public health programs will not be able to adequately design and direct appropriate intervention measures to specific target populations to change or modify their documented risky behaviors.

Estimation of HIV/AIDS in the Philippines

The available epidemiological surveillance data in the Philippines, as of late 1993, are very limited for providing an accurate estimate of the past incidence and current prevalence of HIV infections and AIDS cases. In the Philippines, HIV seroprevalence data have been collected on a variety of different population groups, most of whom are not considered to be at high risk for acquiring an HIV infection. The prevalence of HIV infection in most of these groups such as overseas contract workers and blood donors is well below 0.1% (i.e., well less than one infection per 1000 persons in that group). The few studies/surveys in high risk groups such as female commercial sex workers (CSWs) have indicated that the current prevalence of HIV in this group is also less than 0.1%. However, a recent survey in metro Manila of about 1500 female CSWs yielded a seroprevalence rate of close to 0.5% (about 1/200) indicating that HIV prevalence may be rising rapidly in this risk group.

These limited data suggests that the prevalence of HIV infection in the Philippines is still relatively low and overall, is less than 0.1% among all adults in the most sexually active age group. Since there are about 25 million Filipinos in the 20-49 year age group, this places an upper bound of about 25,000 on the number of HIV infections that may be present in the Philippines, if we assume that the prevalence can be no more than 0.1% or 1/1000. What

might the lowest number of HIV infections in the Philippines be? We can try to estimate the lower bound of HIV infections by back calculating the annual number of HIV infections that would be required to yield the number of AIDS cases that have been reported in the Philippines. This would have to be the absolute minimum number of HIV infections since it is acknowledged that the reported number of AIDS cases in the Philippines, as in most developing countries, is very delayed and very incomplete.

EPIMODEL, is a microcomputer program that utilizes epidemiologically derived estimates of an HIV epidemic curve along with annual progression rates from HIV infection to AIDS and subsequent death to calculate past, current and short-term (3-5 years) annual projections of AIDS cases and deaths. EPIMODEL was originally designed to provide estimates and short-term projection of AIDS cases in countries where AIDS case reporting is considered unreliable. EPIMODEL can also be used to back calculate the number of HIV infections needed to generate reported AIDS cases as well as estimated AIDS cases (i.e., after adjusting the number of reported AIDS cases for delayed reporting and incomplete reporting).

Such calculations using EPIMODEL indicates that a minimum number of about 6,000 HIV infections would be needed to yield a total of about 140 AIDS cases through 1993, if epidemic spread of HIV infections started in the Philippines after the mid-1980s. Conservatively, it can be estimated that the actual number of AIDS cases in the Philippines is at least 3 to 4 times the number of reported cases which, as of October, 1993, was 111. The number of HIV infections needed to generate about 400 AIDS cases through 1993 is from 15

to 20 thousand. All of these estimates using EPIMODEL assumes that the average progression rate from HIV infection to AIDS is about 10 years. If the progression rates in the Philippines is more rapid, then fewer HIV infections are needed to generate the estimated number of AIDS cases and if the progression rates are slower (i.e., a median rate of 12 years or more rather than 10), then larger numbers of HIV infections would be needed.

Projection of HIV/AIDS in the Philippines to the year 2000 and Beyond

There are no known reliable methods for projecting future HIV incidence, and thus, future HIV prevalence. Many methods and models have been developed in the past decade to project the future course of the HIV/AIDS pandemic, but none of them can be validated except with time. In addition, accurate projections of future HIV prevalence depends to a large extent on how accurate estimates of past HIV incidence and current HIV prevalence may be.

Projections of AIDS cases to the year 2000 can be made by EPIMODEL by assuming that annual HIV infections beyond 1993 will continue along the theoretical HIV epidemic curve selected for use in EPIMODEL. It needs to be emphasized that longer-term projections of AIDS cases using EPIMODEL (or any other method or model) are less reliable than short-term projections because of the increased uncertainty of projecting future HIV infections.

The following HIV/AIDS scenario represents a conservative working scenario for the Philippines based on the available data and epidemiologic observations and assumptions:

1. Extensive spread (i.e., more than a few hundred HIV infections per year) did not start in the Philippines until the late 1980s.
2. The prevalence of HIV infections in the Philippines was from 15,000-20,000 by the end of 1993.
3. The annual incidence of HIV infections in the Philippines will not peak until the late 1990s.

Using these assumptions in EPIMODEL the annual and cumulative numbers of adult HIV infections, AIDS cases and deaths can be conservatively estimated and projected. A cumulative total of AIDS cases by the end of 1993 is estimated to be about 400 based on the estimate that in 1993 there were 17,500 HIV-infected adults. By the year 2000, the cumulative number of HIV infections will be over 90,000, and the cumulative number of AIDS cases will be over 15,000. On an annual basis, the number of AIDS cases will be steadily increasing from a few hundred a year during the early 1990s to a few thousand a year by the late 1990s. During the year 2000, over 4,000 AIDS cases are projected. If the spread of HIV in the Philippines were to be totally stopped after 1993 (the best case scenario), a cumulative total of close to 8,000 AIDS cases can still be expected by the year 2000, and the annual number of AIDS cases will still be over 1,000 a year during most of the remainder of this decade. If the conservative HIV/AIDS scenario is continued through the first decade of the next century, the full impact of the projected number of HIV infections that are expected to occur during the 1990s will become evident. Close to 70,000

AIDS cases and deaths due to AIDS can be projected for the Philippines during the first decade of the 21st century compared to about 15,000 during the last decade of the 20th century. Details of these estimates and projections are presented in the accompanying tables and figures. It needs to be emphasized that these are conservative estimates based on the current status and development of HIV/AIDS prevention and control programs in the Philippines. It also needs to be pointed out that, even with the most aggressive and effective HIV/AIDS prevention and control programs, a significant proportion (half or more) of HIV infections can still be expected to occur because it is not realistic to expect that risky sexual behaviors can be totally eliminated in any large human population.

However, reducing the projected HIV/AIDS toll by about half will mean the saving of over a hundred thousand potential future HIV infections and thus over a hundred thousand premature deaths among young and middle-age adults during the next few decades. Aside from the savings of these adults in their most productive years, the health care system alone, in the Philippines, can avoid the expenditure of many billions of pesos which would be needed to care for those AIDS cases which were not prevented by public health prevention and control programs. The window of opportunity for minimizing the HIV/AIDS epidemic in the Philippines is closing fast. If the costs of aggressive and comprehensive HIV/AIDS prevention and control programs are not supported by the Philippines government now, a much greater cost to respond to the health care and other sector impacts of preventable AIDS cases and deaths is a certainty over the next few decades.

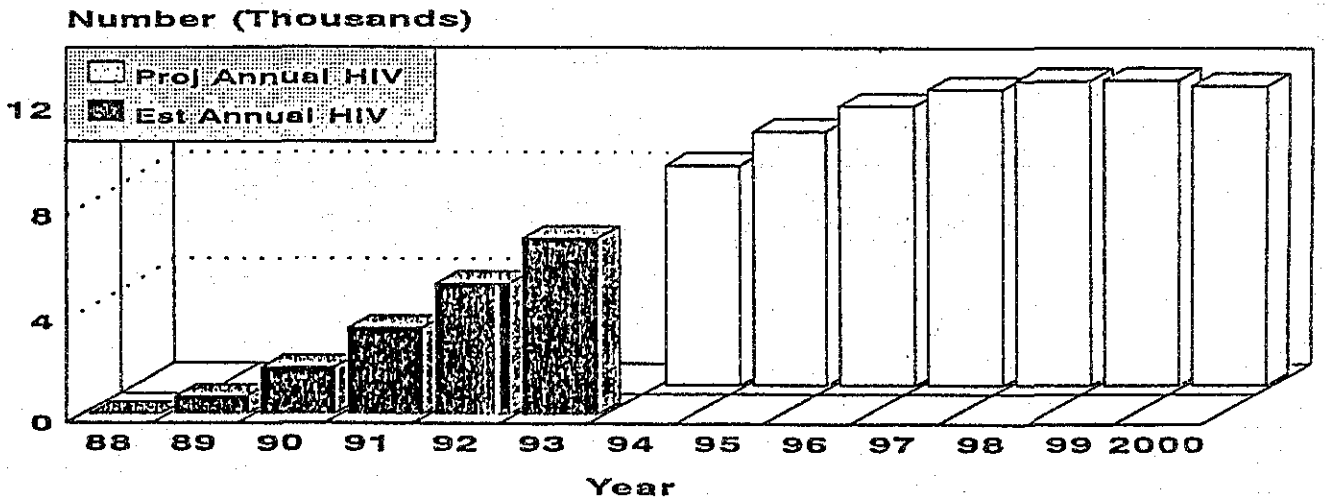
Conservative HIV/AIDS Scenario - Philippines

Year	HIV New	HIV Inc	HIV Cum	HIV Curr	HIV Prev	AIDS New	AIDS Cum	DEATH Cum
1987	0	0.00%	0	0	0.00%	0	0	0
1988	16	0.00%	16	16	0.00%	0	0	0
1989	710	0.00%	726	726	0.00%	0	0	0
1990	1851	0.01%	2577	2573	0.01%	4	4	2
1991	3389	0.01%	5966	5934	0.02%	28	32	18
1992	5113	0.02%	11079	10940	0.04%	107	139	85
1993	6825	0.03%	17904	17500	0.07%	265	404	271
1994	8372	0.03%	26276	25345	0.10%	527	931	667
1995	9654	0.04%	35930	34096	0.13%	903	1834	1383
1996	10619	0.04%	46549	43324	0.16%	1391	3225	2530
1997	11253	0.04%	57802	52595	0.19%	1982	5207	4216
1998	11570	0.04%	69372	61509	0.22%	2656	7863	6535
1999	11604	0.04%	80976	69740	0.24%	3373	11236	9550
2000	11397	0.04%	92373	77039	0.26%	4097	15334	13285

Best Case HIV/AIDS Scenario - Philippines

Year	HIV New	HIV Inc	HIV Cum	HIV Curr	HIV Prev	AIDS New	AIDS Cum	DEATH Cum
1987	0	0.00%	0	0	0.00%	0	0	0
1988	16	0.00%	16	16	0.00%	0	0	0
1989	710	0.00%	726	726	0.00%	0	0	0
1990	1851	0.01%	2577	2573	0.01%	4	4	2
1991	3389	0.01%	5966	5934	0.02%	28	32	18
1992	5113	0.02%	11079	10940	0.04%	107	139	85
1993	6825	0.03%	17904	17500	0.07%	265	404	271
1994	0	0.00%	17904	16973	0.07%	527	931	667
1995	0	0.00%	17904	16112	0.06%	861	1792	1362
1996	0	0.00%	17904	14978	0.06%	1134	2926	2359
1997	0	0.00%	17904	13793	0.05%	1185	4111	3519
1998	0	0.00%	17904	12540	0.04%	1253	5364	4737
1999	0	0.00%	17904	11309	0.04%	1232	6595	5980
2000	0	0.00%	17904	10133	0.03%	1176	7771	7183

