5.5. Discussion

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

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

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

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

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

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

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

II. GOVERNMENT PROGRAMS ON AIDS

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

1. Overview

1.1. Historical background[1]

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

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

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

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

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

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

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

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

1.2. Policy statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.3. Objectives

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

The medium-term objectives of the program are:

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

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

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

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

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

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

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

1.4. Strategies

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

1.5. Program structure

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

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

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

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

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

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

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

2. Programs, Projects and Activities

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

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

2.1. Information, communication, health education/Advocacy

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

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

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

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

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

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

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

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

2.1.1. Illustrative examples of IEC activities undertaken

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.1.2. Advocacy activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3. Training

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.4. Clinical management and care

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

2.4.1. Hospital facilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.4.2. Guidelines for hospital care

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

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

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

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

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

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

2.4.3. Social support

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

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

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

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

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

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

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

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

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

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

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

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

2.5. Surveillance

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

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

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

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

2.5.1. Serosurveys

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

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

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

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

2.5.2. Blood tests

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

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

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

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

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

2.5.3. Testing for HIV

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

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

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

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

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

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

2.5.4. Voluntary testing

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

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

2.5.5. Sentinel surveillance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Budget and Funding Agencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. NON-GOVERNMENT ORGANIZATIONS'PROGRAMS ON AIDS

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

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

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

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

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

1.1. Information, communication, health education and advocacy

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

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

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

1.1.1. Illustrative examples of media-initiated IEC activities

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

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

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

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

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

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

1.1.2. Illustrative examples of NGO-initiated IEC activities

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

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

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

With WomanHealth, ReachOut is co-producing a same-titled video on the social impact of AIDS on women in the Philippines that will focus on the history of the Filipina, her present role and status, the impact of the disease on women, and existing AIDS programs for them. These two NGOs began working together in 1991 on the proposal for this video. Since then they launched with Kabalikat, the DOH and WHO-GPA the 1st International AIDS Video and Poster Festival on March 22-27, 1993 at the Cultural Center of the Philippines.

1.1.3. Special media

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

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

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

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

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

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

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

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

1.2. The social marketing of condoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Networking and Coordination

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

2.1. The HIV/AIDS Network

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

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

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

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

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

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

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

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

2.2. Marching for Life Coalition

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

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

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

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

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

2.3. Kaagapay

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

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

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

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

2.4. The PNGOC

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

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

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

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

2.5. Other Linkages

Coordination has linked the NGOs with many sectors.

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

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

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

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

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

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

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

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

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

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

3. Training

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

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

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

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

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

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

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

3.1. Training on condom use: plays

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

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

3.2. Training on safer sex and condom use: workshops

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3. Integration of information on AIDS with other concerns

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

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

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

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

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

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

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

3.4. Direct training

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

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

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

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

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

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

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

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

Both ReachOut and Remedios train counselors for their hotline service.

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

4. Services and Facilities

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

4.1. Services and information

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

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

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

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

4.2 Support systems: drop-in centers and support groups

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

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

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

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

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

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

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

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

4.3 Resource Centers

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

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

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

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

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

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

5. Research and Development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Discussion

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

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

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

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

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

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

IV. INTERNATIONAL FUNDING/ASSISTANCE/SUPPORT FOR AIDS ACTIVITIES

1. Main Agencies Involved

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

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

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

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

1.1. USAID

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

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

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

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

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

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

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

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

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

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

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

1.2. AIDAB [2]

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

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

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

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

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

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

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

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

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

1.3. WHO-GPA

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

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

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

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

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

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

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

2. Anecdotal Information On Other Sources Of Support

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Funds Disbursement

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

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

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

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

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

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

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

4. Discussion

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

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

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

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

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

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

V. EVALUATION OF THE NAPCP PROGRAM

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

A. PROGRAM REVIEW

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

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

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

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

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

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

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

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

The 1993 review covered surveillance/data collection; diagnostic facilities/ laboratory strengthening (including blood donation); strengthening of the STD program; information, education and training; and program management.

For this situation analysis a copy of the actual report as well as a summary of the findings and recommendations was made available.[3] Whenever feasible the data were compared to an assessment of the NAPCP done by the USAID mission in the Philippines in the course of producing the **AIDS Surveillance and Education Project, Project Paper** dated May 1992.

