REPORT OF FACT-FINDING STUDY TEAM ON AIDS CONTROL IN THE REPUBLIC OF THE PHILIPPINES

# REPORT OF FACT-FINDING STUDY TEAM ON AIDS CONTROL IN THE REPUBLIC OF THE PHILIPPINES

MARCH 1994

MARCH 1994

JAPAN INTERNATIONAL CO

JAPAN INTERNATIONAL COOPERATION AGENCY

(JICA)

# REPORT OF FACT-FINDING STUDY TEAM ON AIDS CONTROL IN THE REPUBLIC OF THE PHILIPPINES

MARCH 1994

JAPAN INTERNATIONAL COOPERATION AGENCY

(JICA)

# Preface

It is estimated that in 1992 about 12 million adults have been infected with Human Immuno-deficiency Virus (HIV) in the world and another million people got infected with HIV in 1993. Without effective means of prevention and cure AIDS and HIV infection prevail in many parts of the world. In Asia, where one million people are infected, the prevalence is rising and its implecation to social and economic develoment of the countries will be quite serious if appropriate measures are not taken.

The govenments of Japan and the United States agreed to reinforce thier efforts in a coordinated manner within the framework for a new Economic Partnership between the two countries, to assist developing countries in tackling the AIDS problems. This fact-finding study was one of the products of the above-mentioned partnership agreement. The team visited the Republic of the Philippines from March 16 to 24, 1994 and during its stay in the Philippines, it collected information, made site visits and had discussions with organizations concerned.

This report is compiled by synthesizing the findings and recommendations by the team with the situation analysis of AIDS in the Philippines prepared by the Philippine Population Association. I hope that this report will serve for Jappan's cooperation for AIDS control and thus contribute to promotion of public health in the Republic of the Philippines.

I wish to express my sincere appreciation to the officials concerned of the Government of the Philippines as well as members of NGOs and international donor agencies for cooperation extended to the study team.

March 1994

Daiji Ozawa
Vice President
Japan International
Cooperation Agency

CONTENTS

Preface

1. Background ..... 1

2. Objectives ..... 1

3. The Mission Members ..... 1

4. The Mission Schedule ..... 2

5. Executive Summary ..... 2

6. Findings ..... 5

7. Recommendations ..... 14

8. Persons met by the mission ..... 16

Annex: Situation Analysis on Aids in the Philippines ..... 19

1. Background

Since its detection in early '80s, AIDS has been penetrating steadly into Aisian countries, and assistance to fight against this deadly disease is considered one of the areas where further and coordinated assistance approach by bilateral and multilateral donors are required due to their profound implications on social and economic development in global terms. In this context, the Japanese government fielded a fact-finding study team to collect and analyze the latest information and data with regard to the HIV/AIDS situation in the Republic of the Philippines.

2. Objectives

The objective of the study is to contribute to the Philippines government's effort to prevent and control HIV/AIDS and further contribute to serve the neighboring developing countries through the cooperation with the Philippines government. The team, based on its findings will prepare recommendations to enable the Japanese government to finalize its assistance to the Philippines.

3. The Mission Members

| | |
|---|---|
| 1) Dr. Akira OYA, | President, Biomedical Science Association Emeritus member, National Institute of Health |
| 2) Ms. Namiko YOSHIHARA, | Chief, AIDS Research Center, National Institute of Health |
| 3) Dr. Ichiro TOMIZAWA, | Deputy Director, AIDS, TB and Infectious Disease Div., Ministry of Health and Welfare |
| 4) Mr. Hideyuki ONISHI, | Staff, Technical Cooperation Div., Ministry of Foreign Affairs |
| 5) Mr. T. KAMIGATAKUCHI, | Technical Advisor, Medical Cooperation Dept., Japan International Cooperation Agency (JICA) |
| 6) Ms. Sonoko IWAMOTO, | Staff, Training Affairs Dept., JICA |

4. The Mission's Schedule

| Date | Program |
|---|---|
| 3/16(wed) | arrival in Manila |
| | briefing by the Japanese embassy staff & local consultants |
| 3/17(thu) | briefing by JICA, Manila; visits to AIDS Program manager, Dept.of Health, BRL & San Lazaro hospital |
| 3/18(fri) | courtesy call to USAID and briefing by its AIDS program personnel, visits to NGOs;ReachOut & Remedious |
| 3/19(sat) | visits to Jose B. Lingad Memorial Regional Hospital |
| 3/20(sun) | data analysis et. |
| 3/21(mon) | visits to RITM and Field Epidemiological Training Program,DOH |
| 3/22(tue) | visits to National Red Cross, Holy Redeemer Blood Bank & WHO/WPRO |
| 3/23(wed) | visits to NEDA & AIDS Program Manager,DOH |
| | courtesy call to Secretary of Health |
| 3/24(thu) | departure for Narita |

5. Executive Summary

The fact-finding mission stayed in the Philippines for a duration of 8-day, visiting the Department of Health(DOH) and other institutions and facilities that concern HIV/AIDS prevention and control program. After analyzing the collected data and information, the mission came to the following conclusion.

The DOH reported in January 1994 that there has been a total of 475 registrations, comprising 125 AIDS cases and 350 asymptomatic HIV infections since the first 2 cases were identified in 1984. However, DOH estimates that there may be approximately 5,000 to 50,000 infections in the country, because an officially announced figure may be a tip of icebergs in consideration of the difficulties to correctly surveying the prevalence due to the nature of the disease. The National Red Cross of the Philippines reported that, according to its survey it found 27 HIV positives among 100,000 blood units. This figure is 60 times that of Japan(0.45/100,000) and 3.6% of

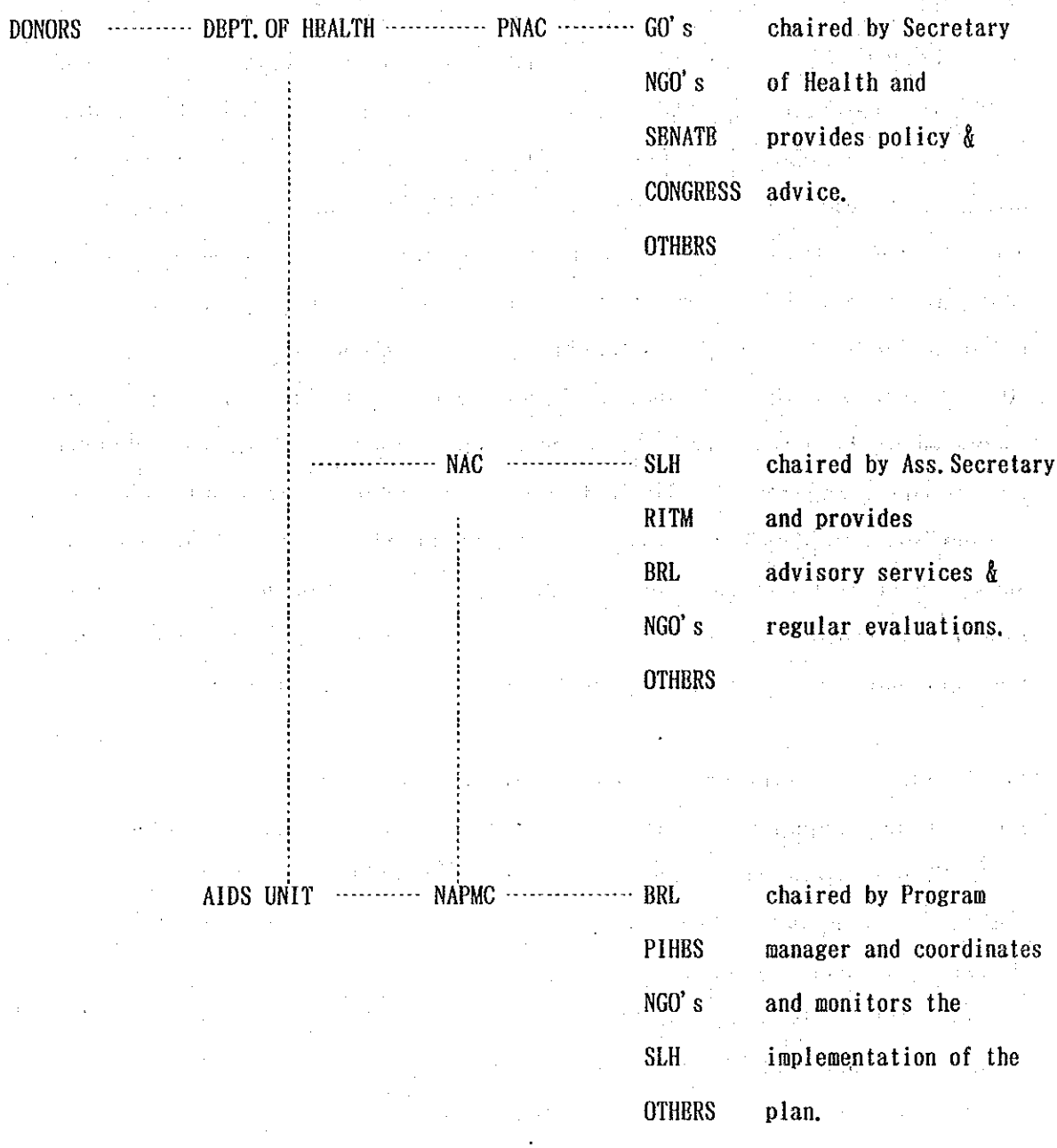
Thailand(760/100, 000). This fact implies that the AIDS prevalence in the Philippines is relatively low among Asian countries.

However, DOH is not optimistic about AIDS because it is a clear fact that critical factors that can spread the epidemic to the greater extent exists in the country, namely due to the poverty and insufficient blood screening system for the transfusion. In the Philippines, the commercial blood banks supply approximately 75% and the Nationl Red Cross and government hospitals supplements remaining 25% of the total supply for the transfusion. The Bureau of Research and Laboratory (BRL) under the DOH regulates that the entire transfusion must be screened for HIV, Malaria, Syphilis, and Hepatitis B, however, the screening could not have been conducted to the entire blood, due to insufficient resources. Recently conducted un-announced inspection by the DOH immediately before transfusion revealed that HIV positive was identified at the rate of approximately one out of 300. As a dangerous factor for the transmission, prostitution does exists in the country and the rate of HIV positives for drug abusers is low, however, it is a worrisome fact that the people have reluctance in using condom due mainly to the religious cause.

In the course of the investigation, the team exchanged views and opinions with USAID regarding how Japan can contribute to the AIDS prevention and control program in the Philippines in coordination with USAID. After the exchange it preliminary indicated to coordinate with USAID to assist the Philippines in the areas of 1) strengthening the epidemiological surveillance system for HIV; and 2) assistance to NGOs to promote their IEC activities. With reference to the Third Country Training Program being conducted jointly by the Philippines government and JICA at RITM, USAID may participate by ways of sending a lecturer or other means.

Based upon the above-mentioned findings, the mission at this moment considers it appropriate to assist the Philippines in 1) establishement of the HIV surveillance network through enhanced laboratory diagnosis capability; 2) strengthening the training capability for AIDS program personnel; and 3) strengthening the IEC activities for AIDS.

## ORGANIZATIONAL STRUCTURE



6. Findings

6 - 1 Epidemiological situation of HIV/AIDS in the Philippines

(1) HIV/AIDS prevalence as of January '94 as reported by DOH as follows:

| | asymptomatic HIV | AIDS | | | unclassified | total |
|---|---|---|---|---|---|---|
| | | alive | dead | s.total | | |
| 84 | 0 | 0 | 2 | 2 | | 2 |
| 85 | 6 | 0 | 4 | 4 | | 10 |
| 86 | 21 | 1 | 7 | 8 | | 29 |
| 87 | 26 | 4 | 8 | 12 | | 38 |
| 88 | 21 | 4 | 10 | 14 | | 35 |
| 89 | 32 | 2 | 5 | 7 | | 39 |
| 90 | 52 | 2 | 14 | 16 | | 68 |
| 91 | 66 | 4 | 9 | 13 | | 79 |
| 92 | 52 | 8 | 9 | 17 | | 69 |
| 93 | 61 | 23 | 8 | 31 | 8 | 100 |
| 94 | 5 | 0 | 1 | 1 | | 6 |
| total | 342 | 48 | 77 | 125 | 8 | 475 |

(2) Based on the above-mentioned figures it is assumed that there are approximately 5,000-50,000 HIV infections and AIDS cases in the Philippines. The available data from DOH is based on the AIDS registry in DOH(reporting from hospitals and laboratories) and result of the surveys conducted by DOH covering high risk groups such as commercial sex workers. Therefore the above estimation may be rather conservative. To derive estimation of a total infected, it is assumed that the rate of HIV infection for the high risk group is 0.1% and the same prevalence may be applicable to the entire population of 75 million, which comes to 75,000. It may be also noted that approximately 10 to 100 fold of the reported number of infections may exist according to the World Health Organization/Global Program on AIDS.

