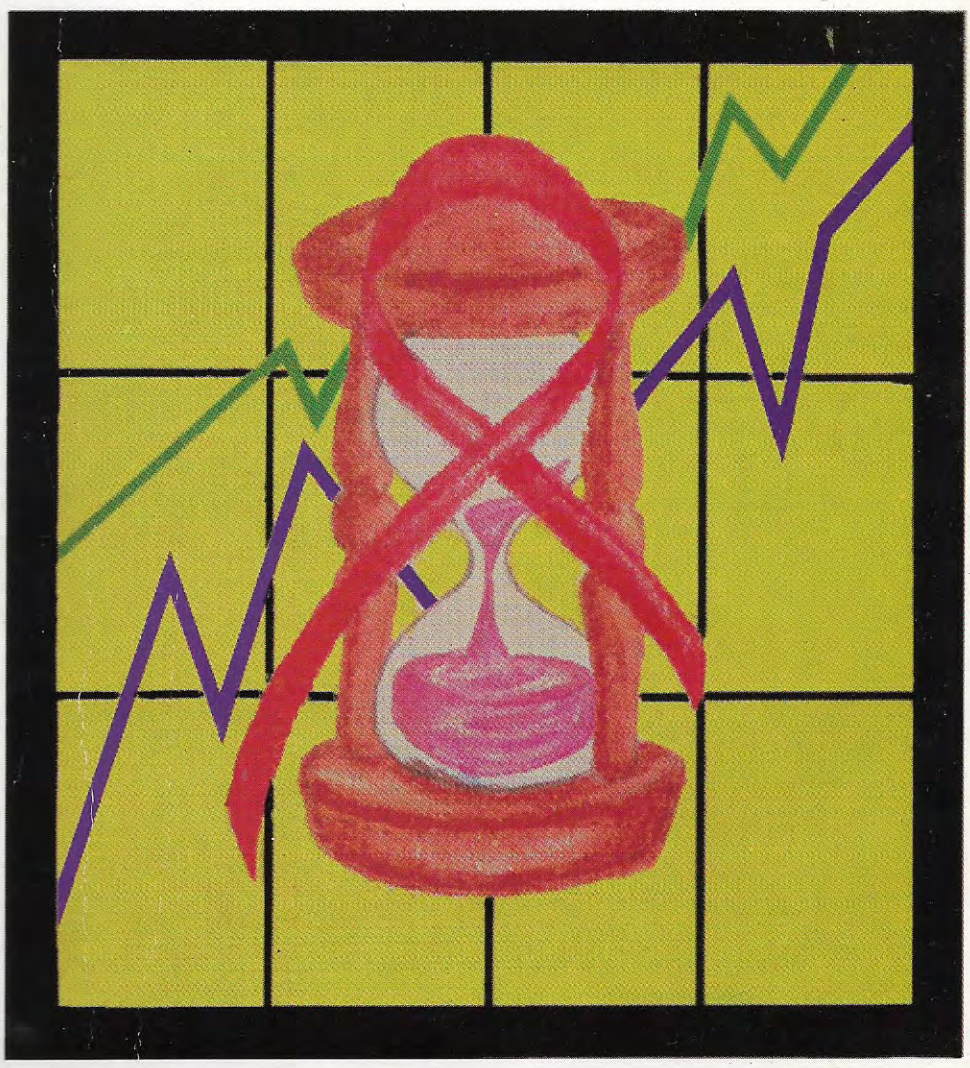
A Matter of Time:
HIV/AIDS and Development in the Philippines



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FOREWORD

HIV/AIDS is now more than a health issue. As has been observed in places with advanced epidemics such as Uganda and South Africa, it can inflict devastating socio-economic consequences.

This study, under the project *Increasing Awareness and Understanding of the Development Implications of HIV/AIDS (DEV AIDS)*, aims for a deeper understanding of HIV/AIDS, looking at it not solely in biomedical terms but in a more encompassing perspective that examines how HIV/AIDS will impact on economic growth rates, life expectancy, poverty, and community and family life. For the first time, better and more focused advocacy and education work has been geared towards convincing stakeholders and decision-makers that indeed, HIV/AIDS is not just a health issue, but a public concern with a devastating impact if not timely and adequately addressed.

The over-all thrust of HIV/AIDS work in the Philippines is first and foremost towards prevention. In effect, this project provides the needed cornerstone for more effective and realistic interventions, anchored on a deeper understanding of what the disease means to the development potentials of the country and to the survival of the Filipino people. This project, thus, pioneers mainstreaming HIV/AIDS in development planning.

As the title of the study suggests, time is crucial. At a particular point in time, there could be a critical mass, which will eventually start an epidemic. On the other hand, we still have time in our hands to do preventive measures now. We have started early on and looking back, we may indeed be winning the war. But for how long? There cannot be complacency. Yes, we have "low and slow" epidemic but this should not push us into lethargy.

This study is dedicated to those who are relentlessly pursuing HIV/AIDS work. We hope that this study will serve as tool for further strengthening our HIV/AIDS prevention and control programs, as well as guide our policy-making and research efforts. We also hope that we will be constantly reminded that HIV/AIDS can be prevented, and that if we have to live with it, we need not live in fear.

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List of Abbreviations

AIDS – Acquired Immune Deficiency Syndrome
AMOSUP – Associated Marine Officers' and Seamen's Union of the Philippines
DALE – Disability-Adjusted Life Expectancy
DALY – Disability-Adjusted Life-Years
DOH – Department of Health
FETP – Field Epidemiology Training Program
FGD – Focus Group Discussion
FIES – Family Income and Expenditures Survey
GDP – Gross Domestic Product
GNP – Gross National Product
HAART – Highly Active Antiretroviral Therapy
HDI – Human Development Index
HIV – Human Immunodeficiency Virus
HMOs – Health Maintenance Organizations
IDUs – Injecting Drug Users
IECs – Information, Education, Communication materials
ILO – International Labour Office
KAP – Knowledge, Attitudes, Practices survey
LGUs – Local Government Units
MDR – Multi-Drug Resistant
MSM – Men Who Have Sex With Men
NDP – National Drug Policy
OCWs/ OFWs – Overseas Contract Workers/Overseas Filipino Workers
PCSO – Philippine Charity Sweepstakes Office
PGH – Philippine General Hospital
PHAs – People with HIV/AIDS
PNAC – Philippine National AIDS Council
RITM – Research Institute for Tropical Medicine
R.A. 8504 – Philippine AIDS Prevention and Control Act (1998)
STDs – Sexually-Transmitted Diseases
TB – Tuberculosis
UNAIDS – Joint United Nations Program on HIV/AIDS
UNDP – United Nations Development Program
UPPI – University of the Philippines Population Institute
WHO – World Health Organization

Executive Summary

This study was commissioned by National Economic Development Authority (NEDA) and United Nations Development Programme (UNDP) with the intention of looking into the implications of HIV/AIDS for development in the Philippines. As we conducted the study, we found that "implications" is a two-way process, i.e., development itself shapes our susceptibility and vulnerability to HIV/AIDS, while HIV/AIDS impacts on development.

The study was conducted from January to June 2000. It is multi-method, multi-disciplinary and multi-site, tapping both primary and secondary research data. The research methods included: (a) two rounds of the Delphi technique with 27 experts from the medical and social sciences for their views on the epidemic, its possible course and impact; (b) gathering of secondary data, mainly studies on HIV/AIDS and development from other countries, but supplemented by local statistics and information; (c) a case study on living with HIV/AIDS, based on interviews with 14 persons living with HIV/AIDS and other key informants; (d) a case study on men who have sex with men, based on a review of literature as well as a consultation with gay community representatives and (e) a case study on Filipino overseas workers, based on surveys with seafarers and maritime students, as well as a review of previous research.

The study reviews and concurs with experts that describe HIV/AIDS in the Philippines as "low and slow", with current estimates of about 13,000 infected Filipinos. We review the factors that may explain this low and slow trend, including: (a) geography, (b) low imports of the virus, (c) circumcision, (d) sexual conservatism (fairly late sexual debut, low incidence of multiple sex partners), (e) low injecting drug use, (f) multisectoral responses, (g) awareness and information campaigns, (h) high literacy rates, (i) rejection of mandatory testing and (j) respect for human rights.

We also review factors that could increase prevalence in the future: (a) increasing population mobility, (b) sexual conservatism (in the sense that this blocks

access to important information about sex and sexuality), (c) commercial sex, (d) casual sex, (e) low and incorrect condom use, (f) the use of *bolitas* and other sexual practices, (g) gender inequity, (h) weak integration with local government units, (i) weaknesses in awareness and prevention campaigns, (j) weak social and behavioral research, (k) HIV's invisibility.

The economic crisis is seen as having variable effects on susceptibility and vulnerability. On one hand, it could increase HIV/AIDS prevalence by: (a) more people turning to sex work, (b) continuing exodus of Filipino labor overseas, (c) reduced budgets for health and social services and (d) increased marginalization of women. On the other hand, the economic crisis could also mean less patronage of sex work. An economic boom in fact may contribute to more HIV, such as in the emergence of red light districts in some rapidly developing cities.

We describe the situation of groups that may be put at additional risk because of social factors including gender inequity, discrimination, and a lack of preventive education. The groups we look at are: (a) women, (b) adolescents and young adults, (c) men who have sex with men, (d) sex workers and (e) overseas Filipino workers. (Separate, detailed case studies on men who have sex with men and seafarers were prepared.)

The macro impact of the epidemic has been, and will continue to be minimal. Studies show that even in countries with prevalence rates beyond 25%, Gross Domestic Product is lowered by only about 1 percentage point. In the Philippines, a high estimate of HIV prevalence is only 0.07%. Using Filipino overseas workers as a case in point, we point out that their contribution to the country's Gross National Product is about 12 percent. In a worst-case scenario, if 1 percent of the total numbers of OFWs are infected and if they no longer contribute to the GNP (an unrealistic assumption), GNP would drop by only 0.12%.

The impact of HIV on life expectancy will also be minimal, although one has to watch out for possible increases in our already high death rate for tuberculosis. We also warn about a decreased quality of life as more HIV infections occur.

In terms of sectors, HIV will continue to have minimal impact on labor. The International Labour Office has a study showing that in a country like Thailand, with an adult prevalence rate of 2%, there will be a 1% contraction of its labor force by the year 2020. Again, the Philippines is a long way off even from Thailand's prevalence rates.

The impact on tourism is also negligible. We point out that even in Thailand, with one of the highest prevalence rates in Asia, tourism continues to boom with 6 million visitors a year compared to 2 million for the Philippines. Our negative image abroad has more adverse impact on tourism than HIV/AIDS.

The health sector is, however, already being adversely affected by HIV/AIDS, even in this current "low and slow" stage. Most health expenditures in the country come from government and from out-of-pocket savings, so the financial burden can be quite serious. In 1999, the DOH budget was only P14.1 billion so resources for HIV/AIDS are scarce. The budget in 1999 for HIV/AIDS was only P45 million, hardly enough to shoulder costs of medicines.