1. Surveillance/data collection [4]

1.1. Regular testing of one group

In 1992 the project paper for ASEP noted that HIV testing was being done on high-risk groups seeking services at social hygiene clinics (SHCs). It likewise observed that while over 200,000 screening tests had been done principally in Manila, Olongapo and Angeles, the current screening program was too biased to be reliable because only one segment of the population got tested and clients were counted twice each time they had the test.

The 1993 external review team report refers to the 1990-1992 Medium-Term Plan which already discouraged the broad sero-survey being done among commercial sex workers since it was yielding epidemiological information on only one group.

The review team noted that commercial sex workers were still being regularly tested and this was seen as an important control activity and a source of epidemiological data. The team wanted an urgent review of mandatory testing and the policy in general.

On another aspect, the review team discovered that the reporting system on AIDS/HIV violated confidentiality and there was lack of clarity of policy and procedure. Despite codes for confidentiality, the team members saw records where an infected person could easily be identified even without a name.

The team acknowledged that testing donated blood might indeed give information on epidemiology but recommended that health professionals or the public should not view the act of donating blood as a way of being tested for HIV infection.

1.2. Sentinel surveys

The ASEP paper pointed out in 1992 the insufficient attention being paid to developing systematic surveillance that can monitor HIV/AIDS infection nationwide.

The system can determine the prevalence of HIV infections yet a year after the ASEP paper, sentinel surveys were delayed partly due to discussions as to which agency within DOH should do surveillance.

It has since been decided that FETP has this responsibility and will continue to have it but the AIDS unit, which is responsible for presenting and publishing monthly statistics, would also like to have responsibility for surveillance.

The review team strongly suggested rapid implementation of sentinel surveys. However, it warned that this should not be the guide for the direction of AIDS prevention program in the immediate future since their value is really in showing trends over time.

The team also proposed that the Field Epidemiology Training Program (FETP) handle surveillance and data collection which has happened since the report was written.

1.3. The monthly report

Some clinicians reported to the team their lament about delayed monthly reports which prevented them from intelligently discussing matters pertinent to program developments.

Some workers mentioned that the monthly data on HIV/AIDS should have a brief commentary and could be better presented, perhaps with charts or diagrams.

The members stressed that the DOH should see if, as in the case of other diseases, the responsibility for presenting and commenting on the data should be FETP's in consultation with the AIDS unit.

2. Diagnostic facilities/ laboratory strengthening

2.1. The RITM and BRL

The review team commented that these two agencies of the DOH appear to be duplicating each other in supplemental or confirmatory testing, in evaluating testing kits, and in accrediting laboratories.

Thus, the team suggested that their roles and functions be re-studied so that only one might support and accredit private and government laboratories and only one to evaluate test kits. The team recommended that the BRL can possibly concentrate on ensuring safe blood supply with RITM providing laboratory support.

2.2. Diagnostics

The team commended the "excellent" training on HIV antibody testing techniques, however, it was also observed that laboratory staff could not use and consolidate their new diagnostic abilities because of shortages in equipment and reagents.

On a related aspect, the system for supplemental/confirmatory testing was found to be working well and hewing to procedures recommended by WHO for initial seropositive results.

However, the public has limited access to HIV testing, must pay for all tests, hardly knows of cheaper facilities at government agencies and may be unable to afford private doctors. Without explicitly stating how, the team also said that it may be possible that many HIV tests are done without explicit consent.

The team believes that the demand for testing will increase with the growth in awareness of HIV infection and AIDS. Thus it asked for ways to meet this demand and to ensure that blood donation does not become a way of getting a free and confidential test.

Also recommended is the training of health workers who may need to discuss HIV and AIDS with patients. This is in connection with the issue of pretest information and counseling. At the same time the team said that the topic should not be shrouded by the belief that only specialists can give pre- and post-test counseling.

2.3. Safe blood

The 1992 ASEP paper disclosed that some 40% of the blood supply was screened for HIV and that screening expertise and supplies for HIV laboratory testing have been devolved to the laboratories of the 14 regional hospitals and 5 medical centers and four social hygiene centers serving as regional referral centers.

