get a basis for comparison of knowledge or behavior after doing a project. For instance HAIN gets benchmark data on the information known to medical science students to be able to document an upsurge in knowledge or a change in attitude towards AIDS-related issues.

Similarly, the Foundation for Adolescent Development conducts baseline surveys to get a basis for work, as has happened in its present sites: Quiapo, Binondo and Pandacan.

Kabalikat has also pretested a newly-commissioned play on AIDS for feedback on comprehensibility of contents, suitability of production aspects to locale (street vs. enclosed theater) and believability of characters. Evaluators were NGO officials, academicians, adolescents and clients of its drop-in center.

Agencies also undertake researches as inputs for informing and counseling clients. ISSA for instance held FGDs to know the knowledge levels and misconceptions held by urban poor women on reproductive tract infections. The rationale is for its field staff to know where and how to begin activities on STDs and AIDS.[24]

Similarly PSPI has used in-depth interviews with women commercial sex workers to surface the lack of time for outside activities. These led to modular sessions on AIDS that were spread out over weeks and held in the afternoons or early evenings in their **casas** or residence-nightclubs.

ReachOut is using in-depth interviews for its peer-led education project on AIDS among members of Greek-letter societies in a number of Metro Manila universities.

NGOs document their projects by means of monthly reports, as in the case of Remedios which records basic data of its telephone counselors, film showing-discussions and other IEC activities, resource center services, lectures, media appearances, and networking activities.

This form of documentation is also done by DKT through photos of its **Kondom Kapers** and monthly records of condom raffles/give-aways, lectures and participation in special events like International AIDS Day.

Aside from conducting research on their own, Kabalikat and DKT have commissioned professional organizations to conceptualize, implement and analyze surveys. The former asked Consumer Pulse to study the market for condoms while the latter asked AV Research Service for a similar study.[25] DKT has used FGDs to select the brand name Trust Condoms (as well as an undisclosed one for low-dose pills).

It is not only professional agencies which have been commissioned to conduct surveys on HIV/AIDS. Four university-based bodies have been asked by the WHO to study specific audience segments: the general population, overseas contract workers, hospitality girls and men who have sex with men.[26]

DKT International reports that its condom marketing program has been the subject of case studies by public relations students at the UP College of Mass Communications and of business marketing students of Silliman University and the Ateneo Graduate School of Business. This might become a trend as AIDS continues to hold the attention of the public through advocacy and lobbying efforts of both government offices.

6. Discussion

A study of NGO activities conducted for the situation analysis of AIDS in the Philippines offers these tentative conclusions:

1. The AIDS-related activities of the NGOs appear to concentrate their efforts on information and advocacy, networking and coordination, training and KAP surveys.

2. Less work is done in relation to counselling, laboratory-related services and facilities, and scientific research and development.

3. The type and extent of AIDS-related services offered depend on their skills levels to conduct other programs. Perhaps an audit could be undertaken of desired directions or perceived assistance needs as against existing capabilities. A needs-based training program for upgrading NGO management and staff may be in order.

4. Two NGOs offer hotline counselling within the same city and practically for the same duration per day. This duplication may work against resource maximization.

5. Persuasive communication for voluntary testing is done by face-to-face counseling where high-risk groups congregate after office hours (i.e., gay bars). There is also a need to systematize the mechanisms for catching vulnerable groups to maximize benefits.

1 − 4 International Funding/Assistance/Support

IV. INTERNATIONAL FUNDING/ASSISTANCE/SUPPORT FOR AIDS ACTIVITIES

1. Main Agencies Involved

The main players in the anti-AIDS program of the Philippines are the United States Agency for International Development (USAID), the Australian International Development Assistance Bureau (AIDAB) and the World Health Organization Global Programme on AIDS (WHO-GPA).

USAID will provide US$ 6.5 million from 1992 to 1997 which will have a counterpart contribution from the Philippine Government amounting to US$ 2.3 million in kind and cash outlay.