ESTIMATED AND PROJECTED HIV INFECTIONS



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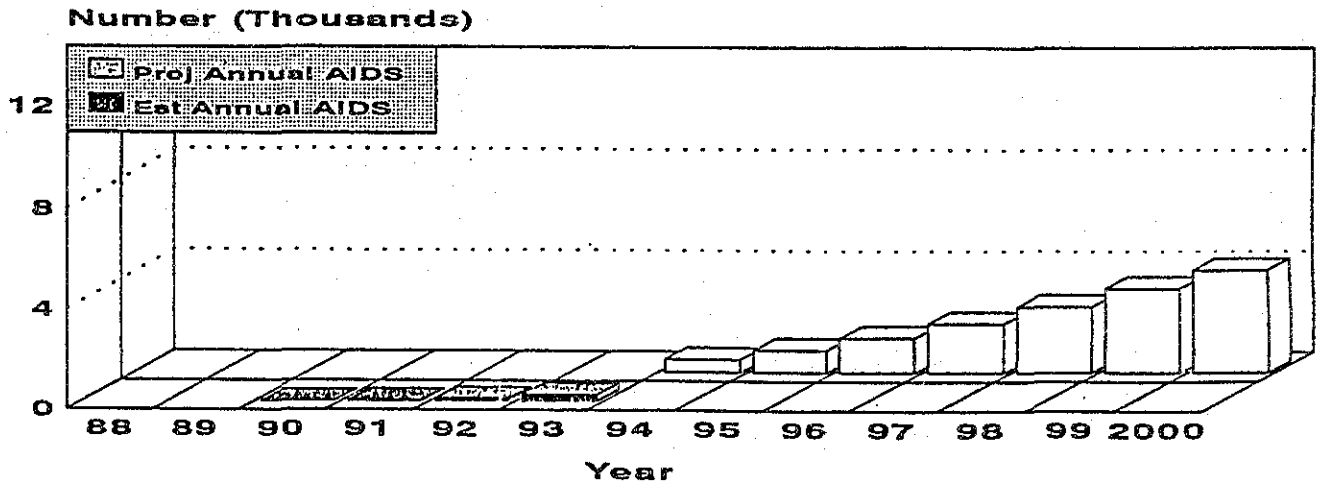
ESTIMATED AND PROJECTED AIDS CASES



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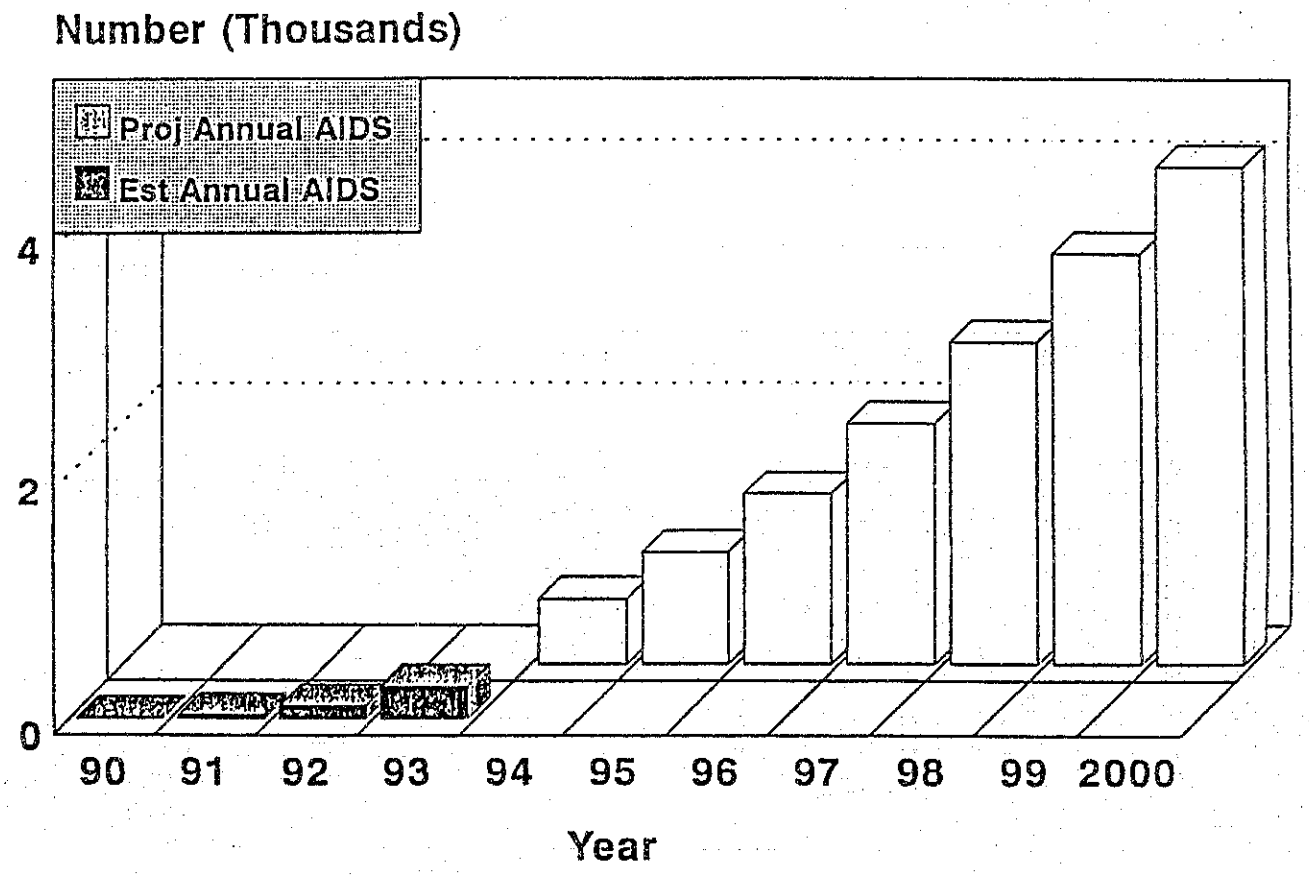

PHPROAIDS/12/93

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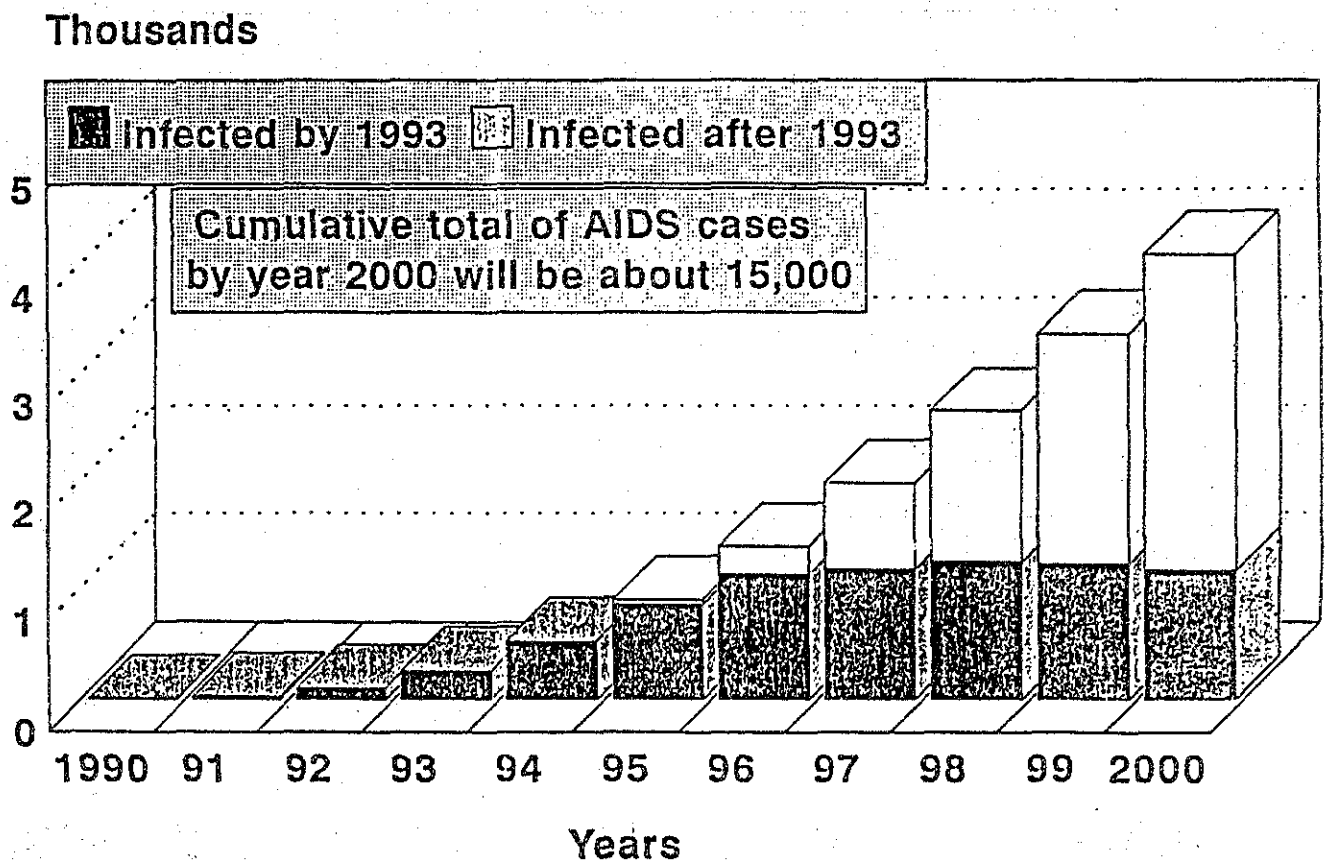
PROJECTED ANNUAL AIDS CASES - PHILIPPINES