The 1993 evaluation noted that figures on how much of donated blood is tested for HIV are not available but estimates range from 35% to 70% at the most because of the lack of reagents and testing equipment.

In any case the team interviewed many who said that private hospitals repeat all the tests done by the Red Cross and commercial blood banks for HIV, syphilis, hepatitis B and malaria.

One center was found using free testing for these diseases as a way to encourage blood donation, despite an increase in the number of voluntary donations.

The team learned too that Red Cross blood donors are asked about risky behaviors but hardly know of self-deferral, that they can postpone donating if they have been at risk for HIV infection.

The external review team believed that commercial blood banks and paid donors would be phased out by legislation within the next five years at the most.

It was also noted that successful education about rational use of blood components is taking place, but very little is being done to encourage doctors to ask whether a transfusion is necessary at all.

The team recommended that all these issues be considered and acted upon.

3. Strengthening of the STD Program

The 1992 ASEP paper did not speak of the link between STDs and HIV, but the 1990-1992 Medium-Term Plan calls for expanded STD services and the integration of the AIDS and STD programs within the context of primary health care and integrated basic health services.

The order for the integration has been issued and its importance emphasized in a recent review of the STD program by Dr. John Gallwey, an external expert.

The external review team fully endorsed the study of Dr. Gallwey, citing how his report shows the need to regard HIV infection as a sexually transmitted disease; to give free, confidential STD services that are attractive and accessible; and to provide testing, counseling, and advice about HIV infection, and care and support for those affected.

4. Treatment, care and support for HIV-infected persons

Against the goal of the Medium-Term Plan to establish AIDS wards, outpatient services, day care center, community-based home nursing and stronger links with voluntary organizations, the review team pointed out that the number of people with HIV is beginning to have an impact on caring services.

Most cases go to DOH facilities. Some go to private hospitals only to be turned away since some health professionals fear infection or lack skills to care for HIV patients.

Another barrier is the lack of care and support in communities and more importantly, existing discrimination or stigmatization.

Patients truly cannot go home and when they do, they find it hard to return to Manila for health care and follow-up due to the distance involved.

One finding of the external review team is that with the classification of HIV as "highly infectious," patients are seen as needing special health care. After an operation the surgery area gets unnecessarily extensive disinfection. Thus, a surgical suite just for them is being considered.

The team concluded that this situation only reinforces or exaggerates fears of infection. The members would like DOH to adopt a policy that HIV-infected patients can be treated in any facility where the staff is duly trained on HIV/AIDS.

On fears of infections, health care professionals and managers should be reassured that standard procedures of preventing transmission of and infection against HIV will suffice and that special wards are not necessary.

The review team also stated that the care of people with HIV extends beyond nursing and medical needs and has to be coordinated with statutory and non-statutory bodies.

Such care and treatment should include the follow-up of cases who live far from centers of excellence and those being supported by NAMRU.

Care should also consider injecting drug users who, in the current epidemic of malaria, caught the disease from sharing injection equipment with peers. These drug users may then sexually spread it to non-drug users, since syringes could be another transmission mode for HIV, the team pointed out.

5. Information, education and training

The 1990-1992 Medium-Term Plan noted that health education and risk reduction are the most effective ways of preventing infection in the absence of a cure or vaccine for AIDS. It is along this line that the NAPCP has conducted its IEC activities.

5.1. IEC

The 1992 ASEP paper enumerated these activities: campaign services and drop-in centers. The paper also noted how IEC and surveillance programs have not had the attention and funding that can make them effective national operations. They must be expanded so that they can have a great impact on slowing down the transmission of the disease.

The 1993 review team identified information, education and training as the areas where the NAPCP has made the greatest progress.

Proofs include the general publics's higher degree of awareness of and interest in getting information on the HIV/AIDS problem; the endorsement of AIDS prevention and control as an urgent national concern coming from the President and the DOH leadership; the access by high-risk groups to IEC services from NGOs; working models of community-based, multi-sectoral IEC programs; and the integration of materials in the curricula of elementary and high school levels.

"Some very excellent" work has been performed by NGOs in IEC, but there is a need to synchronized their efforts.

Donor groups have given strong support to materials development. This resulted in the production of locally suited information materials and replicable schemes for both city and rural folks, and in the successful use of peer counselors and educators. Innovative IEC methods and programs clearly meant for critical groups have also been developed.