AIDAB is giving A$ 1,770,476 from 1993 to 1995. It is uncertain if this is being matched by the Philippine Government.

WHO-GPA will give US$ 439,000 from 1994 to 1995, 13% of which will be for NAPCP support.

1.1. USAID

From 1988 to 1990 USAID together with Family Health International donated more than PhP 10 million to the New Tropical Medicine Foundation of RITM as research grants on seropool, blood banking, STD and a health education/intervention project.[1]

USAID has a five-year project called AIDS Surveillance and Education Project (ASEP) that will monitor the prevalence and transmission of HIV infection and encourage behaviors which reduce HIV transmission.

ASEP provides for sentinel surveillance system that detects HIV infection among high-risk groups and documents its spread into the general population. The lead agency is the DOH's Field Epidemiology Training Program.

The education component will have media and face-to-face campaigns in Metro Manila and other urban areas. The lead agency is a Seattle-based NGO, the Program for Adaptation of Technology for Health (PATH).

There will be education/communication activities by a core group of NGOs for hard-to-access target groups in four sites. An NGO/communication adviser will help PATH work with the sub-grantees and train them on administrative procedures, initial development of proposals, monitoring and evaluation and other aspects.

A local expert will make available for four years skills in designing and implementing education and communication programs.

Expatriate consultants will stay for 12 person-months to give advice and counseling, outreach, public relations and research on the market, lifestyles of users and social marketing of condoms, for which "temporary bridge" money will be available.

There is a direct grant for regular research on the behavior of high-risk individuals. The $300,000 provided for the purpose will also cover research on innovative ideas for AIDS education using existing organizations like the union of health care workers.

Another $ 150, 000 will go to an environmental assessment study of ASEP. There is as yet no itemization for IEC, networking and coordination programs.

Direct grants and payments ($750,000) are earmarked for overseas training and invitational project inspection.

As for the national sentinel surveillance system WHO is the conduit for FETP which will receive commodities worth $470,000 for 30 sites. The New Tropical Medicine Foundation of RITM will get an undisclosed amount as direct grant for local costs associated with surveillance: travel for supervising laboratory and field work, additional staff for the HIV Quality Assurance Program, and gaining access to the individual to be tested.

1.2. AIDAB [2]

AIDAB has approved five projects on IEC and advocacy. One is a community health sector AIDS/STD education project for A$ 458,200.

Another is a peer education project for hospitality women and student leaders in Davao City for A$ 296,827.

The third allots A$ 223,182 for the Remedios Center from October 1992 to March this year.

The fourth gives A$ 68,881 to HAIN to expand education activities for medical and nursing students and to initiate an outreach program for those of dentistry, midwifery and medical technology.

The last strengthens community-based response to AIDS. The project is from May 1993 to April 1995 and is being implemented by Kabalikat and the Australian Federation of AIDS Organizations (AFAO).

AIDAB is funding the formation of a secretariat for Asia/Pacific of the International Council of AIDS Service Organizations (ICASO). For this Kabalikat and AFAO get A$ 253, 710.

As for training, AIDAB funds the peer-led AIDS education project of ReachOut for university fraternities and sororities in the Metro Manila area. It will give a total of A$44,644 for training workshops, a KAP survey to develop modules and a brochure, in-house workshops and others.

AIDAB is not funding any project for logistics, equipment, services, and facilities.

For research, AIDAB is funding the KAP survey of ReachOut's peer-led education project among members of Greek-letter societies. The project also has in-depth interviews and post-evaluation surveys.

1.3. WHO-GPA

WHO-GPA has assigned a technical officer, Mr. Geoff Manthey, to NAPCP.