(3) There is also similar HIV/AIDS prevalence in Japan so that it is considered imperative to prevent and control HIV/AIDS by strengthening the surveillance activities and IEC activities as like the Japanese government's policy to facilitate the same activities. The low HIV/AIDS prevalence in the Philippines when compared to that of the Kingdom of Thailand may be due to its less prevalence of injecting drug abuse and infections through commercial sex workers.

6 − 2 AIDS Prevention and Control Program in the Philippines

(1) The National AIDS Prevention & control Committee(NAPCC) was established under the Office of the Undersecretary for Public Health, Department of Health (DOH) in 1987 after the first two(2) cases of AIDS were reported to and necessity to take measures were recognized.

(2) The DOH executive committee approved the National Medium−term Plan for the Prevention and Control of AIDS in the Philippines('89−'93), and officially launched the plan in August the same year. Simultaneously, NAPCC was replaced with National Advisory Committee(NAC), chaired by Assistant Secretary for Special Concerns. Also a National AIDS Program Management Committee (NPMC) was created under the Office of the Assistant secretary to implement the plan. The Program Manager chairs the NAPMC.

(3) The Philippines National AIDS Council(PNAC) was created in 1992 by President Ramos through an Executive order to give policy advice to the plan. PNAC is a multisectoral response by the government to the plan. It is chaired by Secretary of Health and composed of designated members from the public sector, private sector and NGOs.

6 − 3 AIDS Policy

(1) In September 1998, 12 policy statements were ratified by the National Advisory Committee for AIDS Control and Prevention and approved by Health secretary in January 1989. The following policy statements have been the terms of reference

for all AIDS activities in the country.

1) Prevention and control of HIV infection/AIDS shall be the priority of the National AIDS Control Program.
2) AIDS education shall be integrated in existing school curricula of elementary school, 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 a 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 who were already found positive, under the existing law. Persons who engage in high risk behavior shall be encouraged to undergo a voluntary testing. Pre-testing informed consent shall be required and post-testing counselling shall be made available.
7) Information on the testing, counselling and care of individuals shall be made 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 guided for appropriate counselling and care. As a matter of public policy, no person shall be subject to quarantine or isolation.
10) Health and social assistance for living shall be provided to the infected and sick individuals by government and non-governmental organizations.
11) Tourists shall not be required to undergo a testing for HIV infection unless there is symptom to suggest for the testing.
12) Visa applicants who in the past undergone the testing shall not be required to disclose the results of such tests upon visa applications. (This clause has not been enforced since 1993.)

(2) The Department of Health in order to implement the above-mentioned policies

emphasizes on the IEC activities and AIDS education in school curricula, and strengthening surveillance activities and establishment of the AIDS testing structure.

6 − 4 Surveillance

(1) The Field Epidemiological Training Center(FETC) under the office of Assistant Secretary for Public Health Services undertakes the registration of HIV infcted and data collection and analysis as a national surveillance center. The blood screening activities have been conducted at private and public blood banks, regional health laboratories in 15 health regions, voluntary HIV testings at STD clinics and NGOs, individual testings for transfusion. Also high−risk group such as sex workers, overseas contract workers and homosexuals are subject to the surveillance. The data are collected at regional level and reported to DOH or individual laboratory may report directly. Currentiy, DOH is strengthening the national surveillance network in cooperation with USAID and WHO.

(2) HIV Testing capability

Currently, the following institutions can provide the testings:

−Research Institute for Tropical Medicine

−Bureau of Research and laboratory

−Regional Health Laboratories

−9 social hygiene clinics

and 42 private laboratories.

6 − 5 AIDS Research Activity

AIDS Research and Training Activities at the Research Institute for Tropical Medicine(RITM)

As a nationl health reference center, RITM's AIDS research activities started in 1985 and the Third Country Training Program and In−country Training Program also started in 1988. The achievements and findings by the mission are as follows:

(1) Surveillance

1) conducted from 1985 to 1992 in mainly Metro-Manila for male and female commercial sex workers;
2) conducted for the overseas contract workers in 1989;
3) conducted for blood donors in 1990;
4) conducted for pregnant women in 1991.

According to the results of the above-mentioned activities, HIV infection were found at the rate of one per one thousand for overseas contract workers and commercial sex workers, however, no HIV positives were found among other groups.

(2) Clinical management and care of HIV infected and AIDS cases

The result of the above since 1986 indicated that tuberculosis is the most common and serious AIDS complications in the Philippines. At the time of the mission's visit, no AIDS patient was admitted at the institute. We noted that an AIDS ward in the institute was rather limited facilitywise.

(3) Laboratory

RITM conducts following activities:

1) confirmatory testing for private laboratories and blood banks;
2) evaluation of HIV test kits;
3) workshop for private laboratory and blood bank technicians;
4) development of economical HIV test methods(pooling of serums);
5) studies to determine cost-effctiveness of filter paper collected bloods for HIV testing.

remark:Serum sampling method is approved by WHO.

(4) Education activities

RITM conducts following activities:

1) lectures in and outside the country approximately 200 times a year;
2) AIDS/STD education for male and female commercial sex workers in Metro-Manila;
3) health education for paramedicals in Metro-Manila;
4) AIDS education for high school students;

5) health education for overseas contract workers;

6) a 2–5 days education course for doctors, nurses, social workers and counsellers.

(5) As part of the Third Country Training Program RITM conducts an HIV virus testing course together with Acute Respiratory Infection and Diarrhea Disease for one week. It was noted that some of the participants did not engage in AIDS related activities, thus a request was made to separate the HIV course and strengthen the course by incorporating a PCR method in addition to the presently provided HIV antibody test. The PCR testing facility is desirable here not only for the training but also for the early diagnosis of vertical transmission of HIV. It is also useful for a routine HIV infection diagnosis.

## 6 – 6 AIDS Prevention and Control Measures at Blood Banking Operation

(1) Current situation

In the Philippines there are two sources of blood, one is voluntary blood banking operation run by the Nationl Red Cross and government hospitals and the other is commercially run blood banking businesses, which accounts for approximately 75–80% of the total supply. Basically testings for HBs antibody, malaria, syphilis and HIV are needed to be carried out, however, the Red Cross strategically selects 17 blood centers out of a total of 44 centers where the supply is bigger and conducts the testings, due to the shortage of resources. The testing is said to cover approximately 50% of the total supply from the Red Cross. Blood bags carry a label that indicates whether the HIV testing was carried out. The HIV testing is mandatory for the private blood banks. One of the banks where the team visited in Metro-Manila opted for the PA method of HIV screening. The kit itself costs at least 65 Pesos and together with other consumables such as blood bags and syringes, the total may amount substantially. At the private banks, donors sell the blood of 500cc at 150 Pesos, then it is sold to hospitals at 400 Pesos, and a hospital charges it to the patient at 1,500 Pesos. It was also said that HBs positive was found among those tested by the Red Cross when re-screened.

(2) Rete of HIV Positives

The rate of HIV positive is 27 out of 100, 000 for the National Red Cross and 6 out of 100, 000 for the private blood banks.

(3) Measures to be considered

1) conduct HIV screening for the entire blood at the all Red Cross and government hospital operated blood centers. To enable this the followings may be taken into consideration:

-supply of test kits;

-training for the screening technique(PA method);

For the supply of test kits RITM may consider a cost-effective method such as pooling of serum. The center already conducts the HBs antibody test therefore a short term training may suffice for the PA method.

2) increase the rate of voluntary blood donation

The Public consciousness toward the blood donation must be improved. In this regard, the promotion of mobile bleeding operation can be effective, and other public relations activities likewise.

3) strict enforcement of blood screening at the private blood banks

It is doubtful whether the screening is strictly enforced since the screening rate is low and HBs antibody being found after the re-test.

4) strengthening BRL

BRL is mandated to conduct training programs for licensing laboratory technicians regarding HIV testings, however, its may require assiatance to conduct such a program at a desired scale to equip a greater number of regional laboratories and others. In view of the necessity to strengthen the National HIV surveillance system, the strengthening of BRL also is a priority for success of the entire program.

6 - 7 AIDS Surveyllance and Education Project

The above-mentioned project has been operative since 1993 with inputs of US$2. 1 million in the surveillance field and US$4. 2 million in the education field and expected to continue until 1997, with the objectives to assist the Philippines government to establish an HIV surveillance network to enable it to correctly monitor the HIV/AIDS

prevallence and to reflect the findings in the prevention and control measures. The first field is implemented through WHO/WPRO, with Field Epidemiological Training Program as government implementing agency. It intends to establish a network of 30 social hygiene clinics for the surveillance, selected from a total of 130 clinics nationwide. The surveillance activities cover high risk groups including commercial sex workers, men who have sex with men, STD patients and overseas contract workers and monitor the spread to general population. The latter field is implemented through a U.S. NGO PATH. Currently approximately 20 local NGOs submitted proposals for the assistance that provides for the operational expeces,et..

The team exchanged views with USAID and considersed it possible to coordinate Japais assietance with the above-mentioned program. For example, Japan can assist the surveillance field through strengthening of laboratory diagnosis capability and also provision of equiment to complement the NGO's IEC activities.

6 - 8 WHO Assistance

World Health Organization has been assisting the Philippines government in the areas of policy making, program management, human resources development, and IEC activities regarding AIDS prevention and control program. From its resources $300,000 was allocated for the AIDS program in 1994 and it advised the government to spend at least 15% of the amount for the support of NGO's IEC activities and assigned a program management expert to DOH. It also implements the surveillance field of the above-mentioned ASEP. Furthermore, it considers STD clinics an alternetive point of the HIV surveillance.

6 - 9 NGO participation in the AIDS programs

NGOs have been quite active in the area of Information, Education and Communication activities for AIDS programs. It was found that the first NGO AIDS activities started in 1988, expanding ever since and an NGO network was formed dy 30 members in 1993 to exchange information and improve their activities. Recognizing the effectiveness of their operations, DOH enabled NGOs to direct recipient of foreign aids in the IEC area while DOH tries to provide necessary coordinations concerned. Regarding the involvement of NGOs, five representatives hold seat in the country's top policy

making body for AIDS matters, the Philippines National Aids Council(PNAC). The team visited a few NGOs and noted their grass root activities to disseminate correct AIDS related information, AIDS hot line, councelling set ups, library, etc.. According to one of the NOGs, it heavily relies on external financial support, although effort was being made to source locally, to undertake its operations. Most of the donors are supportive of their IEC activities, however available assistance may not seem to cover for the equipment and facillity.

## 7. Recommendations

The prevalence of AIDS and HIV infection in the Philippines is relatively low among Asian countries, with 125 AIDS cases and 350 HIV infections registered so far. Under the epidemiological situation, it is important to implement an effective prevention and control program which addresses the country's potential risk factors.

In this regard, the following three measures are to be taken as the peiority:

(1) Strengthening of surveillance of HIV infections through laboratory diagnosis network and blood screening.

(2) Training of health personnel to implement the program.

(3) Promotion of education activities on AIDS.

The Japanese assistance to the AIDS Control in the Philippines should follow the same strategies as above, which may include the following projects.

(1) Provision of HIV test kits for;

1) promotion of voluntary blood donation through 100% blood screening and safety assurance for voluntarily donated blood, and

2) effective public health laboratory services to establish surveillance network.

As for the screening of voluntarily donated blood, it is necessary to make arrangement between DOH and the Red Cross so that provided test kits can be used at the Cross blood centers.