These IEC activities may now expand and be sustained by a five-year communication strategy with assured funding which addresses selected audiences.

The team also noted that there are some IEC materials that are based on research but research is also needed in new areas such as high-risk sexual behavior in rural areas and new forms of prostitution in Ermita, Clark and Subic.

Another area for genuine concerned is decreased capacity to plan and do IEC programs on AIDS as one goes down the regional and provincial levels. With devolution, governors and mayors should be targets for IEC. Support personnel must be included too.

On field-level work, AIDS coordinators face overlapping and competing assignments together with an almost total lack of funds and other resources. Thus they should get a minimum and realistic set of expectations about outputs from field-based IEC programs.

As for NGOs with limited resources, these "very important partners" should get active support from DOH in developing a strong network. The team recommended incentives and technical assistance to collaborating agencies.

It was also suggested that the DOH re-examine supervisory and regulatory functions over NGOs since these have been known to initiate larger proposals for funding after establishing their credibility.

5.2. Training

The team noted the good education and training for health care workers in both public and private sectors. Training of laboratory staff on HIV antibody testing was described as "excellent." Training of medical technologists and nurses in HIV testing were found proficient, as well as training of social hygiene workers. The only gap mentioned by many workers was the need for more training on counseling patients about HIV and the test.

The DOH has produced an "excellent" handbook on HIV and AIDS. But they also took note of prejudice in certain hospitals and the ignorance of at least one private hospital about the handbook, underscoring the need for more education, even among receptionists, porters and clerks.

However, training should be coordinated among government, private institutions and NGOs for uniform contents and unduplicated efforts.

On another aspect, health workers told the team that DOH must give guidelines or information on counseling, on their duty to patients with known or suspected HIV infection, on a person's ability to work if he or she is asymptomatic, and on the growing number of OCWs affected.

The team therefore suggested DOH guidelines and information on these matters and on confidentiality and consent to testing.

Attempts were made to obtain more statistics from the AIDS Unit regarding the type of trainings and number of trained personnel in the program, but no data could be obtained. It seems that the Unit is just starting to undertake this kind of inventory.

6. Program management

6.1. Staff, funds and positioning

The ASEP paper of 1992 said that the potential funders have been frustrated by the organizational problems affecting the NAPCP. The absence of an organizational focus "compromises the ability of DOH to implement the various elements of the Medium-Term Plan in a coordinated fashion."[5]

A year later the external review team cited how the NAPCP has been "hampered" by unstable funding and staffing and by the title "unit" that signifies a low-level agency.

Staffing has not been institutionalized. Personnel are borrowed from other units and the Program staff is contractual. Salary delays have adversely affected the motivation of the staff. Frequent repositioning within the DOH structure implied instability program staff items.

The team recommended that the NAPCP organization and staffing be stabilized and the appointments of current personnel assured. The unit has to be defined in terms of identity and leverage.

6.2. Leadership

Effective leadership at the NAPCP has been hampered by its frequent repositioning and by an unclear delineation of specific accountabilities and authority for its head. Effectiveness has been dependent on the program manager's personal skills, credibility and influence.

The review team called for a review of the heads' role, functions, accountabilities and authority and stipulated that the results of such review be communicated to all concerned.

The team added that indefiniteness can be eliminated if there are realistic performance expectations that are applied clearly and consistently.

It is critical that the Program Manager gets the support and confidence of DOH management. Thus, the designation must have a measure of this explicit support.

6.3. Program focus

The 1992 ASEP document called for an organizational focus in the AIDS program so that it would not "continue to languish."

A year later, the external review team called the process one of "rowing" rather than "steering," of direct implementation of activities rather than providing overall technical guidance, coordination and integration for NAPCP activities.

The review team has called for disengagement from less strategic technical work. It also draw attention to and urged implementation of the Department Order integrating the AIDS and the STD programs. The order was subsequently followed on March 28, 1994.

6.4. Relationships

Since the NAPCP depends a great deal on donor agencies, the review team recommended stronger relations especially in terms of technical coordination and administrative facilitation. As a gauge of the movement towards this direction, it suggested regular meetings of the PNAC and its technical secretariat, the AIDS unit itself.