The use of antiretrovirals for HIV/AIDS patients, which slows down progression of the disease and delays AIDS, costs up to P360,000 a year for the medicines and another P50,000 for laboratory tests to monitor the patient. Medicines for opportunistic infections in patients with AIDS are also expensive, some costing up to P2,000 a day.

The heavy burden of HIV/AIDS is highlighted with the example of a donation from the Philippine Charity Sweepstakes of P1.9 million to help pay for antiretrovirals. That amount can only support five individuals.

The impact of HIV/AIDS is greatest, and this is already being felt, on communities and households. Because of weak social security systems in the country, communities and households are the most severely affected even by one individual being infected.

Those most adversely affected are overseas workers. The minimum monthly wage for Filipino seafarers deployed overseas is now US$385 or P15,400 while in Hong Kong, a domestic helper gets a minimum of HK$3,670 per month or about P18,350. These are equivalent to the salaries of middle-range civil servants and is difficult to compete with. We show a hypothetical case where a Filipino seafarer and his wife could earn P6.2 million in 10 years. If, however, the seafarer is infected and diagnosed in year 2, he will no longer be deployed and has to work locally. Eventually, he may have to stop work when AIDS develops. His wife, as a caregiver, may also have to quit work eventually. In this hypothetical case, the combined income of the couple would be only P1.7 million in 10 years. The lost income over the 10 years amounts to P4.5 million, which could have been used to purchase a small but comfortable house, and to put two children through private schools.

We point out how each infected Filipino overseas worker can affect communities in terms of lost investments for new homes, or new businesses. Some regions that deploy more overseas workers than others may be more vulnerable as HIV/AIDS spreads.

Drawing on examples from the HIV-positive Filipinos we interviewed, we show the economic and social costs of HIV/AIDS, including a deterioration in living standards, increased debts, and the withdrawal of children of HIV-positives from school. We also show an erosion of "social capital", of the trust and social bonds. We show discrimination and violations of human rights, as well as AIDS profiteering, where the HIV-positive Filipinos' suffering is used for private gain by politicians and NGOs.

We make several recommendations to reduce susceptibility and vulnerability:

1) Adopting an HIV and development framework for risk analysis.
2) Strengthening social/behavioral research.
3) Monitoring impact of HIV prevention strategies.
4) Expanding multisectoral involvement.
5) Involving local government units (LGUs).
6) Sustaining information, education and communications campaigns.
7) Incorporating gender issues into HIV/AIDS education and training.
8) Respecting human rights.

To alleviate adverse impact of HIV/AIDS, even at this early stage, we recommend the following:

1) Strengthening the social protection system.
2) Strengthening research in relation to clinical care (including exploring the feasibility of community- and home-based care).
3) Strengthening the National Drug Policy and the essential drugs program (to improve access to medicines).
4) Educating the public on human rights.
5) Stop AIDS profiteering.
6) Development to alleviate HIV/AIDS.

We end by explaining the title of the study, "A Matter of Time". We have been fortunate to have had an early start with prevention campaigns, and this may have made some difference. Time is on our side too since we are able to learn from the experiences of other countries. Yet, there is a sense of urgency, because we know that eventually, we might reach a "critical mass" of HIV infections, and that the epidemic can spread rapidly when that happens. Depending on what we do, "a matter of time" can be positive or negative.

I. Introduction

1.1 Rationale and objectives

It was in 1984 that the first HIV case was reported in the Philippines. Over the years, the response to the HIV problem in the Philippines has tended to take one of two extremes. On one hand, there is a tendency to lapse into denial and to pretend that we will not be affected, for reasons that range from "God is protecting us" (told to one of our researchers by a Filipina working with a major donor agency) to speculations that we might have some form of genetic immunity. The other extreme, often used to raise more funds from donors, is to come up with dire predictions of a major catastrophe that will wreck the economy and our social institutions.

Both approaches are dangerous. The conservative approach pretends that if we don't talk about the HIV/AIDS problem, it will go away on its own. The sensationalistic approach, on the other hand, creates unnecessary fears, and because the predicted "disaster" does not happen, government organizations and NGOs working in AIDS then lose credibility.

This study's objective is to look at the implications of HIV/AIDS for development in the Philippines. We have adopted a middle path that neither sensationalizes nor downplays the problem, drawing on the opinions of experts from various disciplines as well as people living with HIV/AIDS.

There have been studies conducted on the impact of HIV (Tan 1993, Solon and Barrozo 1993, Romano et al. 1994). Our present research attempts to present a broader overview of impact on different populations, using diverse research methods.

When our team first started doing research for this project, our framework was one of looking at how HIV/AIDS might impact on development in the Philippines. But as the research project progressed, we realized that there was much more information showing how development was in fact shaping the epidemic in the Philippines, especially in terms of vulnerability and susceptibility. We realized that we had to first understand how development policies speed up or slow down

HIV's spread, before we could understand how HIV would impact on development itself. This report therefore looks at HIV/AIDS as an "intermediary variable", at once shaped by, even as it influences, development.

1.2 The Research Framework: Risk Analysis

To be able to understand the HIV/AIDS problem and how it might evolve in the future, we need to look at our individual and social risks, and the ways we respond to these risks. Barnett and Whiteside (2000a) make a distinction between the terms "**vulnerability**" and "**susceptibility**". Susceptibility is a "term used to describe the individual, group and general social predisposition to infection". Vulnerability, on the other hand, "describes those features of a social or economic entity making it more or less likely that excess morbidity and mortality associated with disease will have adverse impacts upon that unit."

To better illustrate the difference between susceptibility and vulnerability, we can take a hypothetical example of two women, one upper income and the other lower income, both married to philandering husbands. We might say that both have similar degrees of susceptibility for HIV/AIDS in terms of their gender. Whether upper- or lower-class, existing machismo norms may prevent both women from protecting themselves from infection because it is unthinkable for them to ask their husbands to use a condom.

Yet, there will be a difference in their vulnerability. If the two women do get infected, it is obvious that the low-income woman will suffer more. She will not have access to the same kind of treatment and health services that the other woman will have. Neither will she be able to assert her rights and to fight discrimination as effectively as the other woman.

Barnett and Whiteside's distinction is useful insofar as it emphasizes that even an epidemic that is of fairly low prevalence may still have serious effects on certain individuals or segments of society.

Mann and Tarantola (1996) offer a more elaborate breakdown of vulnerability, emphasizing the term as "the extent to which individuals are capable of making and effecting free and informed decisions about their life." This definition shows that the potential adverse impact of HIV/AIDS will depend on the extent to which an individual (or societies) are empowered. Mann and Tarontola point out that vulnerability may be determined by **personal, programmatic** and **societal** factors.

Personal factors deal with the individual and include what is often called "culture", i.e., beliefs and practices. Programmatic vulnerability deals with the quality and content of HIV/AIDS-related information and education campaigns, health and social services, and anti-discrimination campaigns as well as the level of participation of stakeholders in these programs.

Societal vulnerability is the broadest of the three levels of vulnerability and includes many "macro" factors from social definitions of gender statuses and roles to political will.

The factors affecting susceptibility and vulnerability are actually quite similar. We are really dealing with risk factors, which is the focus of our study. In our interviews and focus group discussions, we probed into risk factors as a basis for assessing the implications of HIV/AIDS for development in the Philippines.

The report will first look at where we are today, and how experts assess our situation and the possible course of HIV/AIDS in the future. We then do risk analysis, looking at the assertion of a "low and slow" epidemic to ask why it is so, and then to go a step further to ask if it will always be low and slow. We also present an overview of some of the populations at risk, in order to better emphasize our discussions of susceptibility and vulnerability. After looking at the factors that influence the course of HIV/AIDS in the Philippines, we look at how HIV/AIDS impacts on development, at macro- and micro-levels. We end with recommendations on how we might reduce susceptibility and vulnerability, with specific recommendations for dissemination of this report's findings.

At this point, it would be useful to refer to Barnett and Whiteside's review (2000b) of HIV impact studies conducted globally. They note that most studies conducted on the impact of HIV/AIDS tend to emphasize the economic aspects but that even such studies are limited. Many stop at the macro level and make generalizations which may not be applicable to the real world. Especially for a country of low HIV prevalence, such as the Philippines, attempting to make such macro projections is not feasible, and would in fact be dangerous because it may lead policy makers to think that we are dealing with actual data, rather than hypothetical projections.

Barnett and Whiteside's review points out that earlier impact studies tended to be skewed toward worst-case studies, for example, projections that population growth levels would become negative, and that dependency ratios would worsen drastically. The authors give a more sober assessment, even for the worst hit African countries.

Barnett and Whiteside urge more studies on the range of household coping strategies, especially in urban and peri-urban areas (since earlier studies were mainly in agricultural settings), and to use longitudinal studies of micro and meso impact. They note that "almost nothing has been written by professional social scientists who are not economists about the macro, meso and micro changes occurring in many societies. . ." We hope then that the current study will be an initial contribution toward stimulating more of these studies and that these can be applied toward framing more responsive policies and strategies to prevent HIV/AIDS and to alleviate its impact.

1.3 Research Methods

The study was conducted from January to June 2000. It is multi-method, multi-disciplinary and multi-site, tapping both primary and secondary research data.

1.3.1 Delphi technique

We conducted two rounds of the Delphi technique* with 27 professionals from government, NGOs and the academe, representing medicine, epidemiology, public health economics, anthropology, sociology, gender studies. (See the Appendix I for a list of those consulted.). The first round of the Delphi process involved a written self-administered questionnaire to elicit their views on where we are with the HIV/AIDS epidemic and where we might be headed for.

After this first round, we summarized the responses and furnished the panel members with copies of the findings for them to evaluate. We then conducted face to face interviews with the panel members to try to arrive at a consensus on the various issues raised in the questionnaire.

1.3.2 Gathering of secondary data

We compiled and reviewed data on various aspects of HIV as it relates to development, including economic and social indicators, health statistics, prevalence/incidence of HIV/AIDS and other sexually-transmitted diseases and information on sex work, premarital sex and other risk behaviors. Much of the information had previously been compiled into the Country Profile on HIV/AIDS

*The Delphi technique aims to obtain a reliable consensus of opinion from a group of experts through a series of questioners, interspersed with controlled feedback. The experts are interviewed separetely and are guaranteed anonymity which allows them to be more frank and forthcoming with their opinion (Cf. Garrett 1999:140-142).

(Tan et al. 2000) that HAIN did for the Philippine National AIDS Council (PNAC) but we supplemented this in the current project with more specific data in relation to costs of treatment (including antiretrovirals, as well as a wide range of drugs used for opportunistic infections).