Mr. Manthey's full-time assignment arises from the fact that WHO considers the Philippines as a priority country for strengthening program management skills, the focus of assistance to NAPCP.[3]

For IEC Mr. Manthey helped prepare the two issues of the NAPCP Newsletter for 1993. In terms of advocacy, he takes every opportunity to speak on behalf of the Program. During visits to the provinces he has conferred with local government executives and encouraged the formation of NGO coalitions like **Talikala** and **Alagad**. As a trained counselor by profession he has spoken at skills training workshops.

As an institution involved in networking, WHO facilitates regional-level consultations on AIDS and leads the task force of United Nations agencies working in the Philippines on AIDS-related issues. WHO has observer status at the PNAC.

In the area of training WHO arranges observation tours of successful AIDS programs in other countries. In terms of research it has facilitated the study of the experience of other countries in AIDS, STDs and blood banks so that the Philippines might develop prototype programs.

As for monitoring and evaluation, two of the three members of the external review team for NAPCP were WHO officers. It will be recalled that in 1987 WHO gave technical assistance in the formulation of the first National Medium-Term Program.

WHO will contribute US$ 439,000 to support the activities of NAPCP for 1994-1995.

2. Anecdotal Information On Other Sources Of Support

There are no readily available figures about certain funds mentioned by interviewees and documents used for this study.

In the course of the interview with Mr. Manthey, he referred to donations by the Swiss Embassy, the European Community, the Japanese Government, Levis Strauss and the American Foundation for AIDS Research.

According to a plaque at the entrance of the RITM Compound in Alabang, the complex was constructed with funds from the Japanese Government but the plaque specifies no figures.

Mr. Rustom Dipareine of PSPI mentioned the European Community which funds Marie Stopes International which in turn supports PSPI. With a grant from Levis Strauss this NGO staged its street play **Kaalamang 343.**

Another multinational corporation funding AIDS-related activities is the pharmaceutical firm Wellcome. It supports the Asia-Pacific Council of AIDS Service Organizations (APCASO) and is mentioned by the sticker and poster of the telephone counseling service of ReachOut as a funding agency.

As to United Nations agencies, UNICEF sponsored a workshop on Youth, **Health and Development - Promotion for HIV/AIDS Prevention and Care** on July 6-8, 1993. This was reported in the **NAPCP News** of May-June 1993 without any data on funding.

UNFPA supports the nine community health care centers of FPOP located in Muntinglupa, Pasig, Tandang Sora, Cabanatuan, Tabaco, Tanauan, San Carlos, Butuan and General Santos.

The executing agency for the FPOP clinics is the Margaret Sanger Center which also supports the STD/AIDS-related services of IMCH clinics.

A third UN agency, WHO-Western Pacific Regional Office, is acknowledged by Dr. O. T. Monzon and Ms. F. J. E. Paladin of RITM in their study on particle agglutination. They thank Fujirebio Inc., Tokyo for the test kits and Dr. I. Kinamura of Tottori University, Tokyo for the advice and the "generous" supply for slides.

Data are available on the funding of two RITM studies: AIDS education for health care workers (University of California, San Francisco; PhP 284,698.78) and co-factors in HIV infection (Japan Foundation for AIDS Prevention, PhP 406,000).

Another United States government agency, NAMRU-2 or the Naval Medical Research Unit - 2 based at San Lazaro Hospital funds researches, medical expenses and certain equipment needs of the Anti-AIDS program but exact figures are not available.

After two years of testing for HIV (1985-1987) the agency decided to undertake follow-up studies of prostitutes in Angeles and Olongapo where 85% of the HIV cases were recorded. NAMRU provided the medicines for the 34 women who were positive for the HIV antibody as part of a case control study.[4]

As for equipment, NAMRU-2 has made available to San Lazaro Hospital AIDS Pavilion patients the latest and most sophisticated machines to document clinical manifestations of the infection.