A stronger basis for coordinating the program has emerged. The DOH leadership has made public a commitment to address the HIV/AIDS problem and sustained its advocacy by the NAPCP.

By placing the AIDS program under the Office of Special Concerns with its Assistant Secretary as Program Manager, DOH management has given NAPCP a new level of legitimacy together with the major programs of family planning, child survival and women's health.

The call of the review team for more effective mechanisms for inter-DOH coordination in the different components of the Program must be seen against these changes.

Local autonomy has added a new dimension in the relationships. In the light of devolution, the team recommended two things: (1) greater clarity and coordination with local governments and (2) more effective technical guidance to LGU initiatives so that Program management may more effectively steer projects through the government's bureaucratic maze.

7. Discussion

The report on the findings and recommendations has emanated from an external source relatively free of vested interest in the NAPCP. The WHO-based team members reported to Headquarters and to the Regional Office for the entire Western Pacific and had no personal stake in the results. It can be safely said that the team came up with unbiased field-based findings on programs, structures, facilities, data systems, relationships and management procedures.

Can the DOH readily carry out the proposals of the review team? Perhaps the Department can build on accomplishments, as for example, the training and laboratory accreditation for HIV testing, the completion of a five-year communications strategy, the high level of awareness on AIDS-related issues, and the avilability of a handbook on HIV/AIDS.

Other important questions relate to: (1) how fast the Department can remedy gaps in the skills of health workers or their attitudes towards the HIV-infected; (2)

putting into good use newly-acquired knowledge;.(3) countering the little attention paid so far to psychosocial aspects of health care; (4) defining the roles of non-statutory bodies in health care; (5) supervision of NGOs without the bureaucracy hampering their capacity to experiment with innovative programs; (6) working out a harmonious relationship with funding agencies; and (7) the conduct of studies needed to guide planning, implementation, monitoring, evaluation and other activities.

Obviously same solutions would seem fairly easy to find but others may require more work, more funds and more political will.

In many ways the recommendations of the external review would put to test the ability of DOH to respond strategically and tactically to both short-term and long-term problems.

B. INTERVIEWS

The external review team completed its work almost a year ago - on July 15, 1993 to be exact - and inputted its final report to the NAPCP **Medium-Term Plan 1993-1998.**

Since then some of the recommendations have been implemented while others await action, as may be gleaned from interviews made for this situation analysis.

The interviewees head programs or sections at the DOH AIDS Unit, FETP, BRL and San Lazaro Hospital. They spoke on the activities of their units, the problems they face, and the priority needs they have. In some instances they generously gave copies of reports related to AIDS.

This subsection incorporates interviews with AIDS program coordinator Dr. Dennis Maducdoc; Mr. Geoff Manthey, WHO-GPA techical officer for NAPCP; Dr. Carmina Aquino, formerly with the USAID Mission in the Philippines Office of Population, Health and Nutrition and now with the lead agency for the education component of ASEP; the Seattle-based Program for the Adaptation of Technology for Health (PATH), and other key staff involved in the AIDS program of the government.

1. Surveillance

One of the recommendations of the external review team was a second look at the regular testing for commercial sex workers. A year after the proposal, CSWs must still get clearances from social hygiene clinics but not for HIV testing which remains voluntary and confidential, the interviewees revealed.

In February 1994 the DOH joined hands with at least two NGOs to discretely promote and provide for free testing after office hours and on week-ends. Dr. Maducdoc fears that some local government units may be using the Sanitation Code, the basis of STD clearances for employees, to press for HIV testing.[6]

As for the sentinel surveillance, the first round was undertaken soon after its fast-tracking was recommended by the external review. Less than four months after the recommendation, results of the pilot phase and the initial round were presented on November 12 at a national conference coordinated by FETP.

In an interview for this situation analysis, Dr. Timoteo Badoy, Jr., AIDS Registrar, outlined steps taken to ensure confidentiality of results, one of the recommendations of the external review team.

The anonymous, confidential method is used for five groups - female commercial sex workers, freelance sex workers, females with STDs, injecting drug users and men who have sex with men. The unlinked, anonymous method applies to males with STDs. Code numbers are used, a step which also serves as identity verifiers.