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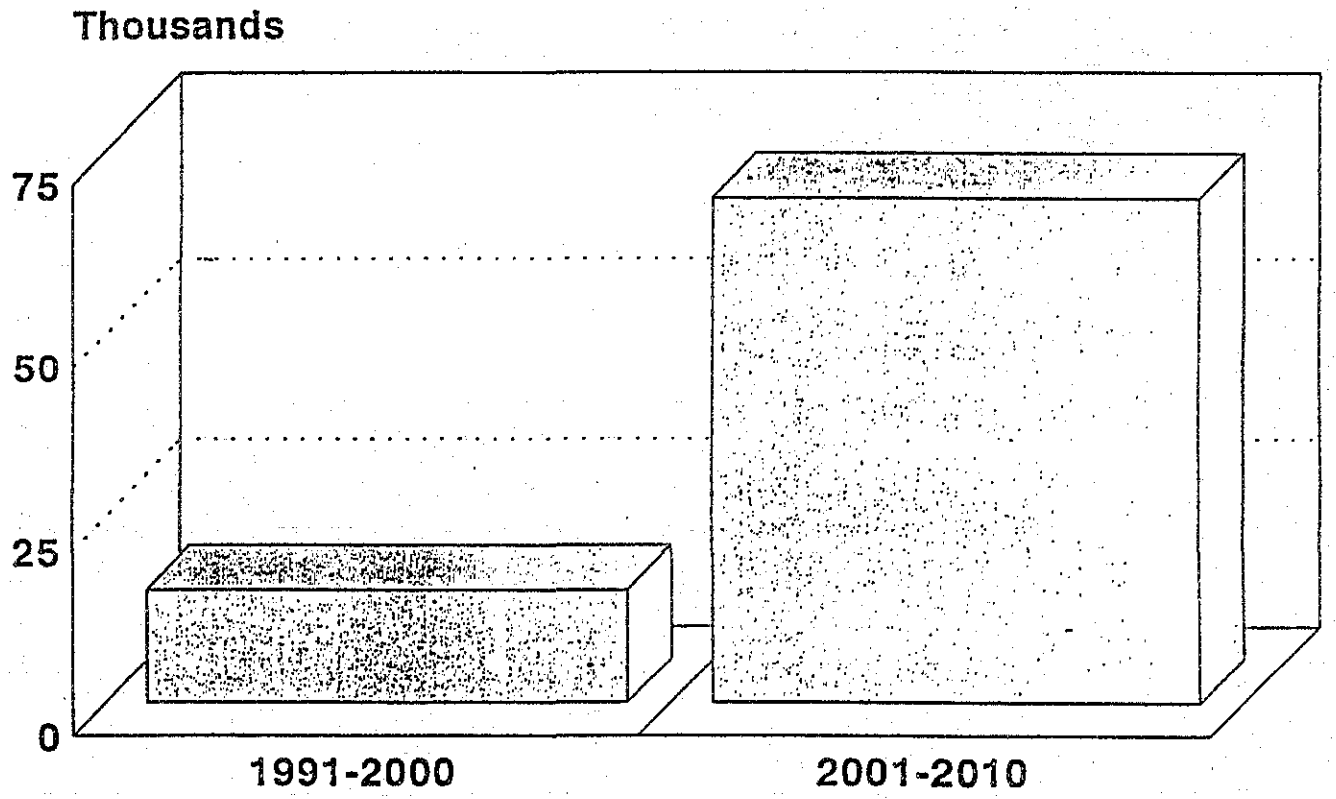
ESTIMATION AND PROJECTION OF ADULT AIDS CASES USING A CONSERVATIVE SCENARIO - PHILIPPINES



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JTC

CONCLUSIONS AND RECOMMENDATIONS REGARDING THE HIV/AIDS EPIDEMIC IN THE PHILIPPINES

- The prevalence of HIV infection is still low, and as a result, the numbers of AIDS cases and deaths will be relatively low during the remainder of the decade.
- A window of opportunity still remains for public health programs to reduce the average number of sexual contacts outside of mutually monogamous relationships, and/or to significantly increase condom usage for these encounters.
- A high priority has to be given to developing baseline data on sexual and injecting drug use behaviors so that these indicators can be used to evaluate the effectiveness of public health programs designed to reduce these behaviors.
- Reliable estimates and projections of the HIV/AIDS epidemic are needed for the planning of health and social services to care for the large projected increase of AIDS cases.

MANC/11/93

JPC

AIDSCAP AIDS Control and Prevention Project

Family Health International

January 18, 1994

Dr. Manuel Dayrit
Assistant Secretary
FETP Program Manager
Department of Health
San Lazaro, Sta. Cruz
Manila
PHILIPPINES

Dear Dr. Dayrit:

I am pleased to forward to you Dr. Chin's comments and recommendations concerning HIV/AIDS control and prevention in the Philippines.

I am sorry I missed the opportunity to spend some time with you during the AIDSCAP workshop in December. Drs. Rau and Sweat have forwarded to this office some comments on the "action plan" you and Dr. Maducdoc developed during the epidemiology/policy workshop, which I will send to you soon.

I would also like to take this opportunity to inform you that we will soon be hiring a Resident Advisor in the Philippines to help manage the STD and behavioral studies AIDSCAP is supporting there. The candidate selected for the position is a Dr. Teodora Wi, who has been working at the Baguio City Social Hygiene Clinic. Our headquarters personnel department in Virginia should be contacting Dr. Wi soon to finalize the contracting arrangements.

I understand that the STD/AIDS Unit at the DOH will provide office space for Dr. Wi, so you and others will be able to work more easily with her. AIDSCAP looks forward to a fruitful collaboration with the DOH on the crucial issues for STD control in the Philippines that Dr. Wi will help investigate.

Please feel free to contact me with any comments or questions you may have on the enclosed material.

Sincerely,

Neil R. Brenden, DSW, MPH
Director
Asia Regional Office

DIV	ACT	INF
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2-14-94		

cc: Patricia Moser, USAID/Manila
Bill Rau, AIDSCAP Policy Unit
Doris Mugrditchian, ARO STD Officer

ACTION TAKEN	
NAN _____	Other _____
Type _____	No. _____
Dated _____	Initials _____

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December 20, 1993

Dr. Manuel Dayrit
Assistant Secretary
FETP Program Manager
Department of Health
San Lazaro, Sta. Cruz
Manila, PHILIPPINES

Dear Dr. Dayrit:

The following are my comments regarding prevention and control of HIV/AIDS in the Philippines and an outline of my major recommendations.

As of late 1993, with the exception of countries such as Thailand, Myanmar (Burma), and some areas in India, large numbers (more than 100,000) of HIV infections have not yet occurred in other Asian and Pacific countries. Does this mean that countries such as the Philippines will not have a major epidemic of HIV/AIDS?

This question cannot be answered with any certainty until more accurate and detailed information is available about the general levels of other sexually-transmitted-diseases (STDs) and baseline data are collected on sexual behaviors in the Philippines. If it can be documented that other STDs and high HIV-risk behaviors in the Philippines are indeed low, then epidemic spread of HIV in the Philippines will be unlikely. However, it is visually apparent that commercial sex is present in Manila and it is believed that this industry is large and thriving in most regions of the Philippines.

The current range of estimates of the number of HIV infections in the Philippines is still relatively low - from a low of 10 to 15 thousand to a high of 30 to 40 thousand. Until additional surveillance data on HIV infections are available to indicate otherwise, a conservative working estimate of 15 to 20 thousand may be used for public health planning. It is my understanding that the most recent "official" estimate of the number of HIV infections in the Philippines was proclaimed to be 50,000. This number is clearly more impressive to the public and policy makers than 15,000-20,000, but the limited data available on HIV infections and AIDS cases in the Philippines simply will not support the impressively high advocacy number of 50,000. At some point in the near future, you will need to address

this potential wide gap between an estimate based on the available data and an estimate made primarily for advocacy. The future credibility of official estimates could be seriously jeopardized if such a wide difference in these estimates continue.

The policy question which must be answered in the Philippines soon is - how many HIV infections and AIDS cases (estimates supported by data) will be needed before a very aggressive and comprehensive public health program to modify those sexual behaviors which lead to an increased risk of HIV transmission is started? It has taken several hundred thousand HIV infections in some Southeast Asian countries before they considered HIV/AIDS to be an actual serious public health threat. Given this overall situation, the following are my major recommendations regarding prevention and control of HIV/AIDS in the Philippines.

1. Give top priority and support (both staffing and funding) to study sexual behavior and other STDs in the Philippines. It is essential that detailed knowledge of the sexual patterns and practices among the most sexually active age group (15-49) be obtained as soon as possible. Without reliable baseline data on the prevalence and distribution of risky sexual behavior, how can it ever be determined if current and future public health programs are changing these behaviors? This is the single most important part of any HIV/AIDS prevention program because the only ways that HIV infection can be prevented are either by reducing the average number of different sexual partners in any given target population and/or by increasing average condom use in non monogamous sexual relationships.

2. Appoint a National AIDS Task Force composed of prominent leaders from government, religious, business, and social sectors to develop national policies related to such sensitive issues as sexuality, prostitution, and injecting drug use. Such policies need to address how HIV infections can be effectively prevented in the Philippines rather than debating what public health measures may be "right" or "wrong" from a moralistic perspective.

3. Reorganize and increase current HIV/AIDS staff in the Ministry of Health to create a Bureau of STD/HIV/AIDS to begin an aggressive and comprehensive program for the prevention and control of STDs, including HIV/AIDS.

4. Separate, to the extent possible, the HIV/AIDS treatment budget from the HIV/AIDS prevention and control budget so that future increases in the cost of care for AIDS patients will not erode the prevention and control budget.

5. Provide more public support for non-government organizations (NGOs) which can work more effectively with "groups," such as commercial sex workers, homosexual men, and injecting drug users, which government agencies in general have difficulty in reaching.

6. Organize a national technical working group from both government units and academic institutions to periodically (at least annually) evaluate the current distribution and general prevalence of HIV infections and AIDS cases and to develop working scenarios to assist in the short-term (3-5 years) planning and evaluation of prevention programs and treatment programs for HIV/AIDS in the Philippines. This latter working group could be a sub-committee of the current National AIDS Committee. Nationally developed and accepted estimates and projections of HIV/AIDS in the Philippines which can be supported by the available data are needed to firmly guide future program and policy decisions.

7. At the present time, systematic HIV sentinel surveillance should be focused primarily among STD patients in metro Manila and surrounding urban areas. The estimated prevalence of HIV, even among STD patients in Manila, is believed to be still less than 1%. Until HIV prevalence can be shown to be consistently higher than 1% among this high risk group in Manila, it would be wasteful to spend resources looking for HIV infections in sentinel groups outside of Manila. In these other areas, public health staff should begin to develop systematic studies to measure sexual partner rates and condom usage rates in different target populations.

If the above recommendations are not implemented now, most of them will likely be implemented at a future time when larger numbers of HIV infections and AIDS cases become evident. I fully appreciate that it is difficult to convince most policy makers, such as your Legislature of the potential seriousness of the AIDS threat to the Philippines until they begin to see large numbers of AIDS cases and deaths. However, you will agree that to take aggressive action at some future date will be too late to prevent or to at least significantly reduce the number of new HIV infections which will surely be occurring in the Philippines during the remainder of this decade. The Philippines still has a great window of opportunity to prevent extensive spread of HIV infections in its population, but that window is closing fast as the sexual behaviors which contribute to high levels of STDs and as commercial sex continues with relatively low condom usage rates.

Please let me know if you have any questions or comments regarding my recommendations and if I can be of further assistance to any of your public health disease control programs. A more detailed report on HIV/AIDS surveillance and estimation and projection of HIV/AIDS in the Philippines is attached.

Cordially,

James Chin

James Chin, MD, MPH
Clinical Professor of Epidemiology

THE NGO NETWORK STAND ON THE AIDS PROBLEM IN THE PHILIPPINES

MISSION STATEMENT

The Network promotes the growth and strengthening of non-government organizations' response to the challenge of HIV/AIDS, with particular emphasis on active solidarity through coordination, collaboration and cooperation.

GUIDING PRINCIPLES

The Network brings together all those groups which respond to the urgency of controlling the spread and reducing the impact of HIV/AIDS. The Network believes that the participation of non-government organizations and communities affected by the epidemic is essential to ensure the provision of support and necessary services. The Network believes strongly that a recognition of the human rights of all persons is likewise central to an intelligent public health strategy to combat the epidemic.

In view of this, the Network is committed to:

(1) The critical role of non-government organizations within national programs, including policy formation, implementation and evaluation of programs and policies.

(2) The right of each non-government organization to determine its own priorities, methods of organization, programs and support for any national and international policies, and to have these choices respected by government and international agencies.

(3) The maximum involvement of women and men living with HIV/AIDS in all aspects if prevention, care, support, treatment, research, program and policy formation and evaluation.

(4) Recognition that there are diverse social and cultural perspectives on HIV/AIDS and approaches to care, prevention and treatment, but these should not override fundamental human rights to respect for individual dignity and protection against political, social and religious intolerance.