The roles and functions of public health laboratories at different levels must be well defined in the AIDS control program, and targets be clearly set dy DOH.

(2) Provision of Equipment for AIDS research activities in the Research Institute for Tropical Medicine.

In the discussion between the team and RITM members request was made for the equipment for PCR and Fluocytometry

(3) Manpower training in laboratory diagnosis and related technologies.

As for the training of the Filipino personnel, the cooperation and coordination of the Bureau of Research and Laboratory and RITM is desirable, as the former is responsible for public sector training and the latter for private sector training.

In addition to the domestic training, the "third country training program on AIDS" may be jointly offered by RITM and JICA to the neighboring countries in Asia and the Pacific, so the human resources and provided equipment can be utilized for training of researchers and health personnel in those countries.

(4) Provision of Equipment for AIDS Education

There are numbers of non-govenmental organization active in AIDS education directed to the general public and various target groups. Measures to support these NGOs by providing with such equipment as personal computers, overhead projectors and video tape recorders will enhance their effectiveness in raising public awareness and knowledge about AIDS.

The small-scale grant aid program administered by the Foreign Ministry through the Japanese embassy in the Philippines may be utilized for supporting NGOs.

Such Programs as above mentioned are to be implemented in the possible cooperation with the United States Agency for International Development (USAID), especially in the area of AIDS surveillance and Education Project.

For coordinated planning and smooth implementation of the project, it is necessary for JICA to dispatch a project formulation team which will work out the detailed plan with the counterparts in DOH and USAID.

8. Persons met with the team

| | | |
|---|---|---|
| DOH | Dr. Juan M. Flavier, | Secretary of Health |
| | Dr. Linda L. Milan, | Assistant Secretary, External Relations |
| | Dr. Manuel M. Dayrit, | Assistant Secretary, Field Epidemiology Training Program |
| | Dr. Mark E. White, | Coordinator |
| | Dr. Dennis Maducdoc, | Program Manager, National AIDS Prevention & Control Program |
| | Dr. Ma. Elena F. Borroneo, | Medical Specialist-STD/AIDS |
| | Dr. Rineveth Bernal, | MSII-STD/AIDS |
| Bureau of Research & Laboratory(BRL) | | |
| | Dr. Marietta D. Baccay, | Director, IV |
| | Dr. Nenita S. Canafrauch | |
| San Lazaro Hospital | | |
| | Dr. Virgilio Gonzales, | Medical Officer, Chief III |
| | Dr. Edna Santiago, | Medical Specialist III |
| Research Institute for Tropical Medicine (RITM) | | |
| | Dr. Remigio M. Olveda, | Director |
| | Dr. Mary Ann Lansang, | Assistant Director |
| | Dr. Noel L. J. Miranda, | OIC, Research & Training Div. |
| | Ms. Ester M. Ramono, | OIC, Chief Nurse, Administration Div. |
| | Dr. Celia C. Carlos, | OIC, Microbiology Dept. |
| | Dr. Mari Rose Aplasca, | OIC, AIDS Research Group |
| | Dr. Fem Julia E. Paladin, | Head, Virology Section, (National Research Center for HIV Testing) |
| Jose B. Lingad Memorial Regional Hospital, San Fernando, Pampanga | | |
| | Dr. Carlota B. Manzano, | regional Pathologist, Region 3 |
| National Economic Develpment Authority (NEDA) | | |
| | Mr. Eugenio B. Inocentes, III | Assistant Director, Public Investment Staff |
| | Ms. Ailene S. Ruiz, | Chief, Health Nutrition Facility Planning Div., Social Development Staff |
| Phillipine National Red Cross | | |
| | Dr. Elepoldo P. Magpusao, | Physician In-charge, National Blood Center |
| | Dr. Cecilia Francisco, | OIC, National Blood Program |
| Holy Redeemer Blood Bank | | |
| | Dr. Jesus M. Garcia | |
| | Mrs. Ellen P. Garcia | |
| USAID | Mr. Thomas W. Stukel, | Director |
| | Mr. Richard Johnson, | Deputy Director |

| | | |
|---|---|---|
| | Dr. Emmanuel Voulgappoulos, | Chief, Office of Population, Health and Nutrition |
| | Dr. Corazon R. Manaloto, | Public Health Advisor |
| | Ms. Patricia A. Moser, | AIDS Surveillance & Education Project |
| | Dr. Asuncion A. Paraan, | Consultant/BRL-Regional Health XI |
| | Ms. Cameron Pippitt, | Project Development Officer |
| PATH | Ms. Leona D'Agnes, | Country Director |
| | Ms. Carmina Aquino, | Consultant |
| World Health Organization | | |
| | Dr. Rabin M. Sarda, | Medecal Officer |
| | Mrs. Lorraine Kerse, | Nurse Educator, Global Program on AIDS |
| | Dr. T. Ito | Medical Officer, Special Technology Transfer |
| | Dr. N. Omi | Regional Advisor, BPI |
| Reach Out | | |
| | Mr. Jomar Fleras, | Managing Director |
| | Dr. Joan Castro | |
| Remedious AIDS Foundation | | |
| | Ms. Pia Arboleda, | Bxecutive Director |
| | Ms. Marianna S. Balquiuedra, | Associate Director |
| The Phillipine Population Association, Inc. | | |
| | Ms. Florina Iteto-Dumlao, | Consultant |
| Embassy of Japan, Manila | | |
| | Mr. Hisato Murayama | Minister |
| | Mr. Kazuo Sunaga | First Secretary |
| | Dr. Etsuro Kashiwagi | First Secretary |
| | Dr. Norihiko Yoda | Second Secretary |
| JICA Philippines Office | | |
| | Mr. Akihiko Hashimoto | Resident Representative |
| | Mr. Yoshifumi Kohara | Assistant Resident Representative |
| | Mr. Biji Iwasaki | Assistant Resident Representative |

# SITUATIONAL ANALYSIS ON AIDS IN THE PHILIPPINES

**Prepared by : The Philippine Population Association, Inc. (PPA)**
**For : The Japan International Cooperating Agency (JICA)**
**1 February - 30 March 1994**

CONTENTS i

FOREWORD iii

LISTS OF ABBREVIATIONS iv

COUNTRY PROFILE vi

MAP OF THE PHILIPPINES x

AIDS IN THE PHILIPPINES : A SITUATION ANALYSIS 1

I - EPIDEMIOLOGY 2

KABP STUDIES 5

1. The General Population
2. Young Adults
3. Men Who Have Sex With Men
4. Overseas Contract Workers
5. Commercial Sex Workers

II - GOVERNMENT PROGRAM ON AIDS 42

1. Overview
2. Programs, Projects and Activities
3. Budget and Funding Sources

III - NON-GOVERNMENT ORGANIZATIONS: Activities on AIDS 62

1. Information, Communication, Health Education and Advocacy
2. Networking and Coordination
3. Training
4. Services and Facilities
5. Research and Development
6. Discussion

IV - INTERNATIONAL FUNDING/ASSISTANCE/SUPPORT FOR AIDS ACTIVITIES 80

1. Main Agencies Involved
2. Anecdotal Information on Other Sources of Support
3. Funds Disbursement
4. Discussion

V - EVALUATION OF THE NAPCP 86

PROGRAM REVIEW 86

1. Surveillance/Data Collection
2. Diagnostic Facilities/Laboratory Strengthening
3. Strengthening of the STD Program
4. Treatment, Care and Support for HIV-Infected Persons
5. Information, Education and Training
6. Program Management

INTERVIEWS 96

TABLES

Table 1 : Reported HIV Seropositives by Year of Diagnosis AIDS /HIV Registry 1984 - February 1994

Table 2 : HIV Seropositives by Gender for AIDS Group AIDS /HIV Registry 1984 - February 1994

Table 3 : Reported Modes of Transmission of HIV/AIDS Cases, AIDS/HIV Registry 1984 - February 1994

FIGURES

Figure 1 : Organizational Structure of the NAPCP

Figure 2 : Profile of Non-Governmental Organizations

FOOTNOTES

REFERENCES

## FOREWORD

This study was undertaken upon the request of the Japan International Cooperating Agency (JICA) to serve as a background material for determining future development assistance for the National AIDS Program in the Philippines. The general objective of the study was to prepare a state-of-the-art on AIDS situation in the Philippines. More specifically, the study aimed to: (1) provide information on the epidemiology of AIDS in the Philippines, with special attention to at-risk groups; (2) describe the national policy, programs and projects of the Philippine Government on AIDS and the nature and extent of support provided by non-government organizations; (3) identify the sources of support and assistance for the national AIDS program and the type and scope of coverage of these assistance; and (4) identify gaps in programs and projects for AIDS in the country.

This situationer was undertaken from 1 February - 30 March 1994 by the PPA-HRN National Secretariat headed by Ms. Ma. Florina Ileto-Dumlao. Also hired specifically for this project was Ms. Perla Aragon-Choudhury, a freelance feature and technical writer. A Technical Working Group provided direction and technical assistance. The Technical Working Group consisted of Dr. Dennis Maducdoc, Programme Manager of the National AIDS Prevention and Control Program (NAPCP), Dr. Corazon Raymundo, Director of the U.P. Population Institute (UPPI) and current President of the Philippine Population Association (PPA) and Professor Eliseo de Guzman, also of the UPPI.

Data sources for this study were basically from published and unpublished studies, reports,records and other publications provided by various agencies. These were supplemented by interviews of selected key personnel of government and non-government institutions and donor agencies.

The Philipine Population Association, Inc. is grateful for the cooperation and assistance provided by the personnel of the Department of Health and other government institutions, the non-governmnent organizations and the key-staff of the donor agencies.

## LIST OF ABBREVIATIONS

| | | |
|---|---|---|
| AFAO | - | Australian Federation of AIDS Organization |
| AIDAB | - | Australian International Development Assistance Bureau |
| AIDS | - | Acquired Immunodeficiency Syndrome |
| ARC | - | AIDS-Related Complex |
| ARO | - | Asia Research Organization |
| ASEP | - | AIDS Surveillance and Education Project |
| BRL | - | Bureau of Research and Laboratories |
| CDCS | - | Communicable Disease Control Service |
| CSWs | - | Commercial Sex Workers |
| DBM | - | Department of Budget and Management |
| DECS | - | Department of Education, Culture and Sports |
| DFA | - | Department of Foreign Affairs |
| DILG | - | Department of Interior and Local Governments |
| DKT | - | DKT International (Philippine Social Marketing Program) |
| DOH | - | Department of Health |
| DOJ | - | Department of Justice |
| DOT | - | Department of Tourism |
| DSWD | - | Department of Social Welfare and Development |
| FAD | - | Foundation for Adolescent Development |
| FETP | - | Field Epidemiology Training Program |
| FGDs | - | Focus Group Discussions |
| FPOP | - | Family Planning Organization of the Philippines |
| GOP | - | Government of the Philippines |
| GPA | - | Global Programme on AIDS |
| HAIN | - | Health Action Information Network |
| HACT | - | HIV/AIDS Core Team |
| HIS | - | Health Intelligence Service |
| HIV | - | Human Immunodeficiency Virus |
| HMDTS | - | Health Manpower Development and Training Services |
| HOMS | - | Hospital Operations and Management Services |
| ICASO | - | International Council of AIDS Service Organization |
| IEC | - | Information Education Communication |
| IMCH | - | Institute for Maternal and Child Health |
| ISSA | - | Institute for Social Studies and Action |
| IVDU | - | Intravenous Drug Use |
| KABP | - | Knowledge, Attitudes, Behavior and Practices |
| KAP | - | Knowldege, Attitudes and Practices |
| MLC | - | Marching for Life Coalition |
| MSM | - | Men who have Sex with Men |
| NAPCP | - | National AIDS Prevention and Control Programme |

| | | |
|---|---|---|
| NCR | - | National Capital Region |
| NEDA | - | National Economic and Development Authority |
| NGO | - | Non-Government Organization |
| NTMRF | - | New Tropical Medicine Research Foundation |
| OCWs | - | Overseas Contract Workers |
| PAWID | - | Pasay City AIDSWatch and Information Drive |
| PCF | - | Philippine Center Foundation |
| PCPD | - | Philippine Center for Population and Development |
| PHIV | - | Person Living with AIDS |
| PhP | - | Philippine Peso |
| PHOs | - | Provincial Health Offices |
| PIHES | - | Public Information and Health Education Service |
| PNAC | - | Philippine National AIDS Council |
| PLCPD | - | Philippine Legislators Committee for Population and Development Foundation, Inc. |
| PNGOC | - | Philippine NGO Council on Population, Health and Welfare |
| PSPI | - | Population Services Pilipinas, Inc. |
| PWA | - | Person with AIDS |
| RAIC | - | Remedios AIDS Information Center |
| REACHOUT | - | ReachOut AIDS Education Foundation |
| RHO | - | Regional Health Office |
| RHU | - | Regional Health Unit |
| RITM | - | Research Institute for Tropical Medicine |
| SHCs | - | Social Hygiene Clinics |
| SLH | - | San Lazaro Hospital |
| STDs | - | Sexually Transmitted Diseases |
| TRENDS | - | Total Research Needs |
| TWG | - | Technical Working Group |
| TW-MAE-W | - | Third World Movement Against Exploitation of Women |
| UNICEF | - | United Nations International Children's Fund |
| UPCMC | - | University of the Philippines College of Mass Communication |
| UPCPH | - | University of the Philippines College of Public Health |
| USAID | - | United States Agency for International Development |
| USNAMRU 2 | - | United States Naval Research Unit 2 |
| WHO | - | World Health Organization |
| WHO-GPA | - | World Health Organization Global Programme on AIDS |
| WomanHealth | - | WomanHealth Philippines, Inc. |
| WPRO | - | Western Pacifi : Regional Office |