Dr. Badoy adds that so far there have been no problems of confidentiality. According to him, informed consent is assured by pre-blood extraction counseling. Counseling is part of the training for surveillance teams.

Post-testing counselling is not mandatory because the surveillance does not release results unless a client requests it. This is according to a paper read by Dr. Florante Magboo at the national conference last November. He is coordinator of the National HIV Surveillance Program.[7]

The interview with Dr. Badoy also highlighted the reason for the delay in the second round of the surveillance system: lack of reagents, which has been noted during the external review.

The issue is self-sufficiency as stressed by Dr. Marietta Baccay, BRL director, who urges the manufacture of inexpensive reagents to eventually eliminate import of this indispensable item. [8]

Along these lines Dr. Mary Rose Aplasca, OIC of the AIDS Research Group of RITM, mentioned the on-going search by the technical staff on filter paper and other materials on which sera may be collected. [9]

As for the monthly case update, the AIDS Registrar cross-tabulates gender, AIDS, occupation and other socio-economic factors with HIV infection. This carries out a suggestion from the field to make the FETP document more attractive to readers.

Aside from the ASEP sentinel surveillance system, the social hygiene clinic network has been undertaking passive surveillance. With the STD Program integrated with the AIDS Program, it can now fully implement a recommendation of the external review team for more sites for HIV testing.

According to a briefing material from Dr. Marlene Borromeo, STD Program Manager, the nine-model clinics which can test for HIV can also be venues for health education programs.

1.2 Diagnostics/laboratory facilities

Still unresolved is the frequent shortage of equipment and reagents that was noted by the external review team in 1993.

Referring to equipment, training specialist Minda Quitoriano needs a portable cold storage unit that can keep sera fresh for out-of-town updates with medical technologists.

To amplify on this lack of equipment, there is but one computer at the Laboratory Licensing and Regulation Division of BRL. According to Dr. Antonio Erese, division chief, this slows down their accrediting, monitoring and supervising various types of laboratories: clinical, blood banks, HIV testing, those which train laboratory technicians, and those which test the safety of water.

At the time of the interview for this situation analysis, the Division had just been asked by the Quezon City government for a list of registered as well as unregistered laboratories within the City.

The request indicates the capacity of local governments to monitor entities that check the status of health - or the lack of it - of the ordinary citizen.

The computer-literate staff member who could generate the list had to go on forced leave so that the Government would not have to pay him cash for leave credits.

So the need is not just for equipment but also for manpower, said Dr. Erese in an interview, to run equipment for both the central office and the year-round field checks on laboratories.

On another matter, equipment like the fluocytometer can check CD4 cells but the one and only machine available will leave with NAMRU-2 when the unit withdraws from the country. When that happens, Dr. Santiago fears that DOH medical technologists testing the patients at the AIDS Ward might then have to resort to manual counting.

The external review team was not amiss in warning about the effects of the phase-out. The Philippine government was appealed for a reconsideration but has received no definite response four months before the July 1994 schedule.

A fluocytometer machine alone costs PhP 1 million, Dr. Santiago estimates, without the centralized air-conditioning units which are essential day and night, the reagents and the trained medical technologists. Also indispensable to the AIDS Ward is an electromicroscope for viewing slides of cultures on health levels of blood components.

As to blood, samples and donations are routinely screened for HIV but a large percentage simply is not, it was reported by the external review team. This has relevance to a report that has made Sec. Flavier consider closing all commercial blood banks.[10]

A study team from the New Tropical Medicine Foundation studied 426 blood units from all over the country and found two positive for HIV. Both were from the Visayas-Mindanao batch, one from a government hospital-based bank and the other from a blood center of the Philippine National Red Cross (PNRC).

Confirmatory testing by RITM later reduced the number to one, but the contamination rate of the lots - at least 4% - is still not acceptable, contends the study team headed by Dr. Asuncion Paraan of RITM.

The team also noted that, based on an inventory of their facilities, the blood banks in question could fully screen for all four mandatory diseases.

It now appears that present procedures cannot eliminate potentially infective blood. The study team suggests that BRL should brace itself for a full range of work that is "overwhelming".[11]

First of all, the Bureau has to review its categories of blood banks (primary, secondary and tertiary) to better reflect the natural rather that the theoretical differentiation of blood banking operations.