NGOs and Community Issues

Michael L Tan

Paper Prepared for a Symposium, "AIDS in the Year 2000: How Worse Off Will We Be?"
Organized by the Department of Health, 12 November 1993, Manila Pavilion

INTRODUCTION

Non-governmental organizations (NGOs) have always played an important role in the health sector in the Philippines. Where, in the past, health work by NGOs has been mainly charity care, the AIDS NGOs have been active in information and education, and in advocacy. The latter has been especially important since NGOs can say certain things GOs may not be able to.

In this paper I will briefly review some of the major issues that the NGOs now face. The first two issues will be general questions about linkages and networking while the last five issues will focus on approaches in NGO and community work.

GO-NGO LINKAGES

The Department of Health has been open about working with NGOs on AIDS projects (and most other units under the Office of Special Concerns). In addition, there are five NGOs in the Philippine National AIDS Council (PNAC) that was set up by a presidential executive order this year. The PNAC is an advisory body with representatives from 12 government departments and the five NGOs.

Generally, GO-NGO relationships have been strong at the national level but weaker at the local government level. In the light of devolution, such linkages will have to be strengthened.

Most NGOs depend on funds channelled through the DOH. This relationship has its advantages and disadvantages. While it keeps the NGOs free from commercial considerations (which would be different once funds are accepted from private corporations), it also puts NGOs in a position where it may have to follow a specific government line. Independence needs to be guaranteed to allow the NGOs to continue its role as educators and advocates.

NGO-NGO LINKAGES

An HIV/AIDS NGO Network Philippines was formally established in February 1993. Its secretariat is presently located at the Remedios AIDS Information Center. There are about 30 member organizations, of which a third have HIV prevention programs while the rest have an interest in setting up programs.

Initiatives for similar networks have been initiated in other regions. In Mindanao, one network called ALAGAD has already been formalized:

In Metro Manila, the NGOs have been conscious about keeping the network loose, without any single organization dominating. This is important given the tendency toward factionalism among NGOs.

Kabalikat has been active in initiating regional (Asia-Pacific) linkages among community-based NGOs.

COMMUNITY-BASED APPROACHES

The nature of the HIV epidemic has forced NGOs to adopt highly focused community-based approaches. Here, the definitions of "community" have gone beyond the geographical, as in the case of initiatives within the gay community,

The NGOs emphasize the participation of communities in all phases of work, and not just as passive recipients of "interventions." The NGO interventions have largely been through workshops with the use of more effective interpersonal approaches. A community base is essential for such workshops.

In relation to the focus of today's meeting, I wanted to mention that even surveillance data has been identified as important inputs for community-based planning. During the organizational meeting for the HIV/AIDS network last February, we reviewed figures the Health Department to assess how we could be more responsive. As an example, we noted the growing number of AIDS cases, and discussed the possibilities of involvement in social support for people with AIDS.

INTEGRATED BIOMEDICAL AND PSYCHOSOCIAL APPROACHES

It has become clear that the Department of Health's involvement in HIV/AIDS work has been mainly in the biomedical field, such as in surveillance. The biomedical focus is apparent even in the government's information campaigns, which focus on issues such as transmission.

On a parallel track, the NGOs have developed its competencies in the psychosocial dimensions of HIV prevention. Most of the NGOs do not limit themselves to "AIDS 101" lectures (i.e., lectures on biomedical issues). Instead, the NGOs have tackled issues of unequal gender relations, and its implications for HIV prevention. The programs therefore go beyond information and into education, with discussions of issues such as unequal relationships between the sexes; discrimination against sex workers; and the relationship of macro-economic issues and HIV. There is much that NGOs can share with GO in this area.

Ideally, both GO and NGO programs would have to expand and integrate the biomedical and psychosocial components of HIV prevention. For example, the biomedical component would have to be expanded to include other issues that relate to HIV prevention, for example, the issue of sexually-transmitted diseases other than HIV. With

prevention programs cannot be limited to information and education activities. A package of health and social support services would have to be offered for such programs to be more effective.

MULTISECTORAL APPROACHES

The NGOs involved in HIV prevention come from different sectors, such as women; gay men; students; labor; the churches. This multisectoral composition is important in responding to the different needs in HIV prevention, as well as in the mobilization of resources.

I would like to note that one weak sector in the Philippines has been the academe. The resources in academe have not been adequately tapped. Perhaps a problem here is that among the academic institutions, it has been mainly the University of the Philippines that is doing HIV work. Since it is a state university, UP would technically be unable to join the NGO network but at the same time, its linkages to government, particularly the Health Department, remains vague.

EXPANSION OF GEOGRAPHICAL COVERAGE

Preliminary figures from the Department of Health's 1992 National Health Survey showed that among 25,000 surveyed households, about 15 percent had never even heard about AIDS. In rural reas, the figure was 23 percent.

Among those who had heard about AIDS, there were still widespread misconceptions. To give two examples, about 70 percent still believe that the disease can be transmitted through kissing while 45 percent believe it can be transmitted through sharing of clothes.

The figures suggest that despite the large amounts of money spent for mass media campaigns both by the Department of Health and NGOs, information and education activities still need to be expanded. The NGOs have in fact concentrated in Metro Manila, and within Metro Manila itself, there has been a tendency to focus on cities like Manila and Quezon City.

Several NGOs -- notably Kabalikat, Council for Health and Development, and Health Action Information Network -- have expanded its services to areas outside Metro Manila. In these areas, community-based groups can be effectively tapped for HIV prevention programs. In all expansion efforts, we have been conscious about linking both with NGOs and GOs.

ETHICAL AND PROFESSIONAL CONCERNS

The NGOs are conscious about ethical and professional issues. The Network has adopted common working principles that include particularly strong statements against AIDS profiteering in all forms.

Given the limited resources available for HIV, some of the

different types of interventions. More sophisticated evaluation and tracking mechanisms are being developed, going beyond the standard (and probably useless) post-workshop evaluation forms. Longer-term tracking for changes in knowledge and behavior are being used by some NGOs.

Staff development has been introduced to ensure professionalism in the delivery of HIV prevention services. The Remedios AIDS Information Center and Health Action Information Network have been building up a reference databank. This would include standardized biomedical information. Since many NGOs now talk about peer education, we have to be conscious of the need for quality assurance in the training of the peer educators, or run the risk of these peer educators further propagating misconceptions.

The databank could include social and behavioral studies that have been conducted, together with critical annotations on implications of the different studies' findings. Many programs are implemented without a review of previous studies, which may mean a duplication of activities and worse, the mistakes.

These concerns are considered to be ethical in nature since with HIV, we are aware that the level of "tolerable" inaccuracy is minimal.

STD STRATEGIC PLAN FOR THE PHILIPPINES

AIDSCAP PROJECT

OCTOBER 9, 1993

DESIGN VISIT

July 25 - August 2, 1993

Prepared by :

Dr. Doris S. Mugrditchian, AIDSCAP STD Officer

In consultation with :

Dr. Rosendo Capul, Public Health Advisor, USAID/Manila
Dr. Carmina Aquino, Development Assistance Specialist, USAID/Manila

and

The STD/AIDS Unit, Office of Special Concerns, Department of Health

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STD STRATEGIC PLAN FOR THE PHILIPPINES

1. INTRODUCTION

USAID/Manila has been supporting STD/AIDS prevention efforts in the Philippines since 1988 through the AIDSCOM and AIDSTECH Projects which ended in 1992. It is currently implementing a $6.5M AIDS Surveillance and Eduction Project (ASEP) as well as a review of blood banking activities in the country. ASEP supports two areas of the MTP: (1) systematic HIV sentinel surveillance; and, (2) mass media and community-based IEC programs targeting persons at high risk of HIV.

The Asia Bureau has recently allocated additional funds to USAID/Manila through the AIDSCAP Project, which will enable the Mission to assist the DOH in addressing a third significant component of HIV/AIDS prevention: STD control.

The proposed STD Strategic Plan was developed in consultation with staff of the STD/AIDS Division of the DOH, WHO/GPA experts, and following discussions with the leading NGOs involved in STD/AIDS interventions in the Philippines.

The implementation of the proposed activities will be in close coordination with the STD/AIDS Division, WHO/GPA and other international donor organizations.

2. BACKGROUND

The close interrelationship between HIV and conventional STDs, many of which are curable, has focussed attention on STD control programs as an important intervention in the prevention of HIV transmission. Persons at risk for other STDs are also at risk for HIV. In addition, certain STDs, both ulcerative and non-ulcerative, facilitate the transmission of HIV. Several experts have closely examined the situation in the Philippines where the emerging HIV transmission pattern, as suggested by currently available data, is mainly heterosexual, and have concluded that a strong STD control program can delay or even prevent the formation of the critical mass of HIV infections that triggers a full-blown epidemic.

Epidemiology of STDs in the Philippines:

As is the case in most countries with passive reporting systems, STD cases are under-reported in the Philippines. The greater part of the statistics available to the DOH are STD cases reported by the 130 Social Hygiene Clinics (SHCs) where female CSWs are screened periodically. It is therefore difficult to estimate the true magnitude of the STD problem in the Philippines.

A review of national STD statistics in the past few years shows that the total number of STD cases reported went up from 26,450 in 1987 to 72,550 cases in 1991. This increase is largely attributed to improved detection and reporting following a training program for SHC personnel implemented by the DOH between 1989 and 1990 (discussed below).

The DOH officially reported 17,168 cases of gonorrhea in 1991 but experts believe that the actual incidence of gonorrhea may be closer to 500,000 per year (WHO/GPA, 1993). It is probable that chlamydia rates parallel those of gonorrhea. On the other hand, genital ulcer disease is reported to be uncommon, and active syphilis is rare. Herpes is less common than in other Asian countries such as Thailand and chancroid is virtually unknown.

STD prevalence data among registered CSWs were collected as part of the clinic-based component of a USAID-funded Health Education project in the Ermita District of Manila. Preliminary results of this study showed prevalence of 11.5% for gonorrhea, 17.5% for chlamydial infection, 4.7% for trichomoniasis and a syphilis seroprevalence of 2.4% (Monzon, 1989). The validity of these data is likely compromised by self-medication, treatment by private practitioners and douching which is routinely practiced by CSWs prior to their mandatory STD health check at the local Social Hygiene Clinic (SHC).

Current STD Control Program:

The current STD control program in the Philippines consists essentially of the activities of the 130 SHCs which carry out weekly or fortnightly STD checks required for the issuance of work permits for hospitality girls, massage parlor attendants and other occupations that front for sex work. There is no such requirement for male workers. In all, some 50,000 registered female commercial sex workers (CSWs) attend the SHCs which are acting more as an arm of the Department of Justice than as a health care service and patient acceptance of these services is still problematic.

Since SHCs operate on lean budgets, resources to effectively detect and manage STDs during the health checks are generally inadequate and CSW attendance at the SHCs has largely become a bureaucratic procedure giving a false sense of security to both CSWs and clients. Furthermore, there are many full and part-time freelance female CSWs not employed in establishments, as well as many male CSWs, who are not registered and are therefore not compelled to attend SHCs.