1.3.3 Case Study: People Living with HIV/AIDS

We conducted a case study on Filipinos living with HIV/AIDS. This involved interviews with 14 persons living with HIV/AIDS in Metro Manila, Angeles and Cebu, probing into their lives before and after HIV with the objective of gaining insights into how the disease impacts individuals, families and communities. Table 1 gives an overview of the interviewees, showing their varied socio-economic backgrounds

Table 1. Demographic background of PHA interviewees

Assumed Name	Sex	Age	Marital Status	Current Residence	Place of Origin	Previous Occupation	Present Occupation
Ana	F	41	Widowed	Angeles City	Manila	Sex worker	
C.A.	F	45	Married	Manila	Bohol	Housewife	
Geena	F	26	Single	Manila	Angeles City	Sex worker	Outreach worker
Glenda	F	23	Single	Manila	Manila	Sex worker	
Liza	F	33	Married	Manila	Bacolod City	Housewife	Part-time peer educator
M.A.	F	36	Single	Angeles City	Pangasinan	Sex worker	Sari-sari store owner
Archie	M	33	Single	Manila	Manila	Factory worker	NGO worker
Bobby	M	35	Single	Laguna	Negros	Operations supervisor	NGO volunteer and counselor
Dong	M	28	Married	Manila	Camarines Sur	Skilled worker	Skilled worker
Gabriel	M	33	Widower	Cebu City	Cebu	Electrician manager	Electrician
Jojo	M	40	Single	Manila	Manila	Canteen	—
Joshua	M	37	Single	Manila	Manila	Working in an embassy	Owns a travel agency
Mar	M	32	Married	Manila	Quezon	Seafarer	NGO worker
Jim	M	44	Single	Manila	Manila	Interior designer	Interior designer
Boyet	M	36	Single	Manila	Bulacan	Tax researcher	NGO worker

In addition, we interviewed key informants involved in the care and support of HIV-positive individuals. After analyzing the interviews, we decided to conduct an additional activity in June 2000, a focus group discussion involving six persons living with HIV/AIDS to get additional insights on issues of human rights since these concerns came out repeatedly during the interviews.

This case study was particularly useful because it provided us with first-hand information, not only on how HIV affects individuals and households, but also on the circumstances that lead to HIV infection. We have given special

prominence to these interviews by extensive use of quotations from the people living with HIV. We should emphasize it was these interviews that impressed us with the need to go beyond statistics. Much of the impact of HIV cannot, and should not be converted into numbers.

1.3.4 Case Study: Overseas Filipino Workers (OFWs)

Because several of the experts repeatedly mentioned overseas Filipino workers as a key population, we conducted focused research on the seafarers and their families, as well as maritime students. We probed into their perceptions of a seafarer's life and work, the financial contributions to families, as well as their knowledge about HIV/AIDS and their risk behaviors. This was conducted in the Metro Manila/Cavite area (using secondary data) as well as Iloilo, Cebu and Bohol, and involved KAP surveys, interviews and focus group discussions.

1.3.5 Case Study: Men who have sex with Men

Since male-to-male transmission is involved in about 20 percent of reported HIV/AIDS cases, we conducted a case study on the situation of men who have sex with men (MSM) involving interviews with key informants and one focus group discussion with gay community representatives from Manila, Cebu and Davao. We use MSM here in a broad sense to include those who self-identify as homosexual or bisexual as well as those who do not (e.g., men who think of themselves as heterosexual but have sex with other men). MSM also includes male sex workers.

1.4 Limitations of the Study

This study was conducted over a short term (six months) and with a limited budget. Many of the questions pertaining to HIV and development — from contextual studies of high-risk behaviors to the impact of HIV on households and communities — will require longitudinal studies that combine both quantitative and qualitative methods (see Barnett and Whiteside 2000b). The current study was designed mainly to surface the important issues toward the formulation of a research agenda for the future.

II. Situation Analysis

HAIN has published a Country Profile on HIV/AIDS in the Philippines for the Philippine National AIDS Council (PNAC), with detailed international and local information on HIV/AIDS. This current report, "A Matter of Time", updates some of the facts and figures reported in the Country Profile and adds other information related to the theme of evaluating HIV/AIDS' impact on development in the Philippines.

2. 1 The Global Pandemic

At the end of 1999, UNAIDS (2000) estimates some 34.3 million men, women and children were living with HIV. In the year 1999 alone, some 5.4 million people became infected with HIV. Put another way, about 15,000 people were infected each day.

An estimated 18.8 million people have died of AIDS since the beginning of the epidemic. Most of the infections occurred in people below the age of 25, and most of those infected die before the age of 35.

Sub-Saharan Africa currently accounts for 70 percent of all HIV cases, but Asia is becoming a new "hot spot". Because of the large populations in our region, even if only a small percentage of the population is infected, this still translates into large absolute numbers. In India alone, with a population of 1 billion, 6 million people are believed to have been infected. In neighboring Thailand, a high estimate puts the number of infected at close to 1 million.

What has become clear is that HIV affects mainly the poor and marginalized sectors of society. Globally, 95 percent of infections occur in developing countries. Within the countries – both developing and developed – those infected are usually from the poor, ethnic minority groups, or populations that are socially marginalized (for example, sex workers and men who have sex with men).

2.2 HIV in the Philippines: Low and Slow?

As of March 2000, there were 1,374 reported cases of HIV infection in the Philippines. This is a cumulative number from 1984 onwards. Our Delphi panelists all believe there are many more infections than are reported but it is difficult to say how much more. In earlier years, the Health Department estimated the

actual number of cases was "100 times" the reported cases, but that method of estimation was crude and simply borrowed from Thailand, without any empirical basis.

Later, an American epidemiologist, James Chin, used computer models to project the number of cases. Looking at test results in different populations and using a computer modeling program called Epimodel, Chin estimated in 1993 that we would have about 100,000 cases by the year 2000.

But epidemiologists, including Chin himself, began to wonder if perhaps that 100,000 figure was an over-estimate. In 1998, a panel of experts from various disciplines met again and reviewed the figures and lowered the estimates to 38,000 for the year 2000. In May 2000, another consensus meeting was held to review available facts and figures and came to the conclusion that the epidemic is "low and slow". The meeting resulted in a further lowering of estimates. The meeting concludes: "Based on data on hand, a reasonable estimate for current HIV infections in the Philippines is no more than 13,000 cases for 2000. There were concerns about a higher estimate considering the limitations of the surveillance system, however, this was not supported by available data." (FETP 2000).

In the current research project, the experts we consulted agreed with the "low and slow" description of HIV. We discussed this matter of a "low and slow" epidemic extensively with our physicians and all agree with this assessment, the differences in their views emerging only when they are asked to project about the future course.

We asked the epidemiologists if perhaps our HIV antibody testing may be inadequate but Dr. Consorcia Lim-Quizon of the National Epidemiology Center points out that nearly a million tests are conducted annually in the Philippines, half of them with blood and organ donors, 35% among job applicants (mainly overseas workers) and the remaining as part of diagnostic procedures. Using last year's test results, with about 150 positives out of 900,000 tests, we would have an infection rate of only 1.5 per 100,000.

Our epidemiologists agreed that Filipino health professionals might be misdiagnosing or not recognizing AIDS cases, but that the missed cases would not be that significant. Lim-Quizon pointed out that it was highly unlikely we would be missing out on so many cases. The HIV/AIDS admissions at San Lazaro Hospital and the Research Institute for Tropical Medicine, the country's two main institutions for care of people with HIV, are quite low. At San Lazaro Hospital and the Research Institute for Tropical Medicine (RITM), where most HIV cases are treated, HIV/AIDS admissions from 1994 to 1999 have never

exceeded 300 in one year (See Table 2). Note, too, that the totals for each year include patients who returned to the hospital several times during the year so the actual numbers of patients are lower than the totals given.

Table 2: HIV/AIDS Admissions, San Lazaro Hospital and RITM

Year	San Lazaro	RITM
1994	146	
1995	263	148
1996	83	174
1997	178	173
1998	128	149
1999	166	193

Source: San Lazaro Hospital and RITM records, including out-patients

Another way of looking at the epidemic in the Philippines is to look at HIV prevalence figures for different countries. Table 3 shows the range from Botswana, where a third of the adult population is now infected, to the Philippines, with one of the lowest rates in the world.

Table 3: Estimated HIV prevalence rates among adults (aged 15-49) in selected countries, end of 1999

Country	Prevalence Rates (per 10,000 adults)
Botswana	3580
Swaziland	2525
Zimbabwe	2506
Zambia	1995
South Africa	1994
Cambodia	404
Thailand	215
Myanmar	199
India	70
United States	61
Spain	58
Singapore	19
Australia	15
China	7
Philippines	7
Indonesia	5
Japan	2

Source: UNAIDS (2000)

The "low and slow" figures should not lull us into complacency. The experts we interviewed all agreed it could change for the worse. Later in this report, we will explain why there are some fears that HIV/AIDS could still become a serious problem.

Moreover, in response to the questions about what "exactly" the numbers of HIV infection are, Dr. Victor Mari Ortega of UNAIDS points out that "If it's 38,000 or 58,000 – to me, it makes no difference. It's not going to change the way we approach HIV." We have to respond, and quibbling on numbers may draw us away from the more important tasks ahead.

2.3 Projecting HIV/AIDS

In April 2000, two experts — Alan Whiteside and Tony Barnett — visited the Philippines to conduct a training workshop on planning for the socio-economic impacts of HIV/AIDS. HAIN was represented in the workshop. During the workshop, participants had the opportunity to do a simulated modeling exercise on modeling but the trainers themselves pointed out that for a country with low-prevalence, modeling is of limited use.

The May 2000 meeting of experts that convened to evaluate HIV prevalence in the country has as one of its conclusions: "It is difficult to operate modeling for projection." (FETP 2000). Dr. Gilles Poumerol of World Health Organization cites these "golden rules" for making projections:

1) Existence of an epidemic. This is not happening yet in the Philippines so it is not feasible to make projections.

2) A good breakdown of data for population groups such as antenatal women, sex workers, etc., to include population size, estimated prevalence in each group.

We also conducted interviews with two other experts, Dr. Mala Ramanathan, an Indian demographer and Dr. Anita Hardon, a Dutch medical biologist, both of whom have worked extensively in reproductive health projects. Both warned that modeling can be deceptive emphasizing there are problems with drawing out data in a low prevalence situation and that data for important variables may not be available, or are not accurate. To predict velocity of an HIV epidemic, for example, one would need sound information on sexual behavior. Such data is still limited in the Philippines. Ramanathan also warns that "Every modeler will come up with his own model and these are often not replicable."

When asked about prospects of using "low, medium and high assumptions" for modeling, Ramanathan says this can be done only for demographic trends because there are enough censuses over the last century that can be used to track trends, backed up by extensive data on reproductive intentions, total fertility rates, etc. Even then, the assumptions for populations can still fail because human behavior, especially in the area of sexuality, can be unpredictable. For Hardon, the use of "low, medium and high assumptions" would be "pure folly, an exercise in futility. . .you're bound to either create undue alarm, or undue complacency." Hardon's point is well made: if we created models with low, medium and high assumptions, we could end up with people using low assumptions to say there is no epidemic, and fund-raisers using the high assumptions to justify bloated budgets.