According to the study team, BRL must review licensing processes to ensure that all blood banks do all the mandated screening tests and that at least one bank per major city and province can prepare most of the blood components.

The BRL must then visit, reassess and reclassify blood banks with a criteria that should include this ability to do all the required tests; staff proficiency; appropriate and adequate facilities, equipment and supplies especially for blood storage, handling and distribution; appropriate practices and procedures for donor and blood screening, blood processing, handling and use including biosafety precautions; and the ability to manage at least 10 voluntary donors per day.

Banks which fail to meet all these criteria should be categorized as mere blood collection centers and should not be allowed to test and process the blood that they had collected.

Releasing assumes testing, the study said. A blood bank which releases blood should test it making sure that no untested blood should be released. In addition, hospitals should document, investigate and forward reports on all transfusion reactions to the national sentinel surveillance system.

The team also studied BRL forms and found them confusing and in need of additional data like monthly donor examination, bleeding and blood purchases. It proposed that reports should be analyzed regularly for limitations, status of services in catchment areas, and improvement of these services.[12]

There are many issues in blood banking system. Three are among the recommendations of the external review team: encouraging blood donations, ensuring donor self-deferral in case of risky behavior, and encouraging doctors to rethink the necessity of orders for blood transfusion. It remains to be seen how soon these will be implemented.

1.3. Clinical management and care

The San Lazaro Hospital and the RITM are in the Metro Manila area but it was in the Visayas-Mindanao area that the RITM study team found two blood samples infected with HIV.

Allowing for the window period of the individuals who gave the blood, it seems that the regions will soon require fully-equipped care systems for AIDS.

To meet this need doctors and nurses from government regional hospitals should be trained at San Lazaro. Last year there were six courses of ten days each. Lectures and laboratory work filled the first week; the second week was a practicum at the AIDS Ward.

Dr. Mina Manalo, medical specialist at the AIDS Ward, cites the draft Department Order that standardizes across hospitals the procedures for admission, care, counseling, support and treatment of both out-patient and confined cases.

These moves strengthen regional capabilities, part of the change of NAPCP response to AIDS - from what Dr. Mina Aquino had descried as "knee-jerk" to one that is multi-faceted.[13]

Thus, the answer to the increase in the number of people with AIDS is more than just increasing the number of hospital beds, a priority expressed by Dr.

Santiago who manages a free ward on an extremely tight budget, but what she herself calls helping patients find a reason to live.

According to her the HIV/AIDS core team must motivate patients to lead normal lives, generate their own income from self-help projects, and willingly take AZT, anti-TB medications and other drugs against opportunistic infections.

Recalling Dolzura Cortez, the most famous patient of the Ward, Dr. Santiago muses on the fine balance between allowing them week-end passes and working out breaches in discipline ("nag-escapo minsan kung busy ang nurse") with one-on-one counseling ("you are our responsibility; why did you come back so late?).

On another front, NAPCP is testing a home care program, perhaps to explore the feasibility of managing opportunistic diseases of the AIDS-related complex at a patient's residence as long as there are provisions for care there. This was one of the recommendations of the external review team. RITM statistics show that in 1990 it had more out-patient consultations than admissions.

There are other aspects to care and support which, Dr. Aplasca believes, is more than the availability of information or on knowledge, attitudes and practices or access to condoms. She sees usefulness in nurturing in the young moral strength to say no to irresponsible sexuality with a values education program. Refusal skills for at-risk situations might in the end lessen the number of people with AIDS who are now beginning to impact on caring services.

1.4. Information, education and training

The information component is the most developed sector of the Program, said the external review team.

RITM for instance may be said to have leaped from print to videotape in the form of lectures that are now being played back at the departure area of the Ninoy Aquino International Airport. For the past three years RITM has also been training medical technologists from other countries on HIV testing skills.

But there have also been gaps. At times the coordination mandate of HEMADETS for training has at times been disregarded by certain units - duplicating efforts within the same program.

Yet much remains to be done in training, states the NAPCP program manager. Hospital staff need training on clinical care and management. Field staff need training on counseling and on the psycho-social impact of AIDS.[14]

Equally pressing is the need for technical training. RITM has a "long list" of applicants from the staff of private hospitals for the twice-yearly course on proficiency in HIV testing. She has BRL from the government sector.