3. Funds Disbursement

At a workshop on the economic implications of HIV infection in developing countries, Ester Romano, member of the RITM Study Group on AIDS and head of administrative services of RITM, reported that as of September 1993 only 41% of the budget needed to implement NAPCP activities for that year had been mobilized and that the major sources of the US$3.35 million mobilized were USAID (60%), the Philippine Government (18%), AIDAB (12%), and WHO (10%).[5]

A budget summary appended to the country report shows differing figures for total budget (US$ 13,644,475 in this case) and available funds (US$ 2,491,845 or 18% of this budget).[6]

Efforts to reconcile the difference have been friutless but it is instructive to study figures on allotments and actual disbursements per program component.

Per the total budget needed to implement NAPCP activities for 1993 (US$ 8.35 million as reported in Romano's text), laboratory services should get 54% of the amount needed. But only 4% of its activities had been funded as of September that year.

In contrast, IEC activities which were alloted 17% of the budget needed to implement NAPCP activities had by then 72%.

Program management and surveillance were supposed to get 2% each but 11% of the total budget of US$ 13 million had gone to the first component and 19% to surveillance.

An appended table shows the distribution of US$ 13 million by funding source: AIDAB (36% of total funded), USAID and the Philippine Government (24% each), WHO (13%) and PHC (2% no data available about this particular organization).[7]

4. Discussion

In absolute figures the international donor agencies of the anti-AIDS program in the Philippines seem to be funding more IEC/advocacy programs than any other activity.

Projects in training, research and coordination appear to be more numerous than those for surveillance, logistics and services.

Beyond a count of programs and going by components, funding is also lopsided in favor of IEC (72% of total funds given out), followed by program management (11%).

The substantial allotments for the two put to question the quality of services for surveillance, laboratory and clinical management.

What does this funding situation also imply for both scientific services and hospital care? Can the anti-AIDS program function well with the apparent priority given to medicines, laboratory work-up and sentinel groups surveillance?

Things may improve with the implementation of the ASEP project in the latter half of 1993 but surveillance is one of the many aspects of the program against AIDS and only four cities are covered by its education component. In the light of competing priorities, it is doubtful if the Philippine Government can compensate for this by adding more funds.

1 − 5 Evaluation of the National AIDS Prevention and Control Program (NAPCP)

V. EVALUATION OF THE NAPCP PROGRAM

There are two documents available for this situation analysis which provides useful insights on the progress of the National AIDS Prevention and Control Program (NAPCP) in the Philippines. The first document is the AIDS Surveillance and Evaluation Project (ASEP) of the USAID which contains a needs assessment portion that served as the basis for USAID project assistance to the NAPCP. The other and more recent document is the Program Review conducted by an external team from the Development Academy of the Philippines (DAP) and the World Health Organization (WHO).

A. PROGRAM REVIEW

The NAPCP has been operating for five years and has conducted reporting, monitoring and evaluation under the component of program management.

From June 16-July 16, 1993 an external review of the program was conducted by a team led by Ms. Carmencita Abella, president of the Development Academy of the Philippines, with Dr. Peter Exon of the WHO Headquarters and Mr. Richard Preston of WHO Western Pacific Regional Office as members.[1]

The purpose of the review was two-fold: to determine the progress of the NAPCP vis-a-vis its goals, targets and strategies from 1988 to 1993 and to generate insights and recommendations for the next NAPCP plan for 1993-1998.

The team went to the regional centers to gauge activity impact both in Metro Manila and the provinces and interviewed 88 officials of DOH and other government agencies, non-government organizations, and local government units in Regions III, VI, VII and XI.

The consultants had technical support from the DOH Technical Working Group and general guidance from the Advisory Committee.

The methodologies included individual and group interviews, review of documents, actual field observations in NAPCP pilot and non-pilot areas, and when possible focus group discussions involving program targets/beneficiaries.

Before the team did the final analysis and synthesis of recommendations, it held a validation workshop for DOH agencies which implement the NAPCP and are in a good position to comment on the findings of the external review.

After two months the team released its final report as an input to the NAPCP **Medium-Term Plan (1993-1998).**[2]