Lack of administrative support and insufficient funds for the STD control program have generally resulted in an absence of technical supervision, monitoring, and training of health care personnel for STD control. In 1989, USAID/Manila funded a project initiated by the DOH to upgrade SHCs and train their staff. Between 1988 and 1991 four SHCs in Manila, Cebu, Baguio and Olongapo were upgraded to serve as model STD case management training clinics, a number of SHC were provided with laboratory equipment and 70% of the country's SHC staff were trained in STD laboratory procedures and techniques at the Bureau of Research Laboratories (BRL) through this program. However, because of high staff turnover at all levels of the SHC system

and insufficient budgetary support, the SHCs have not been able to maintain the program and there has been a gradual deterioration in their operations.

Other Sources of STD services:

Although not restricted to screening CSWs, over 90% of SHC attenders are female CSWs. Very few male CSWs are seen, a few patients are referred, and there are very few walk-in clients. So where do unregistered CSWs and other STD patients seek treatment?

It is believed that the majority of individuals seeking STD treatment in the Philippines do so from private practitioners or, according to a consensus of key informants, a majority will initially self-medicate with antibiotics bought over the counter at pharmacies.

The Infectious Disease and Obstetrics/Gynecology (OB/GYN) Departments of the Philippine General Hospital (PGH) jointly run an outpatient STD clinic three afternoons a week in Manila but fewer than five patients are seen per session. To improve access, the OB/GYN Department intends to start a 24-hour walk-in clinic particularly for female freelance CSWs which will be affordable and not involve stamping health cards.

The non-governmental organization Kabilakat, runs an STD/AIDS education program for CSWs from its CSW drop-in center in the Ermita District. CSWs needing STD services are either referred to the Manila SHC or to the STD clinic at the PGH. In addition, volunteer doctors from the OB/GYN Department have occasionally accompanied the outreach education team to sex establishments and provided STD services on-site.

The Marie Stopes Clinic in Pasay City offers STD services for a small fee on a walk-in basis as part of the family welfare services it provides. About 35 CSWs are screened for STDs each month, about one fourth of them are male CSWs. AIDSCHECK is an outreach education program to CSWs which is based at the Marie Stopes Clinic.

3. RATIONALE

The STD/AIDS Unit has requested assistance to develop a five year STD control plan that addresses the STD problem in the Philippines in a more comprehensive and systematic manner, and as a critical element of HIV control. In order to develop a plan that establishes the most appropriate program priorities, more information is needed on the patterns of infection and disease in priority target groups, their health seeking behaviors, and their access to acceptable, effective STD services. More information on the etiologies and antibiotic resistance patterns of STD syndromes will also be helpful in the development of national STD management guidelines which are a major objective of the national plan. These areas are further discussed in the following paragraphs.

The need to identify and characterize target groups for STD control:

Although the long-term goal should be comprehensive STD services for the entire population, resources should be concentrated in urban centers and on those whose behavior puts them at highest risk of STD and HIV infection. Interruption of STD and HIV transmission in these groups of "high frequency transmitters" will have a larger impact on the overall STD and HIV prevalence in the general population than providing services to the general population alone. These priority groups need to be better characterized on the basis of small scale behavioral and prevalence studies. In the Philippines, these groups include registered as well as non-registered male and female CSWs, their clients, and men who have sex with men (MSM). The results of these surveys will serve to design an STD control program that makes sure that these priority groups have access to effective STD services. In the process of defining these priority groups, it is important to ensure that the process does not further stigmatize the group and defeat the goals of the program by alienating target groups or by suggesting that the disease is a problem caused by the target group.

The need to identify STD health seeking behaviors of target groups and the STD management practices of STD service providers:

As in most countries, care for STD patients in the Philippines is provided through many different services and individuals. It is useful to know where different groups of individuals seek care, as well as the quality of services received at the various sources. This is critical because the "point of first encounter" of the STD patient with the health system (both formal and informal) is the most important. It may be the patient's only contact and may influence future health seeking behavior.

The need to standardize STD case management:

Finally, effective antimicrobial therapy is one of the cornerstones of STD and HIV control. Treatment failures not only prolong the period of infectivity, but erode confidence in health services. In order to ensure effective STD therapy at all levels of health service, WHO/GPA recommends treatment of STDs according to rational standardized protocols. Such protocols also facilitate training and supervision of health care providers, delay the development of antimicrobial resistance in STD agents such N. gonorrhea and H. ducreyi and are an important factor in rational drug procurement.

Since laboratory-based diagnosis often results in treatment delays and is not practical or feasible in most developing world settings, WHO/GPA has developed a set of simplified syndrome-based STD patient management protocols to assist the health care provider in the diagnostic process. The WHO/GPA protocols must however be adapted to local epidemiological and antimicrobial sensitivity patterns.

Proposed activities and outcomes:

The proposed Project will collect some of the pertinent epidemiological and behavioral baseline information necessary to develop a rational and appropriately targeted STD control program, one that: (1) responds to the needs of the population; (2) promotes a public and private sector partnership with collaboration and coordination between governmental clinics, private for-profit clinics and pharmacies, and clinics run by NGOs; and, (3) is fully coordinated with HIV/AIDS control activities.

It is anticipated that the information and insights reaped from this Project will help to attract further external donor support for STD prevention and control in the Philippines.

The DOH has recently made and implemented a policy pronouncement that AIDS and STD control programs should be integrated. The STD control program has been integrated into the STD/AIDS Division under the DOH's Office of Special Concerns. The initiation of this activity is, therefore, most timely. Although not described in following implementation plan, further policy initiatives may want to be pursued in this Project to build awareness and advocacy among the different interest groups described here. Examples may include local regional workshops with managers, planners, clinic staff, CSWs and other target groups to reflect on research findings and and how they may inform the design of the STD/AIDS Unit's 5-year plan. Such activities also serve the policy objective of generating interest and commitment for the long-term to produce and maintain enhanced STD services and minimize costs.

4. PROJECT DESCRIPTION

The proposed Project is a one year project, for $320,000 which will focus on Metro Manila and Cebu City, the two largest urban centers in the Philippines. The cities of Davao and Baguio may also be considered if feasible.

Goal: To reduce the prevalence and incidence of STDs in the Philippines.

Purpose: To assist the DOH establish priorities and select the most appropriate and rational strategies for STD control in the Philippines.

Objectives/Outputs:

1. To determine, in selected urban centers, the patterns of STD infection:

   a. among different groups of CSWs, female and male, registered and unregistered;

   b. among women attending antenatal clinics in selected large urban centers.

2. To describe, in selected urban centers, the disease perception and STD health seeking behavior of:

   a. symptomatic men;

   b. registered and unregistered CSWs.

3. To assess, in selected urban centers, the STD management practices of:

   a. private practitioners (including venereologists, dermato-venereologists, dermatologists, gynecologists and general practitioners);

   b. pharmacists and pharmacy clerks.

4. To develop standard STD case management guidelines that are specific to the epidemiological, laboratory and therapeutic circumstances of the Philippines.

5. To assist the STD/AIDS Unit develop a five year STD control plan for the Philippines

5. IMPLEMENTATION PLAN

This implementation plan is only one step in the planning process. Following the review and approval of this proposal, subagreements and detailed implementation plans will be developed for each component which describe the activities in much greater detail. The implementation plan will remain flexible and can be adjusted as the program evolves and the budget is put into operation.

The objectives of this project will be met by implementing the activities described in this section. Possible implementing agencies are indicated where possible.

A. Assessing the Patterns of STD Infection and Health Seeking Behavior among Different Groups of Female CSWs

Non-recognition of a target population in a specific geographical setting will lead to failure to provide or strengthen services. In order to direct limited resources to those groups or individuals who are at greatest risk of being infected with an STD, it is necessary to know which population groups or subgroups have the highest incidence and prevalence of infection, which clinical syndromes are the most common, which etiologic agents are the most common and what the antibiotic resistance pattern of *N. gonorrhea* is to available antibiotics.

Where do CSWs seek STD care (in addition to the SHC for mandatory checks)? What are the determinants of choice for a particular service? What is the acceptability of services? What are the political, legal and cultural factors that influence health seeking behavior? AIDSCAP has developed a social science research instrument that combines different qualitative and quantitative research methods that will help to gather this information. Additional guidance will be provided by the AIDSCAP Evaluation Unit.

These studies cannot be conducted for every group in every city but the data may be reviewed and cautiously extrapolated from one to another especially since CSWs are usually a highly mobile population moving from one urban center to the next.

Proposed Activities

- Review existing data on the prevalence of *N. gonorrhea, C. trachomatis, T. vaginalis* and syphilis seroreactivity among registered female CSWs attending the Manila Social Hygiene Clinic (Research Institute for Tropical Medicine).

- Conduct a cross-sectional study of *N. gonorrhea, C. trachomatis, T. vaginalis* and syphilis serostatus among registered CSWs attending the Social Hygiene Clinic in Cebu City in collaboration with the laboratory of the Cebu General Hospital.

- Conduct a cross-sectional study of *N. gonorrhea, C. trachomatis, T. vaginalis* and syphilis serostatus among non-registered freelance male and female CSWs. These CSWs will be reached through NGOs working with them such as Kalibakat and AIDSCHECK (based at the Marie Stopes clinic), and screened for STDs at a clinic such as the 24-hour satellite clinic run by the OBGYN Dept. at PGH in Manila or the Marie Stopes clinic in Pasay City.

- Determine antimicrobial susceptibility of *N. gonorrhea* isolated in above studies.

- Study the disease perception and health seeking behavior of these CSWs in relation to STDs through the administration of semi-structured interviews and focus group discussions.

Possible Implementing or Collaborating Agencies

In addition to those specifically proposed above: the Gabriella Commission on Women.

B. Determining the Prevalence of STDs among Women Attending Antenatal Clinics in Large Urban Centers

Women who have been infected by their male partners are often unaware of their infection(s) and as a result don't usually seek or receive treatment. They are usually asymptomatic or they are unaware of the significance of their symptoms which are usually mild until complications arise. In addition, they are often reluctant to attend STD clinic facilities for fear of stigmatization or discrimination, or because services for them are often inaccessible, culturally unacceptable or unaffordable. The prevalence of STDs among these women generally reflects the magnitude of the STD problem in their communities and the general population.

These studies cannot be conducted for every group in every city but the data may be reviewed and cautiously extrapolated from one to another.

Proposed Activities

- o conduct a cross-sectional study of syphilis, *N. gonorrhea, C. trachomatis and T. vaginalis* among women attending their first ANC visit at a major teaching hospital such as the OBGYN Department of the Philippines General Hospital (PGH).

- o Determine the antibiotic susceptibility patterns of isolated *N. gonorrheae.*

Possible Implementing or Collaborating Agencies

In addition to the OBGYN Department at PHG, explore the possibility of linking the studies to the ANC syphilis screening component of the Urban Health and Nutrition Program in Cebu City funded by the World Bank in Cebu.

C. Identifying the STD Disease Perception and Health Seeking Behavior of Symptomatic Men

Where do men seek STD care? What are the determinants of choice for a particular service? What is the acceptability of services? What are the political, legal and cultural factors that influence health seeking behavior? Appropriate groups will include: CSWs, homosexual and bisexual men, clients of CSWs, university students, and the military. AIDSCAP has developed a social science research instrument that combines different qualitative and quantitative research methods that will help to gather this information. Additional guidance will be provided by the AIDSCAP Evaluation Unit.