## COUNTRY PROFILE

### 1. Geographical highlights

Located north of the equator, the Republic of the Philippines is a developing country with a culturally diverse population.[1] About 85 % of Filipinos are Christians, almost 10%, Muslims and the rest, animists. Throughout the 7,100 islands, 87 dialects are spoken; Filipino is the national language and English is widely spoken.

The Philippines has three main islands spread out over 300 square kilometers: Luzon in the north, which holds 54.9% of the total population estimated to be 62 million in mid-1990; Mindanao in the south which has 23.6%; and the Visayas between the two, 21.5%.[2]

The Philippines has a tropical climate with a mild temperature, abundant rainfall and three pronounced seasons - wet or rainy, cool and dry, and hot and dry.

With the Quezon City as the capital, the country is divided into 15 regions, 76 provinces, 60 cities, 1,544 municipalities or towns and 41, 907 villages called **barangays**.[3]

### 2. Population [4]

As of May 1, 1990 the Philippines had a population of 60,685,000 compared to 48, 098,000 ten years earlier. The 1980- 1990 growth rate of 2.3% would double the population size in 30 years.

In 1990 the Philippines had a total number of 11,403,000 households with a mean size of 5.3 persons. There were 202 persons per square kilometer of land; in particular, the range for population density was 12,467 persons per square kilometer for Metro Manila and 63 for the Cordillera Administrative Region in the north.

The median age was around 21 years in 1990. Metro Manila had the oldest population at a median age of 24.5 years; Bicol had the youngest, 18.8 years.

### 3. Economic situation

The main sources of income of Filipinos are agriculture, fishing, mining, logging and small- and medium- scale industries.[5]

The Philippines was in an economic crisis in the 1970s but slowly recovered starting 1987. In the first half of 1993 the real gross national income grew by 1.8%, compared to 1% the year before, but this gain is constrained by a continuing power crisis, natural calamities like volcanic eruptions, armed insurgency and a work force that has an underemployment rate of 22% and an unemployment rate of 11%. [6]

Other factors hampering development are cited by the **Medium-Term Population and Development Plan (1993-1998):** rapid population growth, the balance of payment crisis due to inadequate foreign exchange earnings, heavy importation of inputs, poor foreign investments and huge debt payments. [7]

In 1980 the real per capita income was PhP 12, 595 but this declined to PhP 11, 619 in 1990. The absolute number of poor families continued to grow even if poverty incidence declined from 49.3% in 1985 to 46.5% in 1991.[8] Of the poor families that year, more than 45% had children under 18 and nearly half had less than seven years old. [9] Another way of interpreting this particular piece of data is the dependency ratio per 100 persons in the working ages of 15-64 years. In 1990 the dependency ratio was 70, meaning nearly three people were relying for sustenance on four persons that year.[10]

## 4. The Situation of Women

As the cost of living rises because of the decreasing real value of the peso, women tend to be economically active. But on the average, women in the Philippines have a lower participation rate in the labor force than men at 50% against 80%.[11]

In 1992 the total number of employed men (14.2 million, according to the National Statistics Office), exceeded that of women (8.3 million) by one-third despite the bigger number of women college graduates in all the age groups.

Women were also earning less than men whose average income was about double the females' except in professional and clerical work.

Another set of statistics in 1990 confirms what has come to be known as the feminization of poverty. Women have to work for a living and to support dependents even without legal protection or job security.

More than half of all women workers were married in 1990. About half of all working women were unpaid family workers. The proportion of self-employed women grew from 23% in 1976 to 30% in 1990. They formed 49% of the number of agricultural workers but were being pushed by low economic returns to migrate to cities where they formed 39.7% of the work force.[12]

Some attempted to work abroad but 45% fell victims of illegal recruitment in 1990 and 57% of illegal labor recruiters were women who perhaps were forced to earn a living this way.

In October 1991, of the estimated 752,700 Filipino overseas workers, 40.6% were women. These women formed 75% of the 275,000 service workers as helpers and housekeepers in Hong Kong and Singapore. Of choreographers or dancers working abroad, 90.5% were women; of the nurses abroad, 84.7% were women.[13]

Filipino women seem to be earning less than their male counterparts; contribute invisibly to the production of goods and services; set up their own livelihood in the buy-and-sell business or as street vendors; or work abroad in the services sector. In the government service they are outnumbered by men who comprised 52% of the 1.26 million government employees in 1990.[14]

A 1993 program review by the United Nations Population Fund noted that most Filipinos consider the status of women as a non-issue since they are highly visible in Philippine society. But this visibility has its dark side. Women are shown by the media in unflattering ways: as housewives, domestics and sex objects. Only recently have wife beating, sexual abuse and other forms of sexual violence against women emerged as issues. The wife may hold the purse strings but she gets no acknowledgement for making both ends meet, particularly when the income to be administered is meager from the start.[15]

### 5. Health Situation

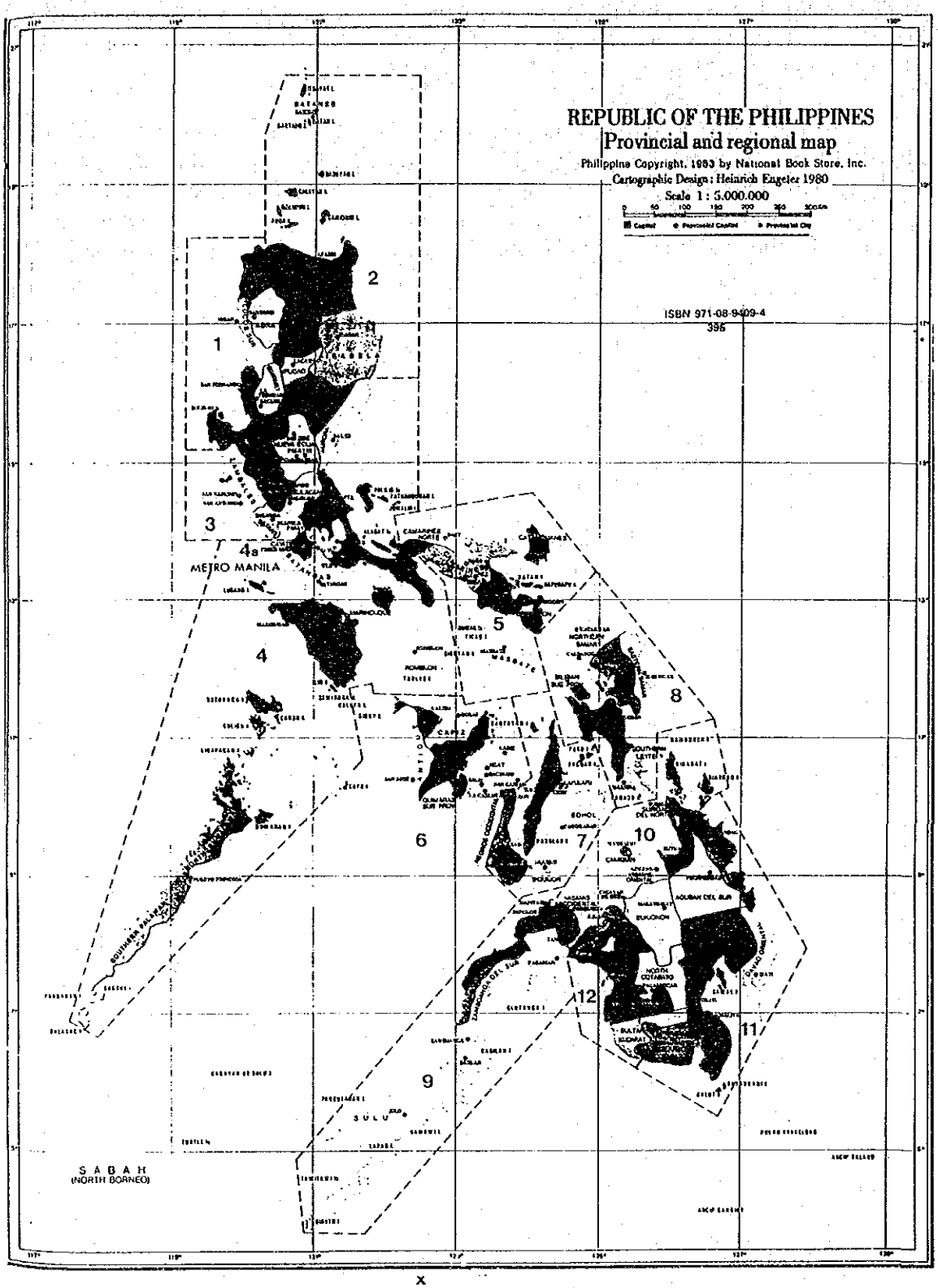
In terms of morbidity, women die most often from pneumonia and the record for the period 1980-1989 was 3 out of 20 deceased females.[16]

Since 1989 the leading cause of maternal death during childbirth has been postpartum hemorrhage (44% to 31% in 1989). The maternal mortality rate has not greatly improved: 9 deaths per 10,000 live births in 1984, 11 in 1986 and 10 in 1989. Pneumonia was also the most common cause of death among males in 1980 and 1985 but was overtaken by heart disease in 1989. Roughly six out of 10 deceased persons died from the ten leading causes of death that year: pneumonia, heart disease, tuberculosis, malignant neoplasm, vascular disease, diarrheal diseases, accidents, measles, nephrosis and septicemia.

As for infants the leading cause of deaths is also pneumonia, comprising one-fourth of the total from 1980 to 1989. Other leading causes are perinatal and respiratory diseases which have gone up between 1985 and 1989. More males than females die of infancy. The infant mortality rate was estimated to have decreased between 1980 and 1989.

Especially true for pregnant and lactating mothers, women are more vulnerable than men to anemia, an indicator of poor nutritional status. Between 1978 and 1987 the incidence of anemia decreased especially among pregnant and lactating mothers. The proportion of underweight children aged 0-6 also decreased from 17.2% in 1982 to 13.9% in 1989.