Heeding the advice of our experts, we have not included any modeling results here and have a strong recommendation to avoid using more projections in any dissemination strategy because it will create very serious problems (see our separate report on Recommendations for a Dissemination Strategy). What we do in this report is to concentrate on presenting the views of our Delphi experts on the factors that affect HIV/AIDS spread. We asked our Delphi panelists what they thought the epidemic's velocity would be like in the next five years. The majority felt it would "increase somewhat".

In retrospect, the problem with questionnaires is that terms like "increase somewhat" remain vague. It is useful to return to refer again to Barnett and Whiteside (2000b), who describe HIV as a "long-wave event". Because HIV is slow acting, with a long period where the infected person will not have any symptoms, it will be many years before it is felt and by then, the numbers of infections could be quite high. Barnett and Whiteside (1998: 6) describe six possible stages for an HIV/AIDS epidemic:

Stage 1: *No people with AIDS are visible to the medical services, some people are infected with HIV.*

Stage 2: *A few cases are seen by medical services, more people are infected with HIV.*

Stage 3: *Medical services see many people with AIDS, there is some awareness of HIV infection and AIDS among policy-makers outside medical specialisms.*

Stage 4: *Numbers of AIDS cases may threaten to overwhelm existing health services. There is widespread awareness of AIDS and HIV infection among the general population.*

Stage 5: *Unusual levels of severe illness and death in the 15-50 age group produces coping problems, or phaning, loss of key household and community members. . .*

Stage 6: *Loss of human resources in specialised roles in production and economic and social reproduction decreases the ability of households, communities, enterprises and even districts to govern, manage and/or provision themselves effectively.*

The Philippines is still in the first stage, with a very invisible epidemic. Lim-Quizon gives a useful metaphor for our situation by saying, "*Wala pa kasi ang bagyo.*" (The typhoon has not arrived.) We may be vulnerable in the sense that the houses are built from light materials but for as long as the typhoon is not here, there will be no risks even if you sleep out in the open. However, it would be foolhardy to continue to take those risks if the typhoon is approaching and when the typhoon does strike, even those inside houses will be affected if their homes are not built well.

Dr. Victor Ortega of UNAIDS points out the typhoon metaphor should be used with caution since there is a difference between typhoons and HIV: the former cannot be prevented, while with HIV, one can prevent infections and alleviate impact.

Several of the medical doctors we interviewed referred to the absence of a "critical mass", i.e., we do not have a pool of infections large enough yet so even people who engage in unprotected sex with multiple partners will escape infection. However, as that pool increases, the risks will increase.

In relation to this critical mass, we would like to propose another metaphor used in HAIN's training workshops, that of traffic. The chances of road accidents increase as the number of vehicles multiply. This is not to say accidents do not happen in areas with low vehicular density. They do happen, precisely because people are complacent and become reckless, thinking there aren't that many cars ("HIV infections").

Our epidemiologists say there are other danger signs showing we are susceptible and vulnerable. A useful surrogate indicator would be the prevalence of sexually-transmitted diseases (STDs), which can significantly increase HIV susceptibility. Recent studies, for example, report very high prevalence of chlamydia (up to 32% among pregnant women in one hospital, according to one study). While such high figures have been questioned by some of the epidemiologists we

interviewed, they are still cause for concern. Dr. Ofelia Monzon, one of the pioneers in HIV/AIDS work in the country, has also been monitoring STDs and she points out that several years ago, they already found high STD rates among women sex workers and that the rates were high in spite of the fact that the women were taking antibiotics, i.e., some infections may have escaped detection because of the antibiotic self-medication.

It is difficult to say what numbers constitute a critical mass and when we might reach that point, but when we do, the number of infections can increase very quickly. This has happened in many countries, including neighboring Thailand. It is therefore important to look at the factors that have kept HIV "low and slow" in the Philippines, even as we recognize factors that could change that situation.

III. Risk Analysis

3. 1 Why Low and Slow?

When asked why the epidemic has been "low and slow", the experts interviewed by HAIN have given different explanations. These factors identified are varied, and include the biomedical, social and behavioral as well as those from the arena of policies. In a way then, the evaluation from our Delphi panelists provided our team with a basis to actually evaluate the impact of past and existing responses from government and from NGOs in terms of policies and programs. It is important to look at these explanations, and examine if the factors that keep HIV low and slow will stay that way in the near future.

3.1.1 Geography

The Philippines and Indonesia, both low prevalence countries, are archipelagic nations which make it more difficult for populations to move around. This may have helped to slow down the epidemic. Note, too, that we are detached from mainland southeast Asia. To some extent, the spread of HIV in mainland southeast Asia was facilitated by their shared land borders.

3.1.2 Low "imports" of the virus

In the early years of the epidemic, AIDS erupted mainly in Africa, north America, Australia and parts of western Europe. The virus then spread to other regions, including Asia, through sex tourism and through injecting drug use. Relative to other countries in the region, the Philippines was not as exposed to tourism in the 1980s, mainly because of our political instability. Even today, tourism is undeveloped compared with neighboring countries. Thailand, for example, gets some 6 million visitors a year while we get 2 million.

Note, however, that we did have US military bases in the country and that these may have been among the entry points for the virus. The number of US servicemen in the country was, however, much lower than the tourists visiting countries like Thailand.

There has been a tendency for xenophobia, and anti-American feelings, to cloud the discussions about HIV/AIDS. The presumption that tourists, western tourists in particular (including, now, U.S. servicemen coming in under the Visit-

ing Forces Agreement) spread HIV/AIDS is tenuous. Some of the informal interviews HAIN has conducted in its work with sex workers suggest that Filipino clients are in fact more "risky" because Filipinos tend to be more reluctant than foreigners to use condoms while sex workers, in turn, think of Filipinos as "cleaner".

3.1.3 Circumcision

Most Filipino men are circumcised and this has been cited as one possible reason why HIV prevalence is low in the country, mainly based on the hypothesis that the foreskin provides more surface area for HIV infection to take place. It has also been pointed out that countries like the Philippines, Indonesia and Bangladesh – countries where most men are circumcised – have low HIV infection rates compared to their neighbors.

The medical experts are still divided on this issue. On the prevalence rates, epidemiologists point out that among industrialized countries, the United States, where circumcision is also a norm, has one of the highest HIV prevalence rates. There are arguments that the foreskin – with increased lysozyme production under the prepuce – may protect against HIV.

Some studies warn that focusing on circumcision may obscure the role of other factors, including other practices (e.g., dry sex) in enhancing HIV infection risk. (See the website www.crip.com for a review of the literature.)

3.1.4 Sexual conservatism

HIV is transmitted mainly through sexual intercourse so sexual behavior is important in determining the course of the epidemic. Specifically, HIV spread is facilitated by unprotected sex with multiple partners.

Dr. Margarita Gosingco Holmes, a clinical psychologist and popular media "sex adviser", was one of our Delphi panelists and shared many views about our sexual culture and its risk factors. In the area of young adult sexuality, Holmes feels young Filipinos have very little sexual experience, their questions quite often centering on masturbation rather than on actual intercourse.

The risks of acquiring HIV through premarital sex may be exaggerated, according to several Delphi panel members. In many cases, females who do have premarital sex do so with marriage in the horizon, and their partner is their future husband. In most cases, this will be their only partner. This is supported by figures from the Young Adult Fertility Study conducted by the UP Population

Institute (Balk and others 1999). In the section on young adults, we give additional cross-country figures about sexual activity among adolescents to show that we are relatively conservative.

Cross-national survey figures from the World Health Organization give us a picture of risks and vulnerabilities faced by Filipinos. Some of these figures were published in an article by Deheneffe, Carael and Noubissi (1998) that reviews social and behavioral research data.

Table 4: WHO studies on risk behaviors, 1988-1990

	Manila	Thailand	Rio (Brazil)	Singapore
Any non-regular partners in last 12 months				
n	84	317	274	99
%	14.7	28.2	44.3	9.8
Commercial sex in the last 12 months				
n	32	263	40	76
%	5.6	21	6.5	7.6
Non-regular partners in last 4 weeks				
n	24	129	114	18
%	4.2	11.5	18.4	1.8
Condom use with non-regular partners in last 4 weeks				
n	7	72	25	7
%	1.2	6.4	4	0.7

n = number of those interviewed

Unfortunately, the figures are slightly dated, drawn from surveys conducted between 1988 and 1990 and the sample sizes were quite small, especially for the Philippines. We did review more recent data for the Country Profile on HIV/AIDS and these older figures seem in consonance with the more recent research showing that local sexual activities may be less risky than in other countries.

For instance, extramarital sex seems limited. In the Young Adult Fertility Study, 4 percent of married women and 16 percent of married men said they had extramarital affairs (Balk and others 1999). Holmes feels Filipino men tend more toward "serial monogamy" even in their extramarital affairs, meaning, they have one partner at a time rather than having several. This "one at a time" pattern may extend even into commercial sex partners.

We would like to emphasize that while all these figures suggest fairly "conservative" behavior, we are aware that people may not always give honest answers in sex surveys, precisely because of our sexually conservative culture.

3.1.5 Low injecting drug use

The sharing of needles and syringes by injecting drug users (IDUs) spreads HIV. So far, there has been only one case of HIV that has been reported in the Philippines as having been acquired through IDU.

Local surveys do not show high incidence of injecting drug use in the country and even those numbers may be over-reported, due to unclear survey questions. (Note the term "injecting drug use" is itself ambiguous. Strictly speaking, it is the sharing of needles and syringes during intravenous injections that spreads HIV.)

A concern that has been expressed is that injecting drug use might amplify an HIV/AIDS epidemic but it has been shown in southeast Asia (mainly Thailand) that even in countries with high numbers of IDUs, the epidemic among IDUs and the epidemic from sex work were separate ones, rather than one amplifying the other (Weniger et al. 1994). Lim-Quizon, who has followed IDU closely through the DOH's sentinel surveillance research, points out that in the Philippines, the sharing of needles and syringes takes place among a small circle of drug dependents. She also notes that the drugs used by the dependents are actually non-addicting, e.g., analgesics such as Nubain and Sosegon. Quizon also questions figures from surveys reporting as high as 5 percent of males involved in injecting drug use. Projecting the figures nationally, this would mean 900,000 users, far too high a figure.

3.1.6 Multisectoral efforts for national AIDS policies

AIDS campaigns in the Philippines have been multisectoral, involving government organizations, NGOs, academic institutions and community groups. Government agencies include those from the executive, legislative and judicial branches.

The Philippine National AIDS Council (PNAC), first created in 1992 by President Fidel Ramos, was able to coordinate activities in HIV prevention and to guide national and local government AIDS policies. PNAC was able to advise Congress and local government units against useless tactics such as mandatory testing (discussed below) and to pour more efforts into prevention and care. Moreover, PNAC was able to help in the passage of the National AIDS Act, which is a comprehensive law that guides efforts for preventing HIV and caring for those infected.