These studies cannot be conducted for every group in every city but the data may be reviewed and cautiously extrapolated from one to another.

Proposed Activities

- o Conduct key informant interviews with public and private health care providers and pharmacists/pharmacy clerks.

- o Conduct semi-structured interviews and focus group discussions with male STD patients attending clinics and, if feasible, pharmacies. These may take the form of exit intercept interviews.

- o Conduct semi-structured interviews and focus group discussions with target populations such as truckers, military or police recruits, overseas contract workers (OCWs), university students, and MSMs.

Possible Implementing or Collaborating Agencies

These studies could be linked to some of the surveys conducted by the ASEP Project.

D. Assessing STD Patient Management Practices in the Private Sector

STD control programs usually focus their attention on services provided through the public sector, but in view of the significance of the private sector in the provision of STD care, including those provided by pharmacists or pharmacy clerks, these services should also be assessed and strengthened. The elements of STD patient management to be assessed include diagnosis and treatment, as well as prevention education including condom promotion and distribution.

Proposed Activities

WHO/GPA, in collaboration with AIDSCAP and CDC/Atlanta, has developed a standard STD service assessment instrument which will be used in this exercise. One, or a combination of the following approaches, will be used:

- o Conduct structured interviews and observations with providers such as venereologists, dermato-venereologists, dermatologists, gynecologists, general practitioners, pharmacists and pharmacy clerks.

- o Mystery shopper (dummy patient) surveys of providers.

The data collected in the above studies will be supplemented by qualitative data collected in the interviews and focus group discussions with CSWs, male STD patients and other potential users such as CSWs, male STD patients, truckers, seamen, military and policemen, overseas contract workers and university students.

Possible Implementing or Collaborating Agencies

To be determined during a future AIDSCAP site visit.

E. Preparing National Case Management Guidelines

One important method to ensure that consistent case management is practiced by all health care providers offering STD care is the dissemination of standard national guidelines. The results of the assessments will form the basis for the preparation of the case management guidelines. This will be a crucial part in the development of the prevention and control program because the guidelines will provide guidance to all health workers offering STD care. It will include flow charts for diagnosis and treatment appropriate to resource availability, guidance on education, counselling, condom promotion and provision, and voluntary partner notification.

Proposed Activities

- Assist the STD/AIDS Unit form an STD case management Working Group in consultation with other appropriate professional organizations.
- Support a consensus workshop to develop STD case management guidelines that are specific to the epidemiological, laboratory and therapeutic circumstances of the Philippines.
- Develop a plan to disseminate the use of the guidelines.

Possible Implementing or Collaborating Agencies

The STD/AIDS Unit, the Philippines Society of Venereologists.

F. Preparing a Five-year STD Control Plan for the Philippines

AIDSCAP will assist the STD/AIDS Unit in developing a five-year national STD plan based on existing and new information gathered in this Project. The plan will be developed as a component of and in the framework of the national AIDS control plan.

Proposed Activities

- Sponsor the chief of Clinical Services at the STD/AIDS Unit was sponsored by AIDSCAP to participate in a two week international course for STD program managers in September 1993 in London

- o Sponsor one member of the STD/AIDS Unit and one member of the Philippines Society for Venereologists to participate in the regional two day workshop organized jointly by WHO and AIDSCAP to build in-country advocacy for a public health approach to STD control.

- o Prepare an assessment report identifying deficiencies in the existing services and provide baseline data for monitoring and evaluation.

- o Establish priority activities and strategies based on effectiveness, feasibility and affordability taking into consideration the services provided by the private sector providers (public and private sector activities should be complementary rather than duplicative).

- o Facilitate the development of a five year plan for STD control in the Philippines including a workplan, timetable, budget, monitoring and evaluation plans.

6. ADMINISTRATION AND MANAGEMENT

The proposed plan will be managed by Family Health International's (FHI) AIDSCAP Asia Regional Office (ARO) in Bangkok. Local coordination of activities will be through an AIDSCAP resident representative who will liaise with the designated medical officer of the DOH's AIDS/STD Program Unit, the USAID Public Health Advisor and the implementing agencies. The AIDSCAP representative will assist the ARO in identifying implementing agencies, monitoring activities, and technical assistance needs.

Local technical expertise will be identified in the Philippines as a first priority and will be engaged and accountable to the ARO and USAID/Manila. Resources of the ARO, AIDSCAP Headquarters and the AIDSCAP Subcontractors will be utilized when the necessary local technical assistance is not available.

For each sub-project, a subagreement will be developed with the implementing agency. Subagreements are contractual documents that incorporate the subproject study design and obligate funds. The concurrence of USAID/Philippines will be required prior to executing individual subagreements.

The FHI cost center system segregates funding by source throughout the organization. Within the AIDSCAP Division this system separates add-on and core funding sources. The system allows for tracking of both field and home office costs for specific subprojects and activities by country. All recipients are subject to routine financial reporting requirements and to internal audits at the discretion of FHI and as requested by USAID.

7. WORKPLAN TIME TABLE

Activities	FY 1994			
	1	2	3	4
I. Identify and appoint the AIDSCAP representative	X			
II. Conduct prevalence and behavioral studies				
A. Select implementing agencies	X	X		
B. Develop subagreements		X		
C. Conduct studies		X	X	
D. Analyze Data and prepare reports			X	X
III. Facilitate the development of national STD management guidelines		X	X	X
IV. Assist in preparing a 5 year STD Control Plan		X	X	X

8. ILLUSTRATIVE BUDGET

A. Subagreements:

Prevalence Studies	$134,000	
Health Seeking Behavior Studies	27,000	
STD Management Practices	32,000	
Development of Management Guidelines	5,000	
Subtotal G&A*	32,000	
B. Technical Assistance	45,500	
Subtotal G&A @ 32%	14,500	
C. In-country Management Costs**	22,700	
Subtotal G&A @ 32%	7,300	
Total Program		266,200
Total G&A		53,800
TOTAL		320,000

Proposed Sourcing: USAID Asia Bureau

AIDSCAP has sponsored one qualified candidate from the Philippines to participate in the two week International Course for STD Programme Managers in Developing Countries in London, September 1993, and proposes to sponsor two qualified candidates to participate in the Regional conference of the International Union for Venereal Diseases and Trepanematoses and a two day pre-conference STD advocacy workshop in Thailand, 26-30 October, 1993. Participation in these meetings will be funded separately through the Asia Bureau/Area of Affinity Budget.

* G&A on Subagreements calculated on the basis of four subagreements with 32% taken on the first $25,000 of each subagreement for the life of the project.

** Includes salary of a full-time, local hire, AIDSCAP Resident Advisor as well as communication and office supplies costs.

EXCERPTS FROM THE OVERVIEW OF THE PHILIPPINE BLOOD BANKING AND BLOOD TRANSFUSION SERVICES

prepared by
The Technical Working Group for the
Project to Evaluate the Safety of the Philippine Blood Banking System

INTRODUCTION

This overview presents the overall picture of the the blood banking activities in the Philippines and in other countries - the historical developments; the organizations, groups and main actors involved; the demand, supply and sources of blood; the costs to patients; the efforts of supervision, regulation and program planning; and aspects that need closer study.

HISTORICAL DEVELOPMENTS

Local Developments

The beginnings of the present day blood banking and blood transfusion services in the Philippines can be traced to the formal launching in July 1948 of a National Blood Program operated by the Philippine National Red Cross (PNRC).

In June 1956, a law regulating the operations of blood banks was enacted (RA 1517). The law allowed the establishment and operation by licensed physicians of blood banks and blood processing laboratories. The reponsibility for standardization, licensing and regulation of these banks was given to the Secretary of Health.

The Bureau of Research and Laboratories was established in 1958. In 1963, a system was set in motion linking the laboratories at the regional, provincial and peripheral levels in the country in an Integrated Laboratory System. By 1966, the law regulating clinical laboratories (RA 4688) gave the BRL additional police powers to regulate clinical laboratories.

In 1971, a Licensure Section was created within BRL tasked with the enforcement of the licensure requirements for blood banks as well as clinical laboratories.

In 1983, the Philippine Blood Coordinating Council (PBCC) was established by a small group of hematologists and pathologists concerned with the safety of blood and with improvements in the National Blood Program especially in increasing voluntary donation of blood, in having more rational use of blood among the doctors, and in coordinating the activities of the various actors in the blood banking services.

In 1989, the revised Blood Banking Guidelines (AO 57 s. 1989) classified banks into primary, secondary or tertiary, depending on the services they provide. The new guidelines also included the requirement to do hepatitis B and HIV testing.

In 1989, nine Manila-based free-standing blood banks organized themselves into a self-regulating and coordinating body which they called the Philippine Association of Blood Banks (PABB).

In 1992, Department of Health Administrative Order No. 118-A institutionalized the National Blood Services Program (NBSP) naming the BRL as the "central office primarily responsible for the NBSP" and creating a committee that will "implement" the NBSP.

International Developments

In 1975, the World Health Organization was asked through a resolution passed during the 28th World Health Assembly (Resolution WHA28.72) to increase its assistance in the development of blood transfusion services.

In 1979, the Acquired Immune Deficiency Syndrome (AIDS) was first described and in 1982, the first case of transfusion-associated AIDS was described in an infant.

Safety in blood and blood products rapidly became a global concern. In 1980, the International Society of Blood Transfusion (ISBT) formulated the Code of Ethics for Blood Donation and Transfusion. By 1983, a postgraduate course was started to train directors and leading experts of national blood transfusion services on the management of blood transfusion services.

In 1984, the ISBT drafted a model for a national blood policy outlining certain principles that should be taken into consideration; and by 1985, the ISBT disseminated guidelines requiring AIDS testing of blood and blood products for transfusion.

In 1990, WHO started to publish a series of technical papers on blood transfusion: Management of Blood Transfusion Services (1990); Guidelines on the Organization of a Blood Transfusion Service (1992); and Guidelines on Quality Assurance Programs for Blood Transfusion Services (1993). Also in 1990, the American Association of Blood Banks published a Technical Manual on Blood Transfusion especially helpful for clinicians.

CURRENT SITUATION OF BLOOD TRANSFUSION SERVICES IN THE PHILIPPINES

Blood Supply

It is estimated that around 600,000 - 650,000 units of blood (a unit is about 450 ml) will be needed annually nationwide. Annual blood bank statistical reports submitted to BRL show that in 1992, only about 449,583 units of blood were collected from around 365,764 donors, or 1.2 units per donor. This means that about 25% of the estimated needs are not met.

Sources of Blood

Of the blood units collected in 1992, 57.7% were supplied by free-standing or commercial blood banks; 23.4% by the PNRC; 12.3% by government hospital-based blood banks; and 6.6% by private hospital-based blood banks, table 1.

Table 1: Sources of Blood Supply,
Blood Bank Annual Report, BRL 1992

Type of Blood Bank	Number of units	Percentage
Free-standing	259,436	57.7
PNRC	105,001	23.4
Government Hospital	55,375	12.3
Private Hospital	29,792	6.6

Calculating the number of units per bank and noting that there are only 24 "registered or licensed" free-standing blood banks throughout the country, we see that each commercial blood bank produces five times more blood than the Red Cross and 15 times more than the government banks, table 2. This emphasizes the heavy reliance of the Philippines on commercial sources of blood.