Communicable diseases remain a serious concern in the Philippines according to the **Medium-Term Plan on Prevention and Control.** In 1989 the rate of tuberculosis was 6.6 sputum positives per thousand population while malaria and schistosomiasis remained endemic in many parts of the country. While not communicable, the rates for cardiovascular diseases and cancer were also increasing.[17]


REPUBLIC OF THE PHILIPPINES
Provincial and regional map
Philippine Copyright, 1983 by National Book Store, Inc.
Cartographic Design: Heinrich Engeler 1980
Scale 1 : 5.000.000
ISBN 971-08-9409-4
356
METRO MANILA
SABAH
(NORTH BORNEO)
1
2
3
4
4s
5
6
7
8
9
10
11
12

x

# AIDS IN THE PHILIPPINES: A SITUATION ANALYSIS

In 1981 a new syndrome was recognized among homosexual men in the United States - a syndrome that has come to be known universally as Acquired Immunodeficiency Syndrome (AIDS).[1] Two years later its etiological agent had been identified as the human immunodeficiency virus (HIV). By the mid-1980s it was clear that HIV had spread throughout the world as a pandemic. What happens when a person is positive for HIV? His body resistance is impaired because his helper cells, the T-4 cells, get destroyed.[2] Opportunistic infections, those which he can normally repel but which produce serious and often fatal diseases if his immunocompetency is lessened, appear and multiply. These opportunistic malignancies and infections include **P. carinii pneumonia, toxopalsmosis** and **coccidiomycosis.** Other viral infections in AIDS are due to **Herpes simplex, Herpes zoster, papovirus, cytomegalovirus, Eppstein-Barr virus and hepatitis B virus.** As for developing countries, infections due to **salmonella, M.tuberculosis** and other bacteria have been reported.

Among the malignancies reported in AIDS are **non-Hodgkins lymphoma** and **Kaposi's sarcoma.** Some children develop bacteria infections and lymphatic interstitial pneumonitis.

AIDS is also known to cause neurological infections. But that is putting the cart before the horse: it might take years for HIV infection to become frank AIDS.

In any case, some HIV-infected patients develop persistent and generalized lymphadenopathy syndrome while others suffer from fevers, weight loss, diarrhea, thrush and a number of illnesses now classified under the term "AIDS-related complex"(ARC). It has been said that one does not die of AIDS but from the complications caused by the ARC.

## HIV: THE TIP OF THE ICEBERG

Because it may take two years before a person develops the symptoms of full-blown AIDS, cases of AIDS may appear later even if HIV transmission were stopped today. Eventually all HIV-infested persons may develop AIDS.

It was in the late seventies and early eighties that HIV began spreading extensively in certain urban areas of the Americas, Australasia and Western Europe, mainly among homosexual or bisexual men and injecting drug users (IDUs), and in the Caribbean and East and Central Africa among men and women with multiple sex partners.[3]

Now the HIV is in all continents of the world and is estimated to have infected 14 million adults since it became a pandemic in the late eighties. According to World Health Organization (WHO), this figure is the **cumulative HIV incidence,** representing **all** estimated HIV infections since the onset of the pandemic. On the other hand, WHO gives a global figure of 12 million for the estimated HIV **prevalence:** the total number of persons with HIV infection alive at any given moment.

## I. EPIDEMIOLOGY

What are the latest figures of HIV infection and AIDS in the Philippines? As of February 28, 1994 the Field Epidemiology Training Program (FETP) of the Department of Health (DOH) has identified 483 cases: 343 are asymptomatic HIV cases; 128 AIDS and 12 unclassified or those that were reported seropositive but could not be definitely categorized as asymptomatic or symptomatic. For January and February, 1994, there were already 14 cases reported as HIV seropositive. (Table 1) [4]

Of these seropositive cases, 230 were female and 249, male. Among females, 155 were in the age group 15-29 years old, while among males 223 belonged to the age group 30-44 years old. Yet, for both sexes, the largest number of cases is concentrated in the 15-29 age bracket, with a combined total of 223, i.e. 155 females and 68 males. (Table 2)[5]

Two hundred forty-nine of the 483 reported cases (52%) were infected heterosexually. For more than a quarter (132) the modes of transmission are unknown, while 86 cases got infected through homosexual or bisexual means. The other modes reported are mother to infant, 8; blood/blood products, 5; and needles and syringes, 3. (Table 3)[6]

Another FETP document analyzing data for the period 1984-1993 shows that of 467 cases, 220 (47%) were females and 243 (53%) were males.[7] The median age for women was 25 years with a range of 1 month to 72 years. For men, the corresponding figure was 33 years ( with a range of 4 months - 57 years). More women were in the 15-29 years group; in contrast more men were reported to be 30 years and above.

The mode of transmission was sexual intercourse for 327 cases, of which 242 were heterosexual. Of these heterosexual transmissions, 169 cases were below 30 years of age, of which 151 or 82% were women. Most of the females were commercial sex workers or CSWs (74%).

The males who got infected through heterosexual means were older; 42 or 74% were above 30 years of age. Sixteen of those in this age group were overseas contract workers (OCWs).

The figures should be interpreted with caution since the AIDS/HIV Registry has been collecting data on groups said to be at risk for infection and most of the tests have been done on CSWs and OCWs. Nevertheless, it is safe to say that HIV infection has been spreading among persons engaged in unprotected penetrative sex with many partners.

### Defining groups at risk

In 1985 serosurveillance for AIDS started as an activity of the Research Institute for Tropical Medicine (RITM), the Bureau of Research and Laboratories (BRL), and the United States Naval Medical Research Unit - 2 (US NAMRU-2).

Two years later a National AIDS Registry was created at DOH for an official, complete, up-to-date and confidential record of cases. According to reports to the Registry and through serosurveillance by DOH, CSWs, homosexuals, bisexuals and OCWs are considered vulnerable to HIV infection.

The sex industry thrives in the Philippines because of massive poverty and unemployment. It is the main source of income to an estimated 65,000 women. It is a major dollar earner from thousands of foreigners who may knowingly or unknowingly pass on the HIV virus to commercial sex workers.[8]

The risk increases with the low rate of condom use among sex workers. This was documented by a study showing that 46% of women attendants at massage parlors in Metro Manila, 21% of bar girls and 62% of male sex workers had had gonorrhea but were hardly using condoms.[9]

As reported to the National AIDS Registry, homosexuals and bisexuals have a high seropositivity rate and experience much risk by choosing casual partners who may be hard to trace.

As for OCWs, their lengthy separation from loved ones make them vulnerable to multiple sex partners and to risks and this is heightened by foregoing condoms.

Many OCWs are illegally recruited who, for fear of reprisals or deportation, reveal nothing about sexual abuse and other forms of maltreatment that exposed them to possible HIV infection.

A third reason why OCWs are considered a high-risk group is that many work as entertainers in, say, Japan where offers of unprotected sex may seem financially rewarding yet are vitiated by the very high cost of living.[10]

**HIV tests and results**

In the Philippines HIV testing has been limited largely to OCWs who must present clearances to host countries and to CSWs who are required by the Sanitation Code to be tested every two weeks for gonorrhea and every six weeks for syphilis.

The Code is used by local government units to make employees of fun houses undergo HIV testing. Screening is done twice before confirmatory testing at RITM, the National Reference Center for HIV Testing, or at BRL, the National Reference Laboratory.

In September 1993 a report presented at a workshop convened by the Asian Development Bank said that as of that time 1,214,634 HIV antibody tests had been reported by both government and private agencies.[11] From 1985 to 1992 a total of 1,050,192 antibody tests were done on groups at risk.

The subjects included OCWs, men who have sex with men (MSM), male CSWs, hospitality girls, male STD patients, blood donors and units for transfusion, the military, intravenous drug users (IVDUs), ordinary residents, TB patients, prisoners, Philippine Navy personnel, unwed mothers and drug rehabilitation center clients.

Testing positive for HIV per 1,000 persons were 22 men who had sex with men, 16 IVDUs, 3 classified under "Others", 2 from the military and 1 hospitality girl.

The results confirmed that the Philippines does have cases of HIV but proponents of a national surveillance system project say that the results may be unreliable.[12] According to them, seropositive cases were identified from among prostitutes who may have been repeatedly tested with each return to the STD clinic for a check-up.

This multiple counting of each person and the type of clients the prostitutes have - US military base personnel who are screened for HIV before being assigned to the Philippines and who are regularly checked - make data statistically unreliable.

Despite these questions discernible patterns emerge. Since 1984 there has been an increase in the reported number of HIV infections and AIDS cases. Since 1988 the number of HIV - positive cases in blood samples has also been increasing. There is a rise in the number of HIV transmissions in the country.

Other countries have experienced that once there is a growth in the number of infected people, the epidemic will grow logarithmically.

In 1989 Thailand reported the same number of actual AIDS and seropositive cases as the Philippines three years ago - 60 - yet it was established when better data were available that there were actually about 100,000 persons infected with AIDS.

In Thailand the infection spread to the general population from CSWs, whose ranks have had prevalence rates rising from less than 1% to 30% then to 40% - and higher in certain areas - in just less than two or three years.

To public and private sectors in Thailand the infection has cost more than $100 million for AIDS prevention in 1992. If uncontrolled the infection would kill 560,000 at the most by the end of the century and extract $8.5 billion from the economy as a cumulative loss.

In 1992 the USAID staff who was then formulating a surveillance and education project noted that Philippine conditions were like Thailand's as far as AIDS was concerned. The staff interpreted this to mean that an epidemic could be growing unobserved.

Can surveillance confirm this? The system installed under ASEP (or AIDS Surveillance and Education Project) shows data for the first round in Quezon City and for two rounds in Cebu City. NAMRU has its set of data in Pasay.[13]

In Quezon City the seropositivity rate from June to August 1993 was still low: 1 out of 300 female CSWs but they were identified as the high-risk group among the six sub-groups tested because of their multiple sex partners (4 per week), non-practice of safe sex (more than half of the 300 tested), and non-use of condoms (57% never used).[14]

In Cebu the first two rounds of surveillance had comparable findings and identified three issues: multiple high-risk behavior among the study groups, low condom use rate, and significant sexual behavior among commercial sex workers and freelancers.[15]

Of the 89 unregistered prostitutes in the first round of the surveillance, 39% had more than one sex partner a day, 9 times more likely in particular, yet 60% of them did not require their partner to use condoms.

In the second round the freelance sex workers were found to have a median of 14 partners a week, to be 17 times more likely than female commercial sex workers to have more than 7 partners a week, twice as likely not to require condoms, and 6 times more likely to use injecting drugs.

NAMRU studied CSWs in Pasay City, Paranaque and Makati and found eight from Pasay to be HIV-positive. All eight accept money for sex, frequently of the penis-vaginal type and had sex 1.5 times per week during the previous 12 months of the study with Caucasian (87.5%) and Asian (37.5%) partners. Half of those positive had genital ulcers and vaginal discharges; 37% used condoms either always or frequently.[16]

These are the most recent findings on surveillance across the country which might indeed just be the tip of the iceberg as far as HIV infection is concerned.

## KABP STUDIES ON AIDS

There is as yet no vaccine or drug against AIDS. Today's most viable tool for preventing it is intervention that reduces risk-taking behavior. Such intervention could be for the general population as well as those at risk because of their activities. Yet what is known about them? What is the impact of the AIDS epidemic on their sexual behavior?

One of the main sources of information is the growing number of studies on AIDS-related knowledge, attitudes, behavior and practices (KABP).

Among the earliest studies were those conducted in 1985 among clients of social hygiene clinics (SHCs) in Metro Manila and in the two former sites of American bases in the country, Olongapo and Angeles. These were followed by an analysis of nationwide data from 1985 to 1989 and by at least three more in Metro Manila from 1989 to 1992.

As for the general public the Asia Research Organization (ARO) conducted a nationwide public opinion survey in October 1987 as one of the 35 affiliates of Gallup International participating in the First Annual George H. Gallup Memorial Survey. The following year ARO was commissioned by the DOH and by the AIDSCOM of the United States Agency for International Development (USAID) to repeat the survey to serve as basis for a television and radio campaign from January to May 15, 1990.

In 1989, another private research firm, Total Research Needs, Inc. (TRENDS), did fieldwork in Metro Manila covering purposive samples of "sentinel" populations: 100 male sex workers, 100 female sex workers, 200 men who have sex with men (MSM), 150 young male adults, 150 young female adults, 100 male overseas workers and 100 female overseas workers. TRENDS developed the questionnaire through exploratory qualitative focus group discussions (FGDs) with groups at risk. For this situation analysis only the results of the male overseas workers were available.