The Philippines' commitment to multisectoral efforts is reflected in the participation of various organizations in AIDS work. These include one gay men's organization, as well as Pinoy Plus, an organization of people living with HIV/AIDS. The active participation of these organizations in policy-making as well as program implementation has been a key factor in increasing the chances of success for many of the prevention and care programs.

The importance of an early start, and the use of a multisectoral approach, cannot be over-emphasized. Among African countries, those with lower rates seem to be the ones that responded early, and that mobilized different sectors of society. Senegal is cited by UNAIDS (2000) as one example, with a current adult HIV infection rate of about 2 percent, compared to rates ranging from 25 to 35 percent in several southern African countries.

3.1.7 Awareness and information campaigns

The Philippine government and NGOs were able to launch AIDS awareness programs quite early, dating back to the second half of the 1980s. Awareness about AIDS is quite high in the Philippines in urban and rural areas. While this does not always mean accurate and exact knowledge about HIV and AIDS, much less safer sex behavior, the prevention campaigns probably had some impact in terms of slowing down the spread of HIV. It is also important to note that local information campaigns were, for the most part, planned systematically. There were conscious efforts to tailor the information materials for specific groups, and to produce materials that avoided messages based on fear (e.g., "AIDS Kills" and "Don't Die of Ignorance") or other counter-productive tactics.

3.1.8 High literacy rates

We have been careful not to claim that our awareness and information campaigns are "effective". The Philippines does have an advantage of a high literacy rate – currently over 90 percent — which makes it easier for AIDS information to get to the population. AIDS awareness has therefore been very high – reaching almost 100% in the surveys – perhaps because of an exposure to information coming from different sources, both local and international. We will point out, however, that awareness does not necessarily translate to accurate knowledge and there are cases where mass media contribute to problems of misconception.

3.1.9 Rejection of mandatory testing

Early on, the Department of Health rejected the use of mandatory testing as a "prevention" measure. This was based on scientific facts, i.e., the knowledge that HIV antibody testing is not reliable. Such tests rely on the detection of HIV antibodies but even if someone is infected, the antibodies take time to appear, sometimes for as long as six months after infection. This "window period" means a person can be infected and yet test negative.

The use of mandatory testing would have promoted a false sense of complacency. There is, in fact, some evidence that this is happening among clients of sex workers, who think that the sex workers' health clearances from Social Hygiene Centers are enough insurance against HIV/AIDS. Several times, Congress and local government units attempted to require these tests for particular populations – from gay men to students — but the Health Department and the Philippine National AIDS Council (PNAC) members were able to convince policymakers to shelve these proposed bills, saving the country millions of pesos.

3.1.10 Respect for human rights

The rejection of mandatory testing is only one example of this respect for human rights but there are many other examples from the Philippine response that reflect this emphasis on rights. The AIDS Act is comprehensive in prohibiting discrimination in schools and in the workplace against people living with HIV/AIDS.

Such measures have sometimes been criticized as being unrealistic, especially by those who would prefer draconian measures such as mandatory testing and quarantine of people with HIV/AIDS. But such drastic control measures being proposed are not only violative of human rights but are unscientific and may increase the risks for HIV spread. As explained earlier, HIV antibody testing is not reliable since there is a lag period before the antibodies show up. Moreover, mandatory testing and threats of detention of HIV- positives will drive vulnerable populations further underground.

In fact, broader instances of discrimination against stigmatized groups have already increased their risks for HIV. An example comes with the police raids that closed down the red light district in Manila. This only drove the trade underground, and to neighboring cities, making it more difficult for government and NGOs to conduct HIV education. Moreover, in such clandestine circumstances, sex workers are in complete control of their pimps, unable to negotiate with customers for safer sex.

3.2 Always Low and Slow?

The low and slow epidemic may be due to a combination of all the different factors described above, rather than just one or two. Moreover, these "protective" factors may change across time. We have mentioned the fear some epidemiologists have, that once we reach a "critical mass", a certain number of infections in the country, the epidemic could then take off and spread quickly. Risk analysis is important to look at how our susceptibilities and vulnerabilities might change, for the worse.

3.2.1 Increasing population mobility

The country's archipelagic nature will not change, but population mobility is on the increase and could increase risks for HIV. We already have some 4 to 6 million Filipinos living and working overseas, often in countries with much higher HIV prevalence. About one out of every 5 reported HIV cases now involves an overseas worker, in many cases the infection taking place overseas. In some cases, the infections have in turn been spread to their spouses or partners after the HIV-positive individual return to the Philippines.

In-country migration, mainly a move toward urban areas, has been increasing rapidly in the last two decades and could increase HIV vulnerabilities. The economic crisis could aggravate the migration to cities, and would include entry of larger numbers of people into sex work. Moreover, cities provide more anonymity and migrants, away from their families, may be more prone to engage in casual sex. Without strong information campaigns, this casual sex could be largely unprotected and lead to an increase in HIV infection rates.

In an international study looking at HIV/AIDS, Over (1998) notes: "A final factor which in the regression analysis is not necessarily associated with development but can be readily affected by government policy, is the level of militarization. . .countries with more soldiers will have higher infection rates. . ." Our Delphi panelists from Mindanao also point out the problem of war and militarization, which involves great population movements in terms of displaced refugees, soldiers entering an area and the concomitant rise of prostitution. These could hasten the spread of HIV if there is a critical mass of infected individuals.

3.2.2 Sexual conservatism

Sexual conservatism is not always protective. Conservatism can block access to important information about sex and sexuality and put people at risk. Existing traditional values – which tend to "protect" young people by keeping

them ignorant – can be dangerous when people are thrust into new situations: rural women, for example, suddenly in an urban setting, or even in another country. As a HAIN study on young adult sexuality concludes: "Ignorance is not always innocence."

Several Delphi panel members pointed out the problem of opposition from religious conservatives to HIV education and the distribution of condoms, and expressed fears that this opposition could result in the epidemic speeding up in the future. One Delphi panel member emphasizes that the problem is not just opposition but outright misinformation, such as claims that condoms do not prevent HIV/AIDS, or that condoms actually increase the rates of infection.

3.2.3 Commercial sex

There was a lack of consensus among our experts on the extent of commercial sex in the country, although all agreed it is a serious problem. Some experts even say there is an emerging "culture of prostitution", which they link to materialism, rather than to poverty. We will discuss commercial sex at greater length later in the report.

3.2.4 Casual sex

The preoccupation with commercial, premarital and extramarital sex as sources for HIV infection may obscure the fact that casual sex is quite significant in the country and that this could pose HIV risks. People involved in casual sex may not think of themselves as vulnerable, or are not reached by safer sex messages to use condoms. The risks for acquiring HIV through casual sex may still be low because we have not reached a critical mass of infected individuals. When that critical mass is reached, casual sex could become a major route for HIV transmission.

3.2.5 Low and incorrect condom use

After "poverty/economic crisis", the low use of condoms was the most widely mentioned factor by our Delphi panel as speeding up the spread of HIV/AIDS. Results from the Health Department's behavioral monitoring studies show that condom use remains unpopular in the Philippines, despite several social marketing campaigns. The Field Epidemiology Training Program (2000) notes that in 1999, "consistent condom use rates remained low (<50%) among all groups", these groups being populations at risk for HIV such as sex workers.

In the Young Adult Fertility Study conducted by the UP Population Institute, 90 percent of males had at least one negative attitude toward condoms. In the same study, only 22 percent of male respondents who knew about condoms said they ever used condoms. Of the men who had sex with a sex worker in the last six months, only 27 percent used condoms every time or most of the time. (Balk and others 1999).

There is also concern that condoms are not being used correctly. HAIN's team of health educators have found that many male sex workers, for example, use condoms but use them improperly, for example, failing to pinch the tip to expel air, unrolling condoms like socks, and using oil-based lubricants. A few sex workers did not even know what a lubricant was. Spruyt (1998) found the following problems in condom use among men in Mexico, the Dominican Republic and the Philippines: opening with sharp object, unrolling before donning, lengthy sex and intense/rough sex. All these defects in condom usage can increase the chances of condom breakage or slippage.

Geena, a former sex worker who continues to do HIV/AIDS prevention work with other sex workers, speaks of the difficulty in promoting condoms:

> *Pag naka-drugs kasi, madaling i-ano na sige, ibigay ko na. Kahit na mali, nagiging tama pag naka-droga ka. Lalo na kung guwapo yung customer tapos ayaw gumamit... naku, wala na. Nung bago pa lang ako nag-a-outreach, iniiyakan ko talaga sila pag may sinasabi silang Geena, may masakit sa puson ko, o Geena, buntis ako. Parang... anong ginawa niyo sa mga condom? Di ko naman pinapakita, pero kung mag-isa ako, talaga naiiyak ako...*
> (If you're on drugs, it is easy to give in. Even if it is wrong, it becomes right when you're on drugs. Especially if the customer is handsome but refuses to use [condoms]... naku, you're a goner. When I was newly into outreach, I would cry whenever they would say "Geena, my belly aches," or "Geena, I'm pregnant." It's like... what did you do with the condoms? I don't show it to them but when I'm alone, I really cry.)

3.2.6 The use of bolitas and other sexual practices

It is not clear if *bolitas* (metal balls inserted under the skin of the penis) affects HIV risk but we have one former seafarer who thinks he may have been infected because of the use of these objects:

May open wounds kasi ako, dahil sa pag-experiment namin sa barko. Nag-testing testing kami. Nagkabit ng mga foreign body, minsan insertion, nag-bolitas, ganoon. May nakasama ako na mahilig magkabit eh katulong niya ako sa pagkabit. Ako naman, ah ganoon pala yun, so... ginawa ko sa sarili ko. Nagkataon na paparating kami sa puerto. Sa ibabaw, nag-heal na yung sugat, pero sa ilalim, sariwa pa pala... (I had open wounds because we were experimenting on the ship. We were doing some testing. I put on foreign bodies, sometimes inserted them – bolitas, things like that. I had a companion who liked to do that, and I was helping him to put them in. For me, 'ah, so that's how you do it...' so I did it to myself. It so happened that we were approaching the port. On the surface, the wound was healed, but underneath, it was still fresh...)

The use of *bolitas* is actually quite common among overseas Filipinos. In one FGD conducted in Iloilo among maritime students, the students said they were aware of the practice of inserting *bolitas*, and described how the seafarers themselves have learned to insert glass and other materials under the penis.

Unfortunately, no research has been conducted to look into the HIV risks for the use of *bolitas*, as well as other sexual practices, for example, dry sex or the use of tawas (alum) for the vagina. In theory, all these practices could make an individual more susceptible to HIV infection because of its abrasive effects on the genital tract, especially of the female partner.