Table 2: Units of Blood Collected per Blood Bank
by Category, Blood Bank Annual Report, BRL 1992

Type of Blood Bank	Total No. of Banks	Number of units collected/bank
Free-standing	24	10,810
PNRC	45	2,333
Government Hosp.	72	769
Private Hosp.	83	359

Types of blood donors

Table 3 shows the types of blood donors in each category of blood bank.

Table 3: Types of Donors by Category of Blood Bank
Blood Bank Annual Report, BRL 1992

Type of Blood Bank	Paid Donor	Voluntary Donor	Total
Free-standing	258,377 (99.6%)	1,059 (0.4%)	259,436
PNRC	175 (0.2%)	104,826 (99.8%)	105,001
Government Hosp	13,948 (25.2%)	41,427 (74.8%)	55,375
Private Hosp	22,927 (77.0%)	6,844 (23.0%)	29,792

Establishment and Creation of Blood Banks

Table 4 shows the number of registered banks from 1986 to 1992.

Table 4: Number of Registered Blood Banks
Blood Bank Annual Reports, BRL 1986 and 1992

Type of Blood Bank	1986	1992	Percentage Increase
Free-standing or commercial	24	24	0
Hospital-based	128	155 (Govt = 72 Priv = 83)	23%
PNRC	36	45	25%
Total	188	224	19%

In 1970, BRL records list 73 registered blood banks. This reflects a 157% increase from 1970 to 1986, which means that most of the existing blood banks were registered between 1970 - 1986, coinciding with the creation of the Licensure Section in 1971 and the more agressive enforcement of the law during those years.

Geographical Distribution of Registered Blood Banks

Table 5 shows the distribution of registered/licensed blood banks in different regions.

Table 5: Regional Distribution of Registered Blood Banks by General Categcry, Blood Bank Annual Report, BRL 1992

Region	Free-Standing	Govt hosp based	Priv hosp based	PNRC	Total
CAR	2	6	3	3	14
I	0	7	7	2	16
II	0	10	4	1	15
III	1	7	9	6	23
IV	1	12	10	2	25
V	0	7	6	3	16
VI	4	11	8	5	28
VII	2	3	11	2	18
VIII	0	5	3	2	10
IX	0	2	3	3	8
X	0	6	4	7	17
XI	1	3	5	5	14
XII	1	3	7	2	13
NCR	11	16	20	3	50
TOTAL	23	98	100	46	267

This data shows that 18.7% of the total number of blood banks are located in the National Capital Region (NCR): 48% of the free-standing banks; 16% of government hospital banks; and 20% of private hospital banks.

Inter-island distribution shows that there is a concentration of blood banks in Luzon (159 banks or 59.5%). There are only about 56 banks (21%) in the Visayas and another 52 (19.5%) in Mindanao.

Blood Screening

Of 600,377 donors examined, only 365,764 (61%) were bled. Of those rejected, 41,200 (17.6%) were rejected because of positivity in the laboratory tests, table 6.

Table 6: Donor Rejection Due to Positive Laboratory Tests
Blood Bank Annual Report, BRL 1992

Infection	Number positive	Percentage
Syphilis	6,657	16.2%
Malaria	432	1.1%
Hepatitis B	34,100	82.8%
HIV	19	0.05%
Total	41,208	

This puts the donor rejection rate due to positive laboratory tests at 6.3%. Many are rejected due to hepatitis B.

Of the 19 HIV positive donors, 17 (89.5%) were detected in NCR and 14 (73.7%) were detected in free-standing blood banks. This underscores the higher tendency for high risk donors to go to the commercial blood banks. All cases have been reported to the National AIDS Registry.

Of 449,583 units of blood collected and tested, 10,995 (2.4%) were found positive in the laboratory tests, table 7.

Table 7: Collected Blood Found Positive in Laboratory Tests
Blood Bank Annual Report, BRL 1992

Infection	Number positive	Percentage
Syphilis	1,883	17.1%
Malaria	260	2.4%
Hepatitis B	8,847	80.5%
HIV	5	0.04%
Total	10,995	

Use of Blood

Of 449,583 units of blood collected, 200,239 (44.5%) were transfused as whole blood, 79,328 (17.6%) as packed red blood cells, 12,528 (2.8%) as plasma, 26,612 (5.9%) as platelet concentrate, and 8,143 (1.8%) as cryoprecipitate.

A total of 14,550 units (3.2%) were not transfused due to the following reasons, table 8.

Table 8: Reasons for Not Transfusing Blood
Blood Bank Annual Report, BRL 1992

Reason for Not Transfusing Blood	Quantity Not Transfused	Percentage
Expired	9,038	62.1%
Contaminated or spoiled	375	2.6%
Positive laboratory test	3,512	24.1%
Others/ unknown	1,625	11.2%
Total	14,550	

Blood which has been found positive for hepatitis B, especially those from PNRC, are sent to the Research Institute for Tropical Medicine for research purposes.

Cost of Blood

As per BRL Order No. 9 s. 1991, the maximum rates for blood are as follows, table 9.

Table 9: Maximum Rates for Blood
BRL Order No. 9 s. 1991

Blood/ Blood Products		Cost per unit
Whole blood	-	₱400.00
Packed RBC	-	₱450.00
Fresh frozen plasma	-	₱300.00
Plasma (liquid or frozen)	-	₱250.00
Platelet-rich plasma	-	₱400.00
Platelet concentrate	-	₱500.00
Cryoprecipitate	-	₱600.00
Washed RBC	-	₱600.00
Leucocyte-poor RBC	-	₱600.00
Rh negative blood	-	₱ 50.00 additional

The above-stated rates include charges for ABO grouping, testing for hemoglobin content, and screening for malaria, syphilis, hepatitis B and HIV antibody.

Blood banks and hospitals are allowed to charge fees for actual costs of expenses for recruiting donors, collection, processing, storing and transportation of blood with reasonable allowance for spoilage and professional services rendered. Other charges may be collected upon approval of application for such from the BRL.

PNRC banks collect a handling fee of ₱ 100-175 per unit of whole blood and ₱ 150-300 per unit of blood components.

Main Actors in the Local Blood Banking and Blood Transfusion Scene

In the Philippines, blood banking and blood transfusion services are arranged in four different ways: Red Cross-run blood centers, government-run blood services, private hospital blood banks, and commercial blood enterprises.

The Philippine National Red Cross (PNRC)

Since the launching of the National Blood Program under the PNRC in 1948, it has continued to open chapters in different parts of the country. To date, it has 46 blood centers nationwide: 1 national blood center, 3 regional blood centers, and 42 chapter blood centers.

Aside from the blood centers, PNRC has blood stations which just issue blood, and blood extension services which collect, store and issue blood but do not process them and instead send them to the nearest blood center. PNRC has around 24 extension services and 15 blood stations.

The Blood Program is just one of six service programs of the PNRC. The other services are: Disaster Preparedness and Relief Service, Safety Services, Nursing Service, Red Cross Youth and Social Services.

PNRC obtains most of its blood by doing mass bleeding campaigns throughout the year. These campaigns are often sponsored by military, civic or religious organizations. The PNRC mass bleeding activities occur throughout the year, with peaks during the Blood Donors' Week in July. A person who donates blood becomes a registered blood donor and is given a certificate of donation. A person who has donated one gallon of blood automatically becomes a member of the "Blood Galloner's Club".

According to the 1992 BRL Registry, only 8 PNRC blood centers have been officially registered nationwide: 1 national blood center, 2 regional blood centers and 5 chapter blood centers. There are 32 applications for license renewal and one new application, all awaiting inspection by BRL staff. However, 4 chapter blood banks cannot be licensed yet because of inability to meet some requirements, mostly in physical facilities.

For 1992, the Blood Bank Annual Report of BRL shows that the following accomplishments have been reported by PNRC, table 10.

Table 10: PNRC 1992 Accomplishments
Blood Bank Annual Report, BRL 1992

Total number of donors examined:	114,885	
Donors rejected:	61,743	(53.7%)
Number of units collected:	120,625	(2.3 units/don) (250 cc/unit)
Type of donors:		
Paid:	15,799	(13.1%)
Voluntary:	104,826	(86.9%)
Number of units transfused:		
Whole blood:	29,316	
Packed RBC:	254	
Plasma:	6	
Platelet concentrate:	830	
Number of units not transfused:	1,543	(1.3%)
Expired:	689	(44.6%)
Contaminated/spoiled:	123	(8.0%)
Positive laboratory test:	626	(40.6%)
Unknown:	105	(6.8%)
Number of donors with infection:	2,680	(2.5%)
Syphilis:	146	(5.4%)
Malaria:	84	(3.1%)
Hepatitis B:	2,629	(98.1%)
HIV:	1	(0.04%)
Number of blood units tested:	90,204	(41 blood centers)
Syphilis:	428	(0.5%)
Malaria:	107	(0.1%)
Hepatitis B:	4,569	(5.1%)
HIV:	0	

PNRC supplies about 1/4 of the blood supply in the country, or about 100,000 units annually. PNRC's monthly blood supply shows this to be stable at about 7,000 - 9,000 units per month.

The National Blood Center, located in Manila, shows that about 44.2% of requests for blood were unserved in 1992. The highest percentage of unserved requests were those for platelet concentrates. Replacement of blood was completed only in 28.4% of cases.

In 1992, only 10 PNRC blood centers were able to perform HIV screening tests, thus only 34.1% of its blood supply was tested for HIV. To date, at least 20 more centers have medical technologists already trained on HIV testing. However, there is a rapid turnover of trained medical technologists.

Four blood centers (1 national and 3 regional blood centers) can process blood components.

Free-standing or Commercial Blood Banks

As mentioned earlier, many of the blood banks were registered between 1970 - 1986. Each registered bank is allowed to have at least 4 "outlets", i.e., the equivalent of the PNRC blood stations.

Commercial blood banks pay donors for giving blood at varying rates between 50 - 150 pesos. The claim that paid donors usually have a higher risk of having blood-transmissible infections is confirmed by the data in table 11.

Table 11: Percentage of Donors Found Positive With Either Syphilis, Malaria, Hepatitis B or AIDS, by Category of Blood Bank, Blood Bank Annual Report, BRL 1992

Type of Blood Bank	Total Donors Examined	Donors Found Positive*	Percentage
Free-standing	393,928	33,172	8.4%
Government Hosp.	80,415	3,399	4.2%
Private Hosp.	60,178	1,777	2.9%
PNRC	114,885	2,860	2.5%
Total	649,406	41,208	6.3%

* For any of the following: syphilis, malaria, hepatitis B, HIV

Breaking this data down into diseases per type of bank, we see the following, table 12.

Table 12: Donors Found Positive by Type of Bank and Type of Infection, Blood Bank Annual Report, BRL 1992

Type of Bank	Number and Percentage Positive by Type of Disease			
	DONORS EXAMINED	SYPHILIS	MALARIA	HEPATITIS B	HIV
Free-standing	393,928	6,062 (1.5%)	47 (0.01%)	27,049 (6.9%)	14 (0.004%)
Gov Hosp	80,415	233 (0.03%)	126 (0.2%)	3,038 (4%)	2 (0.002%)
Priv Hosp	60,178	216 (0.4%)	175 (0.3%)	1,384 (2.3%)	2 (0.003%)
PNRC	114,885	146 (0.1%)	84 (0.07%)	2,629 (2.3%)	1 (0.0009%)
TOTAL	649,406	6,657 (1%)	432 (0.07%)	34,100 (5.2%)	19 (0.003%)

Donors coming to free-standing blood banks are about 3 times more likely to have any of the four tested infections than the donors coming to PNRC.