The 1989 study on unmarried adults was the basis of a tri-media campaign on AIDS the following year. Later TRENDS tracked 200 young adults of Metro Manila whose demographic profiles were comparable to those in the 1989 survey to study their reactions to the campaign. Two years later another mass media campaign was launched and again evaluated with 300 young Metro Manilans as respondents.

As for overseas contract workers, the TRENDS study in 1989 is supplemented by 1991 workshops held among seamen and their wives/regular partners conducted by the Institute for Social Studies and Action (ISSA).

Other attempts to collect information relevant to AIDS include a four-institution survey of Metro Manila in 1990 funded by the World Health Organization (WHO) and surveys initiated by researchers from the University of the Philippines.

The University of the Philippines College of Public Health held a study covering a sample of the general population of 1,617 respondents from 702 households. The UP Department of Psychology studied 225 hospitality girls. The UP College of Mass Communication studied 200 seamen but its report is not readily available.

Other university-based researchers complemented these efforts. De La Salle Social Development Research Center focused on 200 homosexuals.

From September 1991 to August 1992 the Health Action Information Network (HAIN) held a seminar-workshop for freelance male workers who use a major shopping center in central Manila. Changes in their views and behavior were documented by HAIN utilizing pre- and post-workshop questionnaires and the diary method. HAIN has also surveyed Metro Manila students of medical sciences for workshops on HIV/AIDS prevention.

For its part, RITM has conducted surveys among hospital workers and students, the latter for the on-going integration of AIDS prevention concepts into the school curriculum.

Most of the studies used or modified the AIDS interview schedule of the WHO Global Programme.

In 1994, a desk review of 28 studies was commissioned by the Program for Appropriate Technology in Health (PATH) as part of the USAID/Philippines' AIDS Surveillance and Education Project (ASEP) from 1992-1997. Fourteen of the studies and project reports used in this desk review which was done by Dr. Michael L. Tan were available for this situation analysis.

The following sub-sections portray the profiles of the general population and the risk groups relative to AIDS as gleaned from these studies.

## 1. The General Population

Among the receivers of information-education communication (IEC) materials on AIDS are the undifferentiated members of the "general public." In the context of AIDS education, members of the general population may at one time or another join a group at risk and it is important that they know how to reduce the chances of getting AIDS through IEC materials.

It is also the general population that may either support or discriminate against groups at risk on AIDS. The public may either believe or combat stereotypes about prostitutes depending on whether they are aware of the circumstances behind involuntary prostitution. The general population may hold the view that commercial sex workers or gays deserve AIDS because of their lifestyles. In the ARO survey of 1987, Filipinos in general agreed with the statement that it is the people's own fault if they get AIDS. This indicates that the general population hold attitudes that will impinge on programs directed at AIDS.

### 1.1 The two nationwide surveys by ARO

Between 1987 and 1990, three AIDS surveys drawing sample respondents from the general population were conducted. Asia Research Organization (ARO) did the 1987 study as part of a 35-country survey of Gallup International and a 1988 study for DOH- AIDSCOM. Using the same structured questionnaire ARO queried 2000 respondents throughout the country in face-to face interviews. These respondents were drawn from sample provinces, cities/towns, **barangays**(villages) and households chosen at random under a multi-stage sampling scheme.

In the households selected by ARO, the respondents aged 18 years old and over were chosen at random with the use of a selection key (Kish Grid). The 1988 study was supplemented by booster samples of 100 respondents each from Greater Cebu, Olongapo and Angeles areas. The last two hosted the American bases for about 50 years; Metro Cebu now gets many foreign visitors.

The respondents comprised of 745 from urban areas and 1255 from rural areas.

### 1.1.1. Knowledge levels/attitudes

For both studies 78% of the respondents had heard or read of AIDS (sources of information not given). Awareness was higher among the males, the younger generation (18-39 years old), the more affluent and the more educated. AIDS awareness was almost universal in Metro Manila with 96 per cent in both years. In contrast, low levels were observed in Mindanao (75 per cent for both years), and in provincial Luzon (72 per cent for 1988). In Visayas awareness significantly increased from 78 per cent in 1987 to 84 per cent in 1988.

In the identified high-risk areas (those with booster samples) awareness about AIDS was much higher than the national and regional levels.

Concern for AIDS declined between 1987 and 1988. In 1987, AIDS was seen as the most urgent health problem of the country by 23% of respondents nationwide. A year later there was a decrease of 6%. In Metro Manila the proportions declined from 40% to 28%. For Olongapo the figure was 30%, for Greater Cebu 24% and for Angeles 20% in 1988.

In 1987, 62% of the respondents said that AIDS would develop into an epidemic for certain groups; this number hardly changed in 1988 (63%). This number made the Philippines rank third in this type of prognostication among countries that yielded a global average of 33%. Across the nation, respondents identified these groups as people with several sexual partners (94%); married people who had an occasional affair (91%); homosexuals (91%); intravenous drugs users (84%); people who need transfusion (81%); men (75%); women (68%); hemophiliacs (61%); hospital staff and doctors and nurses (35%); and couples who are entirely faithful (11%).

The degree of personal concern about getting AIDS was not high, 39% in 1987 and 36% in 1988 but the country ranked fourth among the 35 surveyed by Gallup.

The older respondents (55 years old and over) and the married ones were relatively more concerned about getting AIDS. This fear was higher in the Ilocos, in Western and Central Visayas, and in Southern Mindanao.

Even as correct knowledge about AIDS increased from 1987 to 1988, so did myths and misconceptions. Among the 35 countries the Philippines had a myth index of 3 and a correct index of 17. Myths were clearly linked with a high concern about getting AIDS and with believing that it would be an epidemic.

Misconceptions abound on how AIDS is caught from an infected person among the lower socio-economic classes, the women, the less-educated, the very young and the very old, and those in small urban towns.

### 1.1.2. Risk avoidance

Of those aware about AIDS, around two-thirds (67%) said that they did not have to change their behavior or have not thought of changing it because of the risk of getting AIDS. This percentage barely changed between the two surveys implying a relatively stable sexual activity on the safeside insofar as catching AIDS is concerned.

An examination of the remaining third who reported that they had changed their behavior or were planning to because of the risk of AIDS, showed that the admission was relatively higher among the men, the young (18-24 years), the singles and those in Metro Manila.

Less respondents in 1988 did things differently than in 1987 because of the fear of getting AIDS. However, 15% more declared that they now choose sexual partners more carefully; 9% more started avoiding homosexuals, and 5% more were using condoms for the first time or more often than before.

Four percent more Filipinos say that AIDS sufferers should be treated with compassion (76% in 1988 as against 72% in 1987 which had given the country a rank of 16th among the 35 countries studied). The Filipinos ranked the highest in believing that AIDS victims have only themselves to blame for their disease. The typical respondents said that they would refuse to work alongside an AIDS victim, making the country rank fifth worldwide in this issue. This aversion was most prevalent in Mindanao and Greater Cebu City than in other sections of the country.

## 1.2. The Metro Manila study

The third study was done by a research team of the UP College of Public Health. Headed by Dr. Teodora Tiglao and co-investigators Sandra Tempongko and Dulce Gust, the team studied a sample of the general population in the four cities and twelve municipalities of Metro Manila in 1990.

This study involved households generated from the household samples used by the National Statistics Office in its 1985 household survey of Metro Manila. In each of the 702 households generated, all those household members aged 15-69 years old were interviewed. These included 975 females and 640 males. More than half (54%) of the total sample were teen-agers (15-19 years) and young adults aged 20-29 years. Slightly more than one-fifth (22%) were in their thirties; 14% in their forties; 10% in their fifties; and only one respondent in his sixties.

Two out of 5 respondents had reached or finished a university-level education while 3 out of 8 were high school graduates or had been students. Expectedly the Roman Catholic religion predominated over other groupings (89 per cent).

The respondents comprised of students (21%), housewives (19%), service and sales workers (18%), professionals (6%), clerks (4%), laborers (3%), crafts and related workers (3%), legislators or administrators and managers (1%), plant and machine workers (1%) and military personnel (0.4%). Other respondents included those engaged in other professions (6%), retirees (0.8%) and unemployed (11.0%). Only a few (1%) declined to specify their occupations.

More than half (51%) were married or had regular partners.

### 1.2.1. Knowledge levels/attitudes

More than 9 out of 10 Metro Manilans had heard of AIDS but half knew just a little about it. The chief sources of information were television, newspapers and the radio. Unfortunately these were shown by correlation studies to be better at creating awareness of AIDS than in changing behavior.

While only less than 1 in 6 were aware of the etiological agent of AIDS, majority already knew the risk-taking behaviors. More than half (57%) mentioned sexual contact with AIDS carriers. Others cited blood transfusions (2%), liaison with homosexuals (1%), contaminated needles/syringes (0.2%) and drug addiction (0.1%).

A sizable number had incorrect beliefs about the prevention, cure and transmission of AIDS. For example, they enumerated droplets, mosquitoes and shared utensils as modes of transmission.

The respondents were asked how risky is intercourse with someone with AIDS. Very risky, said 86% of them. They rated these other activities as also very risky: sexual intercourse with a prostitute, 68%; anal sex with someone you do not know, 46%; oral sex with someone you do not know, 38%; donating blood, 30%; sexual intercourse with persons who inject drugs, 26%; using unsterilized needles, 23%; injecting drugs, 23%; and deep kissing with a person who has AIDS, 17%.

Most (almost 4 out of 5 respondents) believed that they had a small chance of getting AIDS but more than 3 out of 5 were worried about it.

### 1.2.2. Sexual history/patterns

Of the 940 married respondents 9 out of 10 said that they have but one partner in their entire lives. Almost two-thirds (65%) have regular partners since they were 15-24 years of age. The earliest age at which one respondent declared having had a regular partner was 10 years while the latest was 57 years.

The males were more sexually active than their female counterparts. The former likewise started at an earlier age, 44% having had sex when they were only 10-19 years old.

More than 2 out of 7 (29%) did not marry the person with whom they had their first full intercourse. About three quarters had many partners before marriage. About the same proportion holds true for the unmarried individuals who have current partners.

Even after marriage about a fifth (18%) of husbands reported having partners other than their wives.

Majority of the general population were heterosexual. Only a handful said they were bisexual (5%), pure homosexuals (3%) and pure lesbians (2%).

### 1.2.3. Risk avoidance

Many believed that AIDS may be avoided by changing sexual behavior. Three out of 8 stressed avoiding multiple sex partners while around a fourth exercised self-control and shunned pick-up girls.

Some 166 respondents admitted that they needed to change their behavior but only 81 had actually done so.

While half said they knew how to protect themselves against sexually transmitted diseases (STDs), only a small proportion (11%) were using condoms. A quarter said they were protecting themselves by having only one partner.

The other respondents use ineffective means like antibiotics and vitamins (16%), controlling the sex urge when drunk (14%), sizing up a prospective partner (10%), and a combination of methods such as mixing lemon juice with alcohol and hot water, withdrawal, and urination or washing up the genitals after sexual act (9%).

### 1.2.4. Correlation of demographic data with AIDS-related behavior

An analysis was done to discover how personal data are related to AIDS knowledge, attitudes and practice. Indices were made for each factor and correlated to each other.

**Knowledge of AIDS** is closely related to educational attainment, media exposure, perception of threat to one's self and awareness of risk-taking behavior. **Awareness of risk-taking behavior** is determined by educational attainment, media exposure and knowledgeability of AIDS.

The analysis showed that **condom use** is a function of educational attainment, media exposure, and favorable attitude to condoms.

It was also demonstrated that **condom awareness** is determined by educational attainment, media exposure and condom use.

## 1.3. Discussion

These studies show that most Filipinos are aware of AIDS but tend to believe in some myths about it. The gap in knowledge may hamper personal responsibility for AIDS prevention, as was expressed by many interviewees.

But this desire "to do something" should be viewed against the level of sexual activity reported by males in Metro Manila. It has been established that condoms are shunned and an early coital debut is made. With the continuing risks for sexually transmitted diseases, men should get cues from the environment encouraging risk reduction.