3.2.7 Gender inequity

While Filipinas may seem better off than other Asian women, there is still significant gender inequality in the country that could increase vulnerabilities. More details are given in our discussion of women's susceptibility and vulnerability but we would like to cite here one example of how gender inequity affects HIV risk. Ana, a former woman sex worker infected with HIV, talks about the difficulties of getting customers to use condoms:

Yung mga customer kasi sa Maynila ayaw magcondom eh. Eh hindi naman puwedeng ikaw ang magsuot ng condom. Di ba lalaki lang naman. Nakikipag-away kami noon. Pero wala ka ring magagawa kung ayaw, pipilitin ka, masasaktan ka lang. Mga well-known naman kasi ang mga customer nun sa Manila. *(The customers in Manila don't like to use condoms. Eh, you can't be the one to use condoms. Only men can do that. We used to*

quarrel with them. But you can't do anything if they don't want to, they'd force you, you'd just be hurt. The customers are well-known in Manila.)

The matter of gender relations should also be discussed in relation to gay men. While homosexuality is relatively well tolerated in the Philippines, the fact is that discrimination continues and may marginalize men who have sex with men, preventing their access to education and information about HIV/AIDS, and putting them at risk.

3.2.8 Weak integration with Local Government Units

The decentralization of health services to local government units has been problematic since many LGUs still lack the capability – financially as well as in terms of human resources – to deal with HIV/AIDS. Commitment to HIV prevention sometimes depends on politicians, waxing and waning according to whoever is in power. One of our Delphi panelists also warns about politicians using HIV/AIDS for their own interests, mainly to gain publicity. Often, the rhetoric of such politicians does not translate into financial or logistical support.

3.2.9 Weaknesses in awareness and prevention campaigns

There has been some slack in prevention campaigns, with several Delphi panelists saying they have not seen any new materials in the last few years. (One panelist, who does not work in the AIDS networks, went as far as asking, "What materials?") While AIDS awareness remains high, recent informal surveys by HAIN in Metro Manila, Baguio, Cebu and Davao all show that there are still many old misconceptions floating around such as saliva spreading HIV/AIDS. In addition, there are new misconceptions that have been emerging, such is the idea that there is a cure for AIDS, fuelled by media publicity about medicines used in HIV.

Several of the Delphi experts we consulted also pointed out that local information and education programs are not adequately evaluated. "Glossy materials are not always the most effective," points out one expert. Distribution was identified as a problem, meaning there is a tendency to "talk to the converted," with materials not reaching those who need them the most. The lack of materials in languages other than English and Tagalog has also been brought up as a problem.

The tendency to emphasize mass media approaches (radio, television, posters) has also been identified as a weak point, especially when they are not clear on the desired action response, other than referring people to health centers (which

may not be prepared to give HIV information). Given the complexity of AIDS education, more interactive, interpersonal methods are needed.

Finally, some Delphi panelists feel existing information and education programs tend to be biomedically-focused and are weak in addressing important issues, particularly in the area of gender relations and discussing HIV's relationship to development. This leads to unrealistic interventions, for example, even if sex workers learn how to put condoms on customers using their mouths, the fact remains that male clients can still assert their power and refuse to use the condoms.

3.2.10 Weak social and behavioral research

There are still many gaps in our understanding of local risk factors. "Sexual networks" (who is having sex with whom) as well as sexual cultures are still poorly understood in the Philippine setting, sometimes leading to faulty policy advice. There is, for example, a widely quoted speculation that HIV infection rates are low in the Philippines in part because "anal sex is not popular among Filipino gays". This has not been substantiated in any rigorous study. In fact, participants in a focus group discussion we held among representatives of gay organizations in June 2000 rejected this assumption as baseless and misleading.

An example of the data gaps comes from economist Alejandro Herrin, who points out we might need to even look at how condom use correlates with prices charged by sex workers. A study in Thailand a few years back did in fact find correlation between HIV infection rates and prices charged by the brothels: those with lower prices had more clients and greater HIV risks.

Dr. Manuel Dayrit, who at one time headed the National AIDS Program, points out that we only have "snapshots" of reality when it comes to behavior that may affect HIV risk. Our social scientists point to the need for more contextual research that goes beyond surveys and looks instead at the "total picture", to understand why people are put at risk.

To underscore the need for socio-behavioral research, one that probes into the "total picture", we quote from Mar, a former seafarer, as he recalls his behavior while overseas:

> *Kahit na alam mo ang tungkol sa HIV... Sa mga STD na lang eh. Alam mong makakakuha ka ng STD kung hindi ka gumagamit ng condom... Pero yung behavior na hindi ako magkakaroon niyan. Lalo na kung lasing. Kahit na may dala kang condom, hindi mo na gagamitin yun kasi lasing ka na. Sa susunod na lang ako*

gagamit. So gumamit ka sa susunod. Tapos sa susunod, hindi na naman. Eh kung nagka-baligtad – yung ginamitan mo wala, yung di mo ginamitan yan yung meron. (Even if you are aware about HIV...even STDs — you know that you can get STDs if you don't use condoms, but your behavior of 'I won't get that.' Especially if you're drunk. Even if you bring condoms, you won't use them if you're drunk. 'I'll use the condoms next time.' So you do use it the next time. But then the time after that, you don't use it again. What if the reverse happens: when you use a condom, your partner doesn't have it (STDs) and when you don't use it, your partner has it.) [Mar]

3.2.11 HIV's invisibility

In a catch-22 situation, the low HIV prevalence in the Philippines itself becomes a risk factor. Since most Filipinos still do not know someone with HIV, they do not feel the threat of HIV/AIDS. It has not helped that the government and NGOs used alarmist tactics over the last few years with bleak scenarios of large numbers of infected Filipinos. People are asking now, "Where are those large numbers?" Similar to the story of the boy who cried wolf, we may be in a situation where AIDS stories have little effect now on people other than a curious news item.

The invisibility is dangerous. The HIV-positive Filipinos we interviewed sometimes referred to their own denial, based on the idea that HIV was not a local problem:

AIDS ay sakit ng mga foreigner, hindi sakit ng mga Pilipino yun. Inisip ko na wala naman akong naging ka-partner na foreigner, puro Pilipino lang... Sabi ko, parang imposible. (AIDS is a foreigners' disease, it's not Filipinos' disease. I thought that since I had no foreign partners, just Filipinos... I said, it's impossible.) [Archie]

Sabi nila walang AIDS dito, nandun lang iyan sa Maynila. (They said that there's no AIDS here, only in Manila.) [Gabriel, an HIV-positive Filipino living in Cebu]

3.3 The Economic Situation and HIV/AIDS

The Philippines is going through an economic crisis, one that preceded the "Asian flu" that broke out late in 1997. Often dubbed as the "sick man of Asia", the Philippines lagged far behind other southeast and east Asian countries start-

ing in the 1970s, mainly because of economic mismanagement under the Marcos regime. Some signs of economic recovery appeared during the Ramos regime but the gains seem to have been eroded since 1998.

The latest Labor Force Survey showed an unemployment rate in April 2000 of 13.9 percent, which is a 9-year high. The underemployment rate was 25.1 percent, the highest ever recorded since underemployment figures were used. Translated into absolute figures, there were 4.5 million unemployed and 7.1 million underemployed Filipinos in April 2000.

Economists have a "misery index" which combines unemployment rate and inflation rate. Inflation rates have been fairly low, 4.1 percent as of May 2000, but there is much public discontent over periodic increases in oil prices, which the public attributes to the deregulation of the oil industry.

Our Delphi panel members had mixed views about the impact of the economic crisis on HIV/AIDS risk. The consensus was that the economic crisis would "somewhat" increase vulnerability, mainly in terms of: (a) people who turn to sex work; (b) the continuing exodus of Filipino labor overseas and exposure to countries where prevalence is high; (c) reduced budgets for health and social services and (d) increased marginalization of women.

Ironically, an economic boom situation is also seen as a possible factor that increases people's susceptibility to HIV. One anthropologist in our panel points out that areas with high-growth industries could attract more migration, fragmentation of families and the emergence of red light districts. Lim-Quizon, for example, notes that the number of registered sex workers has been increasing in General Santos City, one of the country's boom areas.

The relationship between the economic situation and HIV/AIDS is quite complex, and this is shown clearly when we look at sex work. The economic crisis could drive more people to sex work, yet, because of that crisis, we may also see fewer clients since they would not have the money for the sex workers. Then again, an economic crisis could drive down prices charged by the sex workers. Ofreneo and Ofreneo (1998) point out that in rural areas, the prices of sex workers are sometimes pegged on to the price of rice.

In a review of data from different countries, Over (1998) proposes that both low income and unequal distribution of income are strongly associated with high HIV infection rates. Both problems of low income and income inequity are found in the Philippines.

The 1997 Family Income and Expenditures Survey (National Statistics Office 1999) showed 37 percent of households living below the poverty threshold level. In Mindanao, all regions had at least 45 percent of the population living below this poverty threshold. Income distribution has worsened over the years. Between 1994 and 1997, the share of the richest 30 percent increased from 63.7 percent to 67.2 percent in 1997. The share of the poorest 30 percent, on the other hand, dropped from 8.8 percent to 7.8 percent.

The relationships between low income and HIV are all too pervasive. There is the direct effect of low income, for example, not being able to afford condoms. But there are also indirect effects, such as lower educational attainment, which in turn affects access to information about HIV. Poverty, especially in a society marked by gross income inequities, also breeds power differentials that increase susceptibility and vulnerability. A sex worker is at risk because she is a woman, from a poor family, which makes her more vulnerable to exploitation by a rich client.

3.4 Synthesis: Why People Are Infected

Why are people infected? We have cited different factors that could increase individual and social susceptibility for HIV. It is clear there are economic factors, but as Dr. Loreto Roquero, head of the DOH National AIDS Program, puts it: "There are other reasons, besides economics, that explain HIV/AIDS. Why is it that in some countries poorer than we are, sex work is not as widespread?"

One way of summarizing what we have discussed is to quote again from Geena, one of our most articulate HIV-positive Filipinos. Geena acquired HIV while doing sex work. Could things have been different? We think so, if Geena hadn't been poor, hadn't been a woman, and we could go on and on. . .

> *Pangarap ko nun, makatapos sa pag-aaral, gusto ko kasi nun mag-Air Force. At that time, bali from grade 6, nag-jump ako ng 3rd year. Down na down ako nun, kasi wala akong pambili ng books. Yun na lang eh, kasi libre na lahat. Pero kahit na yung mother ko, di niya ako tinulungan kahit na gustong-gusto kong mag-aral. Sabi sa akin ng mother ko, mag-aaral ka pa, mag-aasawa ka rin lang naman. Nag-focus siya doon sa kapatid kong lalaki, sabi niya iyan ang maghahawak ng pamilya, makakatulong sa kanya ang pag-aaral. Eventually, tumigil din ako nung 3rd*

year. (My dream before was to finish school. I wanted to join the Air Force. At that time, from grade 6, I *jumped to 3rd year. I was so down because I didn't have money for books. Everything else was free.*

But my mother, she didn't help me even if I wanted so much to study. She said, you want to study but you're just going to get married anyway. She focused on my brother, she said he'd be the one to take care of the family, and it would be more useful for him to study. Eventually, I stopped school that 3rd year.)