A regular-sized commercial blood bank sees around 70 prospective donors daily. There are no problems in finding donors, many come to the bank on their own.

In Metro Manila, at least, all the commercial blood banks claim they routinely do HIV testing since 1991.

Blood from commercial banks are usually distributed to government or private hospitals when blood is requested. Many have on-going business arrangements. Many hospitals have their favorite blood bank which can deliver blood within minutes. Such convenience from Free-standing banks makes PNRC procedures - which asks for blood replacement and for handling costs anyway - quite tedious and, for patients in dire need, quite slow.

In 1991, the commercial banks in Manila pooled together blood for HIV testing, tested about 36,000 units and discovered 6 cases of HIV, all males, which were reported to the AIDS surveillance unit. Of these, only one was followed up, a homosexual, and followed-up only once.

Owners and proprietors of commercial banks know they supply the bulk of the country's blood supply. They do not see any reason for phasing out their establishments especially since there are so far no alternative sources of adequate blood supply.

Hospital-based Blood Banks

Hospital needs for blood can be met in four different ways: (a) Red Cross blood can be requested; (b) a blood donor can be brought by the patient, usually a relative; (c) blood can be bought by the hospital from a free-standing blood bank; (d) blood may be solicited from voluntary blood donors. What actually happens in about 80% of the time is that blood is bought from commercial sources.

Some hospitals re-test the blood, some do not. Many do not have projects to solicit voluntary donations, but the several who do, usually are able to get blood from their own staff or from students in their attached schools of medicine, nursing, midwifery or others.

It has been noted by BRL supervisors that government-run blood banks frequently run out of reagents. When they do, they ask the patients to waive the blood tests and declare that blood is urgently needed.

Doctors: the Users of Blood

According to the 1992 BRL Annual Report, whole blood is transfused in about 45% of the cases. This may be an underestimate. Many Filipino doctors are not yet fully trained to on the specific indications for blood component transfusion. They are not aware of the lack of blood supply and do not feel the need to adjust their practices and use of blood and blood products. It also does not matter so much to them where the blood comes from.

The General Public

There are many cultural barriers that discourage voluntary blood donation. Except among selected sectors such as the military, voluntary blood donation is not very popular among most Filipinos. Even relatives of patients find various excuses not to donate blood. Some patients would rather buy blood from a stranger than be indebted for life to a relative. Misconceptions and fear abound. There is even a religious sect which forbids blood transfusion among its members regardless of the patient's condition.

Management of Blood Banking and Blood Transfusion Services
NBSP

Since 1948, the PNRC has been operating a Blood Program through its blood centers, extension services and chapters, many times in cooperation with other civic or religious organizations. Commercial and hospital-based blood banks were established independently in response to the demand that could not be adequately met by PNRC. Aside from distributing blood to hospitals through the patient's relatives, there is really little interaction or shared activity or plans between PNRC and the hospitals. PNRC has nothing whatsoever to do with commercial blood banks.

The DOH for its part played mainly the role of the regulator, defining standards and guidelines for all blood banks and licensing them. It did little in terms of planning or organizing the different groups involved in blood banking and blood transfusion.

The National Blood Service Program of 1989

The DOH began to be involved in planning and organizing blood bank services only in 1989, upon the approval of the National Blood Service Program only.

The NBSP's overall goal is adequacy, accessibility, affordability and equitable distribution of safe blood and blood products.

The adoption of a National Blood Service Program in 1992 was a major step towards the right direction, but there is still a big gap between what is on paper and what is actually happening. For instance, the NBSP states that "commercial blood bank outlets shall be phased out". This is far from reality. There are also no clear steps to be taken how to reach this objective. People who were supposed to be major actors in the NBSP feel they did not have enough participation in the development of this program. This results in lack of awareness or acceptance of their supposed role in the program.

DISCUSSION

Based on the foregoing data, the following areas present complicated problems that will need further study and documentation:

1. Program planning, policy development and coordination
2. Legal provisions and how these are actually followed
3. Lack of blood supply
4. Facility management and Upgrade
5. Training and development of blood bank staff
6. Supervision and quality control

This overview has revealed much of the existing situation, and has raised even more questions in the process. There is need to fully understand the interactions and implications of alternative actions so that practical and acceptable solutions can be arrived at once and for all.

ANNEX 1
LIST OF MATERIALS REVIEWED

RA 95	22 Mar 1947	An Act to Incorporate the PNRC
RA 1517	16 June 1956	An Act Regulating the Collection, Processing and Sale of Human Blood, and the Establishment and Operation of Blood Banks and Blood Processing Laboratories
AO 156	23 Sept 1971	Revised Rules and Regulations Governing the Collection, Processing and Sale of Human Blood and the Establishment and Operation of Blood Banks and Blood Processing Laboratories, as amended by Administrative Order No. 144-32 series of 1973 (amendments AO 144-32)
DC 99	18 Aug 1987	Declaring Basic Policies on Blood and Describing Measures in Support of Such Policies
AO 57	3 Jan 1989	Revised Rules and Regulations Governing the Collection, Processing and Provision of Human Blood and the Establishment and Operation of Blood Banks
BO 5	15 Jan 1990	Technical Standards Governing the Collection, Processing and Operation of Blood Banks in the Philippines
BO 6	16 Jan 1990	Administrative Standard Operating Procedures for Application and Licensure of Clinical Laboratories and Blood Banks
BO 7	16 Jan 1990	Procedures and Guidelines for the Regional Clinical Laboratory and Blood Bank Inspection Team of the Regional Licensing Units
BC 1	1 July 1990	Disposal of Hepatitis B Surface Antigen (HBsAg) and Human Immunodeficiency Virus (HIV) Antibody Positive Units of Blood
BC 2	1 July 1990	Screening of All Blood Units for Hepatitis B Surface Antigen (HBsAg), Human Immunodeficiency Virus (HIV) Antibody, Malaria and Syphilis
BO 9	15 May 1991	Maximum Rates to be Charged for Blood for Transfusion and Its Products
BC 1	19 June 1991	Exemption from the Requirement of Screening of Units of Blood for Hepatitis B Surface Antigen (HBsAG) and Human Immunodeficiency Virus (HIV) Antibody by Blood Banks Prior to Issuance to Hospitals
BC 2	21 Nov 1991	Reporting of (+) HIV Confirmed Blood Donors
AO 118-A	1992	The National Blood Services Program
AO 122	25 May 1992	Hepatitis B Surface Antigen (HBsAg) and Human Immunodeficiency Virus Antibody (HIV Ab) Positive Units of Blood: DOH Policy, Procedures to be Followed and Sanctions for Violations

7．エイズ関連の活動を行っているNGOリスト

HIV/AIDS NETWORK, PHILIPPINES:

THE PHILIPPINE NETWORK OF ORGANIZATIONS WORKING ON AIDS

HIV/AIDS Network, Philippines

Regular Members

Caritas Manila
Christian Children's Fund (CCF)
Congressional Research and Training Service (CRTS)
Council for Health and Development (CHD)
Dayang Women's Center
Eddie Guazon Foundation (EGF)
Family Planning Organization of the Philippines (FPOP)
Foundation for Adolescent Development (FAD)
Foundation for Resources in Economic and Ecological Development
GABRIELA
    Commission on Women's Health and Reproductive Rights
    Commission on Violence Against Women
Health Action Information Network (HAIN)
In-Touch Foundation
Institute for Social Studies and Action (ISSA)
Kabalikat ng Pamilyang Pilipino
Kalayaan
Kapatiran-Kaunlaran Foundation, Inc. (KKFI)
Katlo
Philippine National Red Cross (PNRC)
ReachOut AIDS Education Foundation
Remedios AIDS Center
Stop Trafficking of Pilipinos Foundation, Inc. (STOP)
The Library Foundation
Third World Movement Against Exploitation of Women (TWMAEW)
Trade Union Congress of the Philippines (TUCP)
Women in Development Foundation (WID)
Women's Health Care Foundation (WHCF)
Women's Media Circle Foundation
Women's Education, Development, Productivity and Research Organization (WEDPRO)
Womanhealth Philippines, Inc.

Affiliate Members

DKT International, Inc.
Employer's Confederation of the Philippines (ECOP)
Enfants et Development (EED)
The PhilAid Foundation
Save the Children's Fund
U.P. Center for Women's Studies

New Members

Salvation Army
KAAGAPAY
Population Services Pilipinas, Inc.

MEMBERS OF
THE
ALLIANCE AGAINST
AIDS IN MINDANAO
(ALAGAD)

1. TALIKALA
2. Community Based Health Service
3. The Davao Medical School Foundation
4. KAABAY
5. KONSUMO Dabaw
6. Korondal Valley Foundation, Inc.
7. Medicins Sans Frontiers
8. Night Spots Association of Davao
9. The Philippine National Red Cross
10. The Population Commission
11. The Social Hygiene Clinic, Davao
12. The Trust Foundation
13. The Women's Studies and Resource Center
14. Department of Health
15. Department of Social Welfare and Development

THE NGO NETWORK STAND ON THE AIDS PROBLEM IN THE PHILIPPINES

MISSION STATEMENT

The Network promotes the growth and strengthening of non-government organizations' response to the challenge of HIV/AIDS, with particular emphasis on active solidarity through coordination, collaboration and cooperation.

GUIDING PRINCIPLES

The Network brings together all those groups which respond to the urgency of controlling the spread and reducing the impact of HIV/AIDS. The Network believes that the participation of non-government organizations and communities affected by the epidemic is essential to ensure the provision of support and necessary services. The Network believes strongly that a recognition of the human rights of all persons is likewise central to an intelligent public health strategy to combat the epidemic.

In view of this, the Network is committed to:

(1) The critical role of non-government organizations within national programs, including policy formation, implementation and evaluation of programs and policies.

(2) The right of each non-government organization to determine its own priorities, methods of organization, programs and support for any national and international policies, and to have these choices respected by government and international agencies.

(3) The maximum involvement of women and men living with HIV/AIDS in all aspects if prevention, care, support, treatment, research, program and policy formation and evaluation.

(4) Recognition that there are diverse social and cultural perspectives on HIV/AIDS and approaches to care, prevention and treatment, but these should not override fundamental human rights to respect for individual dignity and protection against political, social and religious intolerance.

(5) Non-discrimination in all areas of the grounds of HIV status, gender, religion, race, sexual orientation, sex-work, drug-use or cultural or social status.

(6) Recognition that life affirming approaches which support diverse lifestyles and sexual behaviors are intrinsic to

success for HIV/AIDS programs. Coercion, fear and scapegoating are ineffective in dealing with the challenge of the epidemic.

(7) The need for collective, cooperative and coordinated efforts to combat HIV/AIDS at the community and national levels, involving a partnership in which those who are living with HIV/AIDS and non-government organizations are equal partners with government and health professionals.

(8) The right of everyone to equal access to information, care, medical treatment, and technology and tools appropriate to effective prevention and control strategies (e.g., condoms, etc.).