These cues could come from a number of sources: personal sources such as peer or friends, or institutional such as health authorities and the mass media. It is therefore imperative to make these three important sources up to date and knowledgeable on AIDS. Since they are generally perceived as people-friendly, they can help correct inaccuracies in information that can aggravate the situation and increase levels of infection.

Aside from these sources, the school system itself, both formal and nonformal, can educate a "captive" audience about responsible sexuality from an early age. The tasks at hand is to systematize AIDS education - facilitating it with methods and materials that are truly useful and meaningful. However, accurate information must be matched by services for the general public and for high risk groups. Indeed there is a need for a multi-pronged strategy against AIDS.

## 2. Young Adults

### 2.1. TRENDS study

In 1989, the Department of Health commissioned a private research firm, Total Research Needs, Inc. (TRENDS) to conduct a study aimed (1) to guide the development of communication/education strategies on AIDS prevention and control among young adults in the Philippines and (2) to have a baseline of knowledge, attitudes and behavior to assess progress of the program for AIDS prevention and control.

#### 2.1.1. Demographic profile

A sample of 300 adults aged 18-24 were interviewed in Metro Manila, with an equal number of males and females. It included 126 respondents (42%) who were between the ages 18 and 19; 75 (25%) between 20 and 21, and the rest (99 respondents) between the ages of 22 and 24. The last age group covered an equal number of men and women. There were more women (58%) in the 18-19 age group, and more men (63%) in the 20-21 year old group. Most of the respondents were educated. Only 7% did not finish high school; 21% completed high school; 52% had some college education and 20% obtained a college degree. As should be expected, those in the upper income levels had more with college education (82%) as compared to 63% of those in the lower group.

Most (72%) were not gainfully employed. A few (5%) held managerial or professional positions while 22% were in sales, clerical, services or crafts occupations.

#### 2.1.2. Knowledge levels/attitudes

Nearly all respondents (98%) had heard of AIDS through the media, primarily television. Fewer (33%) heard of it from friends or colleagues and from school (19%).

The men were less inclined than women to say that "any sexual activity" is a very likely mode of transmission (61% against 71%). Likewise, the men were less likely than women (49 vs. 68 per cent) to believe that lessening casual sex can very effectively reduce the risk of AIDS.

Men were also less likely to say that they reduce the risk of AIDS very effectively by "having sex with people known to me" (30% compared to 40% among women); by having fewer sex partners (43% as against 67%); by avoiding sex with prostitutes (70% vs. 83%) and with strangers (61% as against 78%).

More than half of the men (52%) compared to only 36% of women gave careful sex practice as a way of making themselves resistant to AIDS. One-fourth of the women felt that "anybody" is very likely to catch AIDS, as against 14% of the male respondents.

Many women believed that AIDS can be transmitted by sneezing or coughing, inhaling the air, using or sharing needles and utensils or through swimming pools, public toilets and mosquitoes.

Women are more likely than men (10-20% more) to believe that they can lessen risks by practising withdrawal, reducing the frequency of casual sex and of the number of partners, having sex only with well-known people, and avoiding sex with prostitutes and strangers. Almost all women respondents (95%) felt that those at-risk for AIDS should be tested; only 87% of the men were of the same belief.

### 2.1.3. Sexual history and patterns

Close to 63% of the males have had sexual experience. Of these males 57% did it with women, 27% with prostitutes, and 9% with men.

The men in the survey reported a median age of 17.7 when they first had sex with a woman. Only 1 in ten of the women have had sexual experience with the median age of first sex with a man pegged at 19.7 years.

None of the women reported having multiple partners in the past six months but 2 out of 5 had sex within the same time, all with the same partners.

Two out of 5 men and 3 out of 5 women felt that only married partners can have sex. More than half (51%) said that it should be limited to one partner only, as against 73% for the women.

More women than men felt that partners should discuss previous partners before having sex (63 per cent vs. 42 per cent).

### 2.1.4. Risk avoidance

More men than women (41% against 21%) confessed "When I get sexually excited I forget about AIDS," yet more men than women (20% vs. 14%) declared that they have changed behavior or lifestyle "a lot" to avoid the risk of AIDS. Close to 4 out of 9 men have changed sexual behavior because of the disease in contrast to only 1 in 8 women.

Less than 20% of the males always or sometimes used condoms whenever they had sex. Much less women have ever asked their partner to use a condom before sex (5%).

A full 77% of the women reported they would make an effort to get more information about AIDS compared to 3 out of 5 men.

### 2.1.5. Discussion

It would seem that sex is a factor for extent of concern about AIDS. Women are more prone to believe in myths about how AIDS is transmitted.

This is a cue for the contents of information suitable for women: materials that discuss and debunk myths and misconceptions about AIDS and reinforce positive information now possessed.

Another area of concern is the inconsistency of behavioral partners: men more than women admitted that they have changed both lifestyle and sexual behavior because of AIDS, but they forget AIDS when they get sexually excited and generally shun condoms.

Men disagreed with statements that sex should be limited to married partners, to one partner alone and that there is a need to discuss previous partners before having sex. Such disagreements make men appear to be at greater risk than women to contract AIDS.

Men must be invited to modulate these feelings into AIDS-free sexuality. But will they pay attention to fear appeals in the face of their insistence on sexual freedom? It is apparent that men and women will respond to different types of communication materials, both face-to-face and mass media, on the basis of their disposition about the disease.

## 2.2. Evaluating a media campaign on AIDS for young adults

In June, TRENDS surveyed 200 young Metro Manilans with demographic characteristics comparable to those of the respondents of the 1989 survey on young adults. The study aimed to know their reactions to the mass media campaign.

In 1992, a campaign was conducted from February to April to encourage dialogue among young adults as well as risk reduction through postponement of sex and avoidance of commercial sex.

The 1992 media campaign was also evaluated by TRENDS with a probability sample population of 300 unmarried males and females from Metro Manila, aged 18-24 years, from the socioeconomic classes ABCD. For this situation analysis the evaluation study was not available. Data on it were extracted from Dr. Michael Tan's review of 28 studies.

### 2.2.1. Knowledge levels/attitudes

In 1990, the main sources of information for AIDS advertising were television (virtually all respondents and across sex and economic standing) and radio (by 58% of the females).

For this situation analysis there are no data available for 1992 save that television remains the most frequently cited source of information for HIV, followed by radio and newspapers. Newspapers (mostly tabloids), magazines, posters, hand-outs, brochures and leaflets were identified as minor sources.

After five months of continuous airing of the plugs in 1990, unaided recall for AIDS as a health issue affecting Filipino youths had doubled the pre-survey score (21% vs. 46%). Regardless of economic or age segmentation, 96% were aware of the campaign materials on AIDS. Most vividly remembered was the primary message that the disease is transmitted sexually (55%). The second most recalled message corrected misconceptions on the transmission of AIDS (30%).

Most young adults (64-94%) who were aware of the advertising could correctly identify the modes of transmission of AIDS, thus retaining in their minds the points both stated and implied by the ads.

After the campaign, knowledge about AIDS improved. Even when the young adults said that they knew very little or even nothing about it, many recognized the message on careful sex practices (90% versus 44% in the pre-study).

A majority correctly perceived that direct sexual contact is the main channel of AIDS infection. Myths that were included in the advertisements decreased: using public toilets, sneezing/coughing and being bitten by a mosquito.

While not all myths were corrected in the media campaign, those prevailing in the 1989 survey decreased: deep kissing/lips to lips, living in the same house with a person with AIDS, using or sharing utensils, breathing infected air, social kissing, and hugging/shaking hands.

The effectivity index of having a monogamous relationship rose slightly from 3.4 in 1989 to 3.6 in 1990. The index for praying (not a message in the advertisement) decreased from 3.2 to 2.9.

When the media campaign ended, 84% of those surveyed said that they were at low risk to AIDS infection. The figure had been 74% before the campaign. Of those who considered themselves at low risk, 49% said the same situation would apply to their personal acquaintance. The figure was 63% in 1989.

Less than a third of the young adults (30%) saw AIDS as a personal concern. The respondents believed that AIDS concerns every Filipino. This is shown by the 88% who disagreed with the statement that "We will all die anyway so why worry about AIDS" and 92% agreed that "Anyone who engages in behavior/lifestyle that may put him at risk should be tested."

In reviewing these tracking studies Dr. Tan pointed out that the analyses "tend to read in too many changes in knowledge and attitudes, and to attribute these to the campaign."(p. 15)

According to Dr. Tan retrospection would suggest the existence of a high level of awareness in 1989 - "approaching saturation" - about HIV/AIDS. Many of the respondents correctly recalled that AIDS could be acquired by sexual contact with an infected person, but others mistakenly recalled that "AIDS can be cured" or that it could be transmitted through the air.

Dr. Tan points out that a mass media campaign can be interpreted in many ways and should probably support other strategies. It was useful but still inadequate, according to him,
that the campaign was linked to a more interpersonal strategy as the Remedios AIDS hotline.

For 1990 some 18% said the message of the campaign was "to call the hotline" and 60% said they were very/somewhat interested and definitely would likely call. But 24% were apathetic about calling. In 1992 only 6% correctly got the key slogan of the campaign (AIDS. Think about it. Talk about it.) Only 5% could remember the message "Call up the AIDS hotline." None could remember the number.

### 2.2.2. Risk avoidance

Since they claimed to be abstaining from premarital sex and to be avoiding high-risk sex partners, 3 out of 5 of the respondents saw no need to change their behavior in order to avoid AIDS.

The few who have changed their behavior focused on careful sexual practices. The greatest was in the area of abstention from premarital sex.

Yet myths persisted. Some of those who promised to be careful on sexual practices said they would practise ineffective methods like washing genitals before and after sex, practising withdrawal, and refraining from donating/selling blood.

### 2.2.3. Discussion

The usefulness of media as a change agent is undeniable. Advertisements that are well made can find a niche in the minds of television viewers, thus facilitating attitude change.

It has been demonstrated that the media can drastically change wrong beliefs.

It is hard to combat rumors and misconceptions but a headway is made through mass media. Efforts in this direction must be maintained. Moreover, the gains from media campaign must also be sustained.

The campaign through the airwaves must be complemented by interpersonal communication. Peers that are trusted can now correct remaining myths in a face-to-face setting. Authority figures in different areas of concern can reinforce these learnings. Informal as well as formal leaders can be harnessed for the day-to-day implementation of new learnings.

## 3. Men Who Have Sex With Men

There appears to be a lack of scientific data on the sexual and preventive behavior of homosexuals relative to HIV infection. Such data could help design programs intervening with their risky behavior. It was this need for empirical evidence on such behavior that personal interviews were conducted from January to December 1990 among 200 male homosexuals in Metro Manila. Two in-depth interviews generated case studies on a beautician and on a marketing manager.

The study was done by De La Salle University Social Development Center as part of a four-institution collaborative research funded by WHO on sentinel groups.

The study confirmed the risk faced by homosexuals from casual partners and from the transfer of body fluids.

No study on female homosexuals were available for this situation analysis.

### 3.1. Demographic profile

Most of the respondents (79%) were below 30 years of age. Almost all (98%) were single. All had formal education; 59% had some college education.

Respondents came mainly from two sectors: fashion, entertainment and beauty culture, 37%, and white collar, 35%.

Of 152 who were gainfully-employed, three-fifths were earning along the poverty line, PhP 1,001-5000 a month, while a fifth were earning PhP 9,001 or more a month.

The respondents belonged to large-sized families; 2 out of 5 respondents had four to six siblings, seven to nine, 27% and one to three, 25%.

Two-thirds had both parents still alive while 29% had but one living parent.

Majority (53%) were living in the same household as their parents. Their fathers were white-collar workers (51%) while mothers were predominantly housewives (55%).

### 3.2. Knowledge levels/attitudes

All the respondents had heard of AIDS but 45% said they know just a little and 37% said they have moderate knowledge of it.

The most important sources of information were television, newspapers, magazines and friends, in that order. Doctors, psychiatrists, nurses, television, and newspapers were singled out as the preferred sources of information.

Half of the respondents scored moderately in a test of knowledge of risks (7-11 out of 17 activity-items); 43% had high scores (12-17 items correctly answered).

Though 88% correctly said that AIDS could be passed on through sex, 13% mentioned mosquito bites or personal effects of someone with AIDS as means of transmission.