IV. Populations at Risk

During the early years of the HIV/AIDS epidemic, the term "high-risk groups" was widely used. The use of that term was discouraged because it tended to stigmatize particular groups such as gay men. AIDS activists pointed out that there was no such thing as high-risk groups, only high-risk behavior.

Health activists replaced the "high-risk group" paradigm with one that suggested everyone was at equal risk for HIV/AIDS. Over the last 5 years, however, this paradigm has also been challenged as more social and behavioral studies show that certain populations may indeed be at higher risk for HIV than others. Unlike the "high-risk group" label, however, the term "populations at risk" (or "vulnerable populations" or "susceptible populations") simply states that in particular societies, some groups may be at higher risk than others because of a combination of economic, social and even biological circumstances. It is important to identify these sub-groups and to initiate appropriate strategies to address their needs.

In this report, we discuss five groups that may be more susceptible than other populations for HIV in the Philippines: (a) women, (b) young adults, (c) men who have sex with men, (d) overseas Filipino workers and (e) sex workers. We will discuss each of the groups as they relate to the risk factors that we discussed in the earlier section, showing why they may be more susceptible to HIV.

We urge caution, however, in using this section of the report. First, the labels, one should note, are not discrete and exclusive. For example, one could be a young adult female working overseas as an entertainer, which would place that person in four of the five populations at risk that we included for this report.

Second, we have prepared longer case studies only for two groups: (a) men who have sex with men and (b) overseas Filipino workers. We did not do studies for the other groups since there are other comprehensive studies that exist. We will cite those studies in the pertinent sections.

Third, naming the five groups here does not mean other populations are at low risk. Risk will vary for specific populations at different times. For example,

in areas with war and intense militarization, sex work could increase and increase HIV transmission in the militarized areas. Again, the matter of critical mass is crucial. If a pool of infection exists, it could spread rapidly in a previously "virgin" population. As a whole, the critical mass has not been reached in the Philippines but when it does, the potential for more populations being put at risk will increase as well.

4.1 Women

The UNDP (2000) has a gender development index (GDI) that seeks to measure gender equity. The Philippines ranks 65th among 174 nations, doing better than many other countries. We do fairly well with almost no difference in literacy rates between males and females (except in Mindanao), and have more females than males enrolled in schools. Females also have higher life expectancy than males. It is mainly the economic sphere where there are gender differences, with females having a real per capita Gross Domestic Product of US$2,510, compared to $4,513 for males. We also fare poorly in terms of representation in Congress, in elective executive posts (e.g., mayors and governors) and in vital government positions.

In the National Demographic Survey of 1993, 10% of women said they had been subjected to domestic violence (National Statistics Office and Macro International 1994). The National Demographic Survey of 1998, on the other hand, showed that among couples who stopped using condoms, the reason cited by 10% was the husband's disapproval (National Statistics Office and Macro International 1999). Such statistics suggest Filipinas are not always in control of their own lives, and that this could affect their ability to protect themselves from HIV and STD infections.

Gender inequality, however mild, may affect HIV/AIDS risk. Women are more vulnerable to HIV/AIDS for biological as well as social and cultural reasons. HIV is passed more easily from men to women, rather than from women to men because of anatomical and physiological reasons (European Study Group on Heterosexual Transmission of HIV 1992). Socially and culturally, women are less likely to be able to protect themselves or to negotiate for safer sex. This applies to women sex workers and their relationships with clients, as well as with women in general in relation to their regular partners or their spouses. In fact, the latter situation may create more problems in the future, for example, as infected male overseas Filipino workers come home and their wives are unable to protect themselves.

The National AIDS Registry already reflects the effects of gender inequity. Most reported cases among females are in the younger age groups while among males, infection tends to take place among older men. Since many of the reported infections occur in the context of sex work, it suggests that the clientele tends to consist more of older men, while the women who are vulnerable are the young sex workers.

Even outside of commercial sex, age and gender can be a dangerous combination that puts young girls at great risk for HIV. Young girls' reproductive tracts are still underdeveloped and may be more prone to traumatic injury during intercourse, which means STIs, including HIV, can be more easily transmitted.

There is, however, the danger that we may think only women in sex work are at risk. We have pointed out how gender inequity puts women at risk, including housewives who may not be able to question their husband's philandering.

All too often, women are made vulnerable not because of their own action but because of their partners. For example, we found that the wives of seafarers were often trapped in a situation of denial, many believing that seafarers were "by nature" promiscuous, but also saying their husbands were different. The situation of these wives becomes even more precarious because we found low levels of awareness and knowledge about HIV/AIDS among them.

Another situation where women become vulnerable because of their partners are those whose husbands or boyfriends are sex workers. In our survey of one establishment's sex workers, 19 out of 32 were married or living in with a woman. If they acquire an HIV infection through their work, they can easily spread this to their wives or live-in partners.

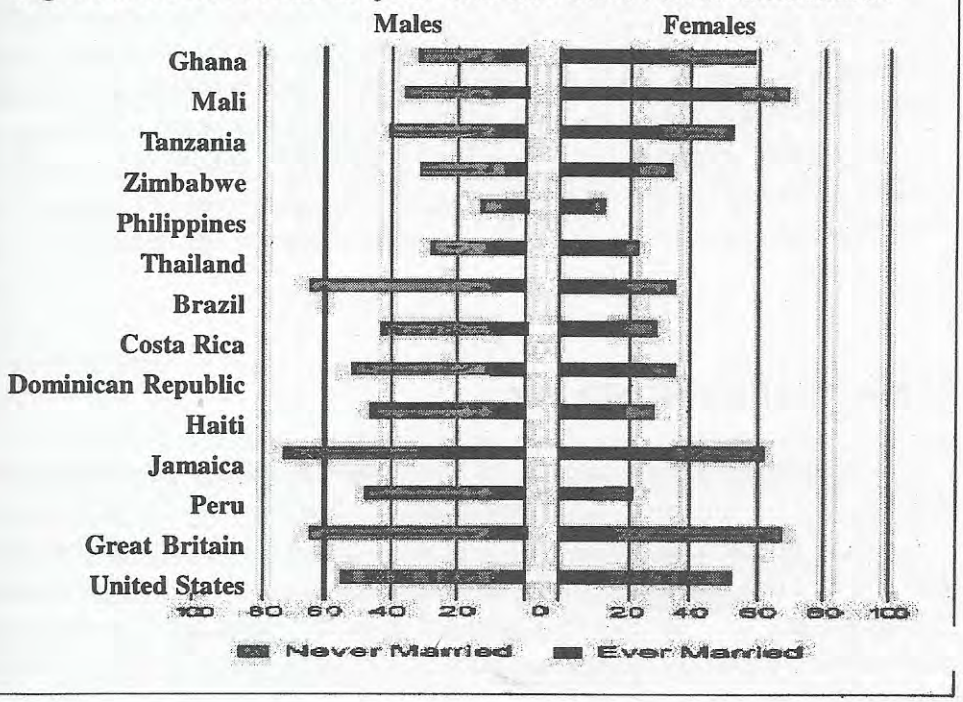
Women's vulnerability, ultimately, may relate to economics. The April 2000 labor force survey (National Statistics Office 2000) showed that only one half of females aged 15 and over were employed or looking for a job. Because many women are unable to find jobs in the formal sector, they have no stable sources of income and may become economically dependent on their husbands or boyfriends. If they are caught in an abusive relationship, they may not be able to escape because of these economic considerations. Given the power inequity that comes with economic dependence, a woman's ability to protect herself from the consequences of her husband or boyfriend's high-risk activities will be greatly reduced.

4.2 Adolescents and Young Adults

Young adults (those aged 15 to 24) comprise almost 20 percent of the Philippines' total population. They face many risks in relation to sex and sexuality, mainly premarital pregnancies that often lead to early marriage, and sexually transmitted infections including HIV/AIDS. The National AIDS Registry in fact shows that a third of all reported HIV infections occur in individuals aged below 30.

There has been a tendency to point at premarital sex as the reason for this pattern of infections. The media, as well as NGOs, often cite distorted statistics to "prove" there is an increase in adolescent sex. The survey figures from the Young Adult Fertility Survey of 1984 and 1994 do not show such an increase. Moreover, research shows Filipino adolescents are not as sexually active as their counterparts in other countries (Figure 1).

Figure 1. Percent of 15-19 year olds who have sexual intercourse



Note: Marriage includes legal and consensual unions and in Jamaica visiting relationships.
Source: Singh (2000)

This is not to say that with the low sexual activity among our young adults, there will be no risk for HIV. Note that even in a country like Zimbabwe, where adolescent sexual activity is fairly low, HIV rates are still among the highest in the world (about one-fourth of the population is infected).

We want to emphasize that Filipino adolescents do face risks, but that these are not created solely by premarital sex. A young married woman, for example, is also put at risk for HIV/AIDS, perhaps even more than her single friends, because she is more frequently exposed to the consequences of her husband's high-risk activities. She may think she is "safe" because she is married but maybe at greater risk because her young husband may be having unprotected sex with many extramarital partners.

The young are put at risk because of the lack of access to accurate information not just on HIV/AIDS but on sexuality in general. Conservatives have opposed sex education for young people on the mistaken notion that this will lead to increased sex but a World Health Organization review of sex education programs (1993) disputes this view, finding that the programs help young people to postpone sex.

Not all young people are at equal risk for HIV/AIDS. Rivers and Aggleton (1999:2) point out that:

> The risk of HIV infection for young people in developing countries is increased by socio-cultural, political and economic forces such as poverty, migration, war and civil disturbance. Young people may also face the increased risks of HIV infection by virtue of their social position, unequal life chances, rigid and stereotypical gender roles, and poor access to education and health services.

4.3 Men who Have Sex with Men

Among reported HIV cases in the Philippines, more than 20 percent involve male to male transmission. Our Delphi experts feel this may be under-reported since many infected men may be unwilling to admit they had sex with another man and that this was the route for HIV infection. An epidemiologist observes: "Males are not likely to say they engaged in homosexual activity especially if interviewed by a complete stranger such as a medical technologist or a doctor."

MSMs is a general term first used during the HIV/AIDS epidemic in an attempt to come up with a more neutral term than "homosexual" or "gay". The term was coined recognizing that many men who have sex with other men may not self-identify as homosexual or, in the Philippines, as *bakla*. Many of these men are married and have families, and therefore may form important epidemiological "bridges" for HIV transmission.

Because of social stigma, MSMs often lack access to the information they need about sexual health matters, including HIV/AIDS. Because of the need to keep their sexual identities hidden, sexual encounters tend to be anonymous and casual. These take place in sites that may be hard to reach by health educators.