But BRL now faces a shortage of reagents for its training programs since WHO has not yet released funds this year and since the World Bank ends its support this year. Ms. Minda Quitoriano, training specialist, said in an interview: "For three years I did not have to worry about supplies. We were able to meet field demands and even overshoot goals. But now ..."

The interview with Ms. Quitoriano brought to light a ban on peer training by medical technologists accredited by the BRL to test for HIV. Also surfacing was the need to re-train employees of 20 years' standing who repeatedly fail to recognize Hepatitis B virus despite re-tests.

In the case of San Lazaro, the training of embalmers against infections from handling corpses of AIDS cases is long overdue, said Dr. Santiago.

WHO has not yet been able to release funds for 1994. Soon the World Bank ends support for the Philippine Health Development Program. The picture one can paint is that of over-reliance on international funds for a most basic need - health.

1.5. Program management

To carry out its mandate NAPCP must have a cash flow. But once again it seems to be in the situation uncovered in 1993 by the external review team. The lack of funds is occurring despite the articulation of a goal by Dr. Maducdoc for the entire NAPCP: expansion and intensification of operations beyond Metro Manila.

To be sure, certain activities may be postponed without unduly affecting Program goals. But a shortage of a very basic ingredient such as reagents can ultimately set back effective care and support of patients.

Positive developments have not been lacking. Role definitions have been set, according to Dr. Maducdoc. The NAPCP technical staff tracks technical aspects of the program - in reference to the recommendation of the external review team for a "steering" approach - as NGOs generate social support and disseminate information to target audiences identified by the 1992 communication strategy document.

The Secretary of Health continues to have enthusiasm in leading the endorsement of AIDs prevention and control as a national priority. This is according to Mr. Geoff Manthey, WHO-GPA technical officer for NAPCP who enumerates another asset: the ability and willingness of NAPCP staff to view matters with an open mind.

But Mr. Manthey also notes that within DOH the Program is not yet institutionalized. It has not found its niche yet, having been placed within the Office of the Secretary, the Assistant Secretary for Public Health, the Communicable Disease Control Service, and now the Assistant Secretary for Special Concerns.

Mr. Manthey refers to its "ad-hoc nature" that is not helped by the dwindling of funds and that can erode its credibility. AIDS is acknowledged as a special concern - yet is not fully part of DOH by this very nature: special, not yet institutionalized within the Department.[15]

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

Year	Asymptomatic HIV	AIDs			Unclassified*	TOTAL
		Alive	Dead	Total		
1984	0	0	2	2	0	2
1985	6	0	4	4	0	10
1986	21	1	7	8	0	29
1987	26	4	8	12	0	38
1988	21	4	10	14	0	35
1989	32	2	5	7	0	39
1990	52	2	14	16	0	68
1991	66	4	9	13	0	79
1992	52	8	9	17	0	69
1993	61	23	8	31	8	100
1994	6	3	1	4	4	14
Total	343	51	77	128	12	483

* Reported cases that are seropositives but we cannot say if they are asymptomatic or symptomatic

Source: Department of Health AIDS Registrar's Office

Table 2 HIV Seropositives by Gender for Age group AIDS/HIV Registry, 1984 - February 1994

Agegroup (years)	Female	Male	Unknown	TOTAL
0-14	4	7	0	11
15-29	155	68	0	223
30-44	42	118	0	160
45>	6	25	0	31
Unknown	23	31	4	58
TOTAL	230	249	4	483

Source: Department of Health AIDS Registrar's Office

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

Modes of Transmission	February 1-28, 1994 (n = 8)			Cumulative: 1984-Feb. 1994			TOTAL
	HIV	AIDS	Unknown	HIV	AIDS	Unknown	
Sexual							
Heterosexual	1	2	0	185	62	2	249
Homo/Bisexual	0	1	0	33	53	0	86
Blood/blood products	0	0	0	2	3	0	5
Needles & syringes	0	0	0	2	1	0	3
Mother to Infant	0	0	0	4	4	0	8
Unknown	0	0	4	117	5	10	132
	1	3	4	343	128	12	483

Source: Department of Health AIDS Registrar's Office