About 4 out of 5 were of the opinion that AIDS threatens the health of homosexuals at present and within the next few years. Even if a third said they would never get it, they were worried about it.

### 3.3. Sexual history

The homosexuals in the sample had no sexual contact with women, further establishing the study criterion that the men interviewed were indeed homosexuals.

The respondents first had sex with men when they were between 15 and 19 years of age, perhaps during the period of adolescent experimentation.

Over the years, 64 respondents (32%) reported having had 1-35 sexual partners; 22 (11%) have had 26-50; 15 (7.5%) have had 51-75 partners; 17 (8.5%), 76-100 partners and 82 respondents (41%), 101 partners. Each year the sample respondents had an average of 36 sexual partners.

The homosexuals had only one to four regular partners on the average of nine years of homosexual activities, but had an average of four casual partners in the month before this study.

They meet casual partners in moviehouses (44%), gay bars, discotheques and beerhouses (41%) and open streets (28%).

While most respondents paid casual partners, they said they could get "noncommercial sex" in third-run cinema houses where they perform a wide range of sexual acts with casual partners like fondling, kissing, oral sex, etc.

Semen exchange had been done by 75 respondents: 29 with regular partners and 46 with casual ones.

Despite multiple partners and unsafe sexual practices, only six respondents said they have had sexually transmitted diseases.

### 3.4. Risk avoidance

A majority (52%) felt no need to change sexual behavior. Three-fourths said that they could control themselves to avoid getting sick.

To avoid getting AIDS, 36% would carefully select partners or know them before having sex, and 22% would lessen or avoid sex.

Genital fondling is considered a safe act commonly practiced by 55 homosexuals with their regular partners and 98 with casual partners.

Twelve used a condom with every sexual contact while 41 seldom or rarely did. Vitamins and antibiotics and showers were taken before (21 per cent) and after sex (18%). Avoiding oral or anal intercourse was adhered to by 14 per cent and the swallowing of semen was rejected by the same number.

### 3.5. Discussion

Thinking that sex with men pose no risk and that they are protected by careful choice of partners or vitamins and showers, few homosexuals use preventive measures. However, many recognize their vulnerability to the disease along with the prostitutes and the sexually-active individuals.

This realization of a threat can encourage homosexuals to change sexual practices and avoid partners that endanger them. They can be assisted in this by prevention programs that take into consideration their sexual orientation, including their probable under-reporting of STDs.

More research on their lifestyle is needed since they form a subculture that requires a rigorous - yet understanding study.

## .4. Overseas Contract Workers

No less than former President Corazon Aquino has called them "**ang mga Bagong Bayani natin.**" The estimated two million overseas contract workers (OCWs) are the new heroes of the Republic as they prop up the national economy with dollars earned at great risk to their personal and family lives. In addition, OCWs face great risks with AIDS, officially as early as 1984 when one of two persons diagnosed as having HIV was an OCW. Eight years later, 39 of the 355 reported HIV-positive individuals (11 per cent) believed that they had contracted the disease while working abroad.[17]

OCWs resemble sero-positive cases in that both are in the prime ages of their economic productivity and sexual activity and are skilled enough to move between domestic and international work places.

OCWs have been ranked by an RITM study to be more likely HIV-positive than prostitutes. They are at risk because they work in traditionally high-risk occupations like entertainment and service which may lead to prostitution. Moreover, those with questionable travel documents encounter hazards of sexual abuse and exploitation for job security and salary augmentation in the face of revised contract terms. Compensating for loneliness they relate with prostitutes or establish homosexual relations or liaison with multiple partners.

Three studies on OCWs are available for this situation analysis: (1) three focus group discussions (FGDs), (2) a survey by TRENDS as part of a sentinel group study, and (3) an education-cum-prevention project of the Institute of Social Studies and Action (ISSA), a non-government organization engaged in advocacy and education on women's reproductive health and health rights.

The respondents comprised of male and female OCWs and the spouses or partners of seamen. All three studies were done in Metro Manila although in addition, there were some interviews in the provinces of Batangas and La Union.

The research instruments were adapted from the TRENDS (1989) and HAIN (1991) surveys.

### 4.1. Demographic profile:

The TRENDS FGDs had 27 male participants from the C and D economic class.[18] Most had worked in Saudi Arabia. Eleven were 21-30 years old; ten, 31-40 years old; and six, 41-50 years old.

The TRENDS survey had a purposive sample of 100 male and 100 female overseas workers aged 21-44 years old. All had worked abroad for one to two years before the study. Jobs followed the stratification of leading occupational groups of overseas workers set by the Philippine Overseas Employment Administration (POEA). Those from the medical and allied services were excluded.[19]

The respondents to the ISSA interviews were 60 seamen connected with El Greco-Tsakos Manning Agency. The agency arranged for the conduct of physical examinations by medical staff of Women's Health Care Foundation, the sister organization of ISSA.[20]

Almost half of the male ISSA interviewees (29) were middle adults (29-48 years of age), 25 were early adults (19-26 years of age) and 6 were late adults, 49 years or above.

Thirty-three of the male interviewees were veteran seamen (having had more than one trip on board a ship); 15 were new (only one trip); and twelve were applicants.

The male interviewees were not necessarily the participants of the education/prevention lecture-workshops on AIDS.

Like their spouses, the wives/regular partners of the respondents were interviewed before and after separate lecture-workshops. In Metro Manila, there were 25 women, 20 in Batangas, and 14 in La Union.

The detailed demographic profile of only 37 participants who completed the workshop evaluation forms could be ascertained.

Of these participants, 23 were male and 14 female. The average age was 28 years for the seamen and 37 years for the women.

A large proportion of the men were college graduates (91%); the rest (9%) were high school graduates. Of the women, 58% were college graduates; the rest were high school graduates.

As to socioeconomic grouping, 53% of the men were earning PhP 5,000-10,000 or above monthly; 30% less than PhP 5,000; 13% above PhP 10,000; and 4%, no income.

Among the women, 36% were earning PhP 5,000-10,000 monthly; another 36%, above PhP 10,000; 14%, below PhP 5,000; and another 14%, no figure.[21]

### 4.2. Knowledge/attitudes

All of the overseas workers had heard about AIDS but the quality of knowledge about AIDS varied. In fact they scored lowest among the four sentinel groups surveyed by TRENDS.

Only the FGD study groups have data on sources of information for AIDS. However, these were not ranked or quantified: readings, seminars and discussions with friends, relatives, peers, medical practioners and affected personalities.

Information from the FGDs shows that most of the respondents knew that AIDS is a new form of sexually transmitted disease and that it is incurable and fatal.

The less-informed mentioned incorrect transmission routes: exchange of saliva or any fluids, kissing lips-to-lips, sitting beside a carrier, being in the same room as him or her and using personal effects or utensils.

Like the FGD participants, those in the TRENDS survey had inadequate knowledge about AIDS. Only 31% of the male respondents recognized that it is incurable (the average for the sentinel groups is 35%) and 18% classified it as fatal. Ten per cent said they "knew nothing" about AIDS.

In contrast, the respondents of the ISSA workshops who accomplished all the evaluation questionnaire scored an average of 7.5 of a potential perfect score of 15 in a pre-test on knowledge about modes of transmission of AIDS and a post-test average of 8.1 correct answers. They may be said to have a fair level of general knowledge about AIDS.

That the male respondents learned more about AIDS is seen in the change in their score on mosquitoes as a vector of the virus: 38% on the pre-test and 70% in the post-test.

All OCWs knew that there is a test for AIDS because they must undergo one before working in a receiving country. In the TRENDS survey, for instance, 85% of the males were aware of diagnostic test and 78% knew about blood tests. About 1 in 5 also believed that a urine test is diagnostic.

All three surveys reveal misconceptions about AIDS. On blood transfusion for instance, 61% of the TRENDS survey respondents believed that donating blood can transmit AIDS. About 7 out of 10 seamen (ISSA study) were not willing to donate or sell blood because of this misconception.

Across all three surveys, the male respondents scored low in the perception about AIDS as a serious problem (82% in the TRENDS survey as against 87% of the total population of the four sentinel groups surveyed), as a definite threat that would spread thoughout the Philippines (45% as against 62% average for all four groups), and as a personal risk (22% as against 32% of all respondents).

The FGD participants believed that only the perverse and the depraved, which they thought they were not, would contract AIDS. Since they were careful and clear, the prescription to change sexual behavior to avoid AIDS did not apply to them.

The FGD participants considered the homosexuals as at greatest risk, because of their "perversion." So are the male youth who are "daring and ready to try new things." They conceded that female prostitutes also spread AIDS, but those they use abroad are safe and clean.

As for the females, those in the TRENDS survey had a low 6% awareness rating about AIDS (the average was 24% across all groups). Seven per cent admitted that they knew nothing about it, as against 17% for all the groups.

Only 25% of the women in the same survey knew that it was incurable (the average across the four groups was 35%). Only 9% knew that it was fatal as against 19% for all respondents.

While the women overseas workers knew that AIDS is sexually transmitted, they also had higher scores in misconceptions on transmission such as living with infected individuals and sharing utensils.

Only about three-quarters (74%) of the women overseas workers perceived AIDS to be serious. Less than half (49%) believed that it would definitely spread in the country.

Only a handful (18%) believed that AIDS was a personal threat to someone like them. In fact, less than a fourth of the women overseas workers believed that they would ever get the disease.

As to the wives of seamen, they had higher scores than their spouses in knowledge both pre-workshop and post-workshop levels. What is interesting in the workshop scores is that while 74% of the seamen declined to donate blood for fear of transmitting AIDS, 65% of the women were willing to do it. Close to four-fifths of the seamen (78%) said that withdrawal before orgasm could help avoid AIDS; only 60% of the spouses did.

But it is also interesting that while 75% of the men did not believe in taking antibiotics and vitamins against AIDS, only a third of the women debunked this myth. The women were also convinced that washing the genitals before and after sex can prevent AIDS infection.

### 4.3. Sexual history/pattern

In the TREND group, 73% of the males and 52% of the females recognized that working overseas would increase their risks to AIDS.

Most of the men (70%) and the women (52%) admitted that they engaged in sexual activities that they would never consider at home.

About 17% of the male participants in the same survey had some sex encounters. Two of 5 admitted they have been sexually active with sex workers. Of that figure half had encounters in the year before the survey. The FGD participants and the seamen also confided that they had sexual encounters abroad.

The FGD participants also said that their sex practices with their wives were modest when compared to "avant-garde" techniques (they would not think of asking their wives to do oral sex on them, for instance) and what they did with sex workers was calculated and well-thought out rather than spontaneous.

The FGD participants also said that even if they used partners overseas, they went back to their wives.

There was also a strong aversion to anal sex among partcipants of all three studies, part of what the FGD males called "**kababuyan**"- perversions that correlate with AIDS.

Still machismo values are strong. Only half of the seamen preferred to have only one partner and were perceived by their wives as being capable of killing them (wives) if they should catch them being unfaithful.

Almost all of the seamen (92%) saw masturbation among men as natural. In the same vein more than half of the TRENDS survey participants (60%) said that it is natural for men to pursue sex at every opportunity.

Condom use was low: 51% had tried using it but only 2% reported using it "always" and another 6% "occasionally."

The same was true for the FGD participants. One said he would feel choked by a condom. Another said that it takes away the pleasure of sex; he would rather masturbate than use one. Still another called it an absurdity inasmuch as one engages in sex to fully enjoy and not to control the enjoyment.

As for the seamen, 27% of the 60 interviewees have not used condoms even if 83% did perceive a threat of getting STDs and 77% of AIDS.

The same pattern was true for the seamen in the workshop. Almost 83% perceived condom use as an interference during intercourse and 92% said that it reduced pleasure.

Amidst all this insistence on full sex enjoyment, however, it is interesting to note that 17% of the male overseas workers in the TRENDS survey said that they have not had any sexual intercourse.

Almost a third of the women workers reported the same. The women seemed to be restrained by society from full sex enjoyment. A full 93% of the seamen's spouses preferred having only one partner. A number of them denied practising or claimed ignorance of masturbation.

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.