Some surveys (e.g., Iwag Dabaw 1999 and De La Salle University n.d.) suggest that there is high-risk activity, including anal sex and low use of condoms. A problem with surveys is that they are often very intrusive and will not elicit frank answers especially for stigmatized behavior. HIV prevention workshops conducted by gay organizations such as The Library Foundation tend to be more effective in surfacing information – albeit non-quantitative – about high-risk behaviors. The work here shows that there is a strong KAP gap: many gay men are aware of HIV/AIDS and may have accurate knowledge, but this knowledge does not translate to safer sex behavior. MSMs tend to be in denial about the HIV/AIDS problem, mainly because many do not know or have not met HIV-positive MSMs.

Support for HIV prevention among MSMs has dwindled through the years, partly because both government and NGOs have tried to "de-gay" the epidemic. To make people more conscious about HIV/AIDS, IEC campaigns have emphasized that the epidemic has been mainly heterosexual, which is true to some extent. Nevertheless, this argument fails to recognize that MSMs are being infected in large numbers and that prevention programs can reduce these infection rates.

4. 4 Sex workers

The extent of sex work in the country remains unclear, and will never be established through surveys. Perhaps more importantly, we should recognize that there are many different kinds of sex work, each with their own risk factors: males versus females, adults versus children, establishment-based versus freelance; karaoke bars versus beer gardens and KTV lounges and massage parlors. In recent months, media coverage of sex work has shown the amazing range of sex work settings, from shopping malls to cigarette vending.

Our Delphi panel members gave differing views on the susceptibility of various types of sex workers. Women and child sex workers are seen as more susceptible to infection than males because of their decreased ability to negotiate for safer sex. Freelance workers, as well as male sex workers, may be getting less information about HIV/AIDS because there are almost non-existent HIV/AIDS prevention programs for them. In one pre-workshop test conducted by HAIN

among male sex workers, the average number of correct answers was only 20 out of 33 items.

A problem is that education campaigns for sex workers are sporadic, often donor-driven. NGOs will launch an activity only when there's money, and then stop when the funding runs out. Some NGOs attempt to do peer education but this, too, will not have sustainable effects because our research shows there is rapid turn-over among sex workers. They move from one bar to another, so unless lectures and workshops are conducted every month and in as many bars as possible, many sex workers will not be covered.

There is also concern that the increase in prostitution may involve mainly part-time and freelance sex workers. This would include very young people, including students who do sex work to earn tuition money. Dr. Carol Sobritchea, head of the UP Center for Women's Studies, feels there is an entire subculture here, from recruitment to soliciting of clients. "It is a culture in the sense that they have a set of values regulated by certain customs and traditions, how to dress, where to go to, even the way to communicate. ." Such subcultures remain unreached by current HIV prevention programs and could impact greatly on the spread of HIV in the future.

4.5 Overseas Filipinos

There is a wide range in the estimates of Filipinos living and working overseas, going from 4 to 6.5 million. It is difficult to have exact figures because so many Filipinos may be working overseas illegally.

Our use of the term "overseas Filipinos" includes permanent migrants as well as short-term contract workers (often referred to as overseas contract workers, OCWs, or overseas Filipino workers, OFWs).

There are large numbers of Filipino permanent migrants. Between 1981 and 1999, there were 1,023,360 registered Filipinos who migrated permanently, mainly to the United States, Canada, Australia and Japan (Commission on Filipinos Overseas 2000).

These Filipino migrants are susceptible as well to HIV. Skeldon (2000) points out that international long-distance migration often involves the better educated and that this would minimize high-risk behavior. We would question this assumption. Our overseas workers and permanent migrants are indeed often highly educated and literate but from our interviews with infected overseas work-

ers, we find that they can still end up with high-risk behavior and eventually acquire HIV. In California alone, as of March 1998, there were 700 reported cases of Filipinos with AIDS, larger than the number reported for the entire Philippines (Filipino Task Force on AIDS website).

The situation of short-term OFWs may be different in the sense that they leave for shorter periods of time, and often keep to themselves. Nevertheless, the DOH's National AIDS Registry reports that out of 1,374 reported HIV cases in March 2000, 298 were former OFWs. That is 20 percent of the total.

Women who have to work overseas may be put in vulnerable situations. There are, for example, women employed directly as entertainment workers such as those in Japan. It is dangerous, however, to presume that "only" entertainment workers are at risk. When HAIN staff conducted research among domestic helpers in Hong Kong, we found that some – probably a very tiny minority – engage occasionally in paid sex (see also Bandyopadhyay and Thomas 2000). Two months ago, one Taiwanese TV station featured a park in Taipei where Filipino overseas workers tend to congregate. The news report said that every morning, park workers would find condoms strewn around. Informants say that Filipinas engage in free casual sex as well as paid sex, charging fellow Filipinos lower fees that they would for Taiwanese clients. Similar reports of overseas Filipinas "servicing" Filipino visitors in Singapore and in Japan surfaced in our focus group discussions conducted in Iloilo City among seafarers.

There is, unfortunately, a dearth of research on the reproductive and sexual health needs of overseas workers. There are too many assumptions made that still need to be tested through rigorous research. For example, how much risk do entertainment workers face in Japan? Condom use is very high in that country so it is possible that the risks may not be as high as we think. On the other hand, we tend to forget that casual sex does occur among overseas workers, both male and female, and that HIV infection can occur through such liaisons.

Among the OFWs, there is particular concern about the risks faced by seafarers, who number some 250,000. A separate report is available summarizing our studies on the seafarers and their family. In our research as well as in an earlier one by Simbulan et al. (1997), knowledge levels about HIV/AIDS were found low among seafarers, accompanied by high-risk sexual practices.

The case of seafarers challenges existing notions about HIV risk. Unlike other overseas workers, the seafarers move from one place to another. UNAIDS Country Representative Dr. Victor Mari Ortega points out that it is not right to talk about OFWs going to countries of high prevalence. The problem is

of risky situations. A person can remain uninfected even living in a high prevalence country; conversely, he or she can get infected in a low prevalence place. Overseas Filipinos give us a chance to understand how different factors converge to create risk. The seafarers talk, for example, about particular preferences in nationalities, such as Latin American mestiza sex workers.

We see here, in Mar's account, how ready cash, long periods of isolation, the machismo culture, all conspire to put seafarers at risk:

> *Alam mo naman pag ilang linggo kayo sa dagat, ilang buwan, pag dadaong sa puerto... meron kasing puerto na maganda, may masasalubong kayong barko na galing dun sa pupuntahan niyo. Magtatawagan iyan sa radyo...o pare, magaganda ang mga babae dito, mura lang! Ganon. So kami, excited naman kami. Pag bukas dadaong yung barko... o pare, di pa tayo duty, 4 hours pa, labas muna tayo! Balik na lang tayo mamayang ano! Hanggang sa hindi na nakabalik.* (If you're at sea for a few weeks or a few months, when you arrive at the port... some ports are nice, there would be ships that came from the port where you are headed. You'll call each other on the radio... o pare, the women here are pretty and cheap! So we're excited. Tomorrow, the ship will dock...o pare, it will be four hours before our duty, let's go out! We'll just come back later! But you won't be able to come back on time.)

What we see in Mar's account is only part of the story. Our case studies also show how seafarers are put at risk even before they leave. We found that among maritime students, there were low levels of knowledge about HIV/AIDS. Even more sadly, we found that some of the schools have already been reached by "HIV education programs" sponsored by conservative groups that concentrate their attention on claiming that condoms do not work. We fear that such miseducation will cost many future seafarers their lives.

V. Macro Impact of the Epidemic

The UN Development Program (UNDP) has developed a **Human Development Index (HDI)**, reflecting achievements in the most basic human capabilities – "leading a long life, being knowledgeable and enjoying a decent standard of living." (UNDP 1999) Three variables are used to measure the HDI — life expectancy at birth, adult literacy rate and adjusted per capita income (using real Gross Domestic Product per capita).[1] In this section, we will focus on two of these components – life expectancy and GNP.

In 1999, the Philippines ranked 77th in its HDI, among 174 nations, classifying us among the "medium human development" countries. Our high adult literacy rate (94.6%) and mid-range life expectancy (68.3 years) helped to compensate for our lower per capita GDP (US$3520).[2]

5. 1 Impact on GNP and GDP

Barnett and Whiteside (2000a:32) observe that "it has become apparent that while it is possible to model the impact of HIV and AIDS on the national economy, it is extremely difficult to identify and measure macro-economic impacts. The problem is made worse as economies, especially in developing countries, are constantly being subjected to shocks and pressures."

The World Bank does offer some estimates of the impact on GDP, observing that when a country's HIV infection rate goes beyond 25%, as it currently affects several countries in Africa, GDP is lowered by at least one percentage point. At lower infection rates, down to 8%, GDP is decreased by 0.4 percentage points per year. At rates lower than 8%, as is the case in the Philippines (at 0.07%), the effect on GDP is negligible. (Anonymous, from The Economist 2000)

Bloom and Mahal (1995), after reviewing data from 51 developing and industrial countries, including countries with advanced epidemics, conclude that "the AIDS epidemic has had an insignificant effect on the growth rate of per capita income, with no evidence of reverse causality."

[1] For purposes of our discussion, we will be using GNP instead of GDP because of the importance of overseas Filipino workers, whose remittances are calculated as part of the GNP.

[2] These figures are for 1997. The GDP is adjusted for Purchasing Power Parity to enable comparisons among countries. Official figures usually put our GDP at about US$ 1200.

Barnett and Whiteside (1998:16) offer additional insights on economic impact studies: "Some studies have found that the impacts may be small, especially if there is a plentiful supply of labour and worker benefits are small. Other studies have found significant macro-economic impacts. The magnitude of the impact depends partly on the structure of the economy. Economies based on extractive industries or export agriculture are likely to be most severely affected."

There is some concern that if prevalence rates increase among overseas Filipino workers, our economic growth will suffer. In 1999, total registered remittances from overseas Filipino workers amounted to almost US$6.7 billion. This excludes remittances sent through unofficial channels or, in the case of seafarers, money remitted to their labor unions to pay for housing and other union benefits. The contributions of the OFWs are therefore quite substantial.

Table 5. Overseas Filipinos' remittances and Gross National Product

Year	Remittances (US$, 000)	GNP, Current Prices (Pesos, Millions)	Remittances as % of GNP
1997	5,741,835	2,528,321	9.1
1998	4,925,889	2,815,259	7.0
1999	6,794,550	3,155,635	8.6

Base Source: POEA, NEDA (Our calculations are based on a conversion rate of US$1 to P40.)

For purposes of our study, we can do some crude projections on the possible impact of HIV/AIDS. The available figures from 1997 to 1999 show that remittances from overseas workers accounted for 7 to 9 percent of GNP. (See Table 5) We will make an admittedly unscientific projection that unofficial remittances would boost the figure to 12 percent. In a worst-case scenario, if 1 percent of the total number of OFWs are infected and if we assume they no longer contribute to the GNP in any way (an unrealistic assumption), then the GNP would drop by only 0.12%. Note that the projection of a 1% infection rate is already very high. Currently, it is more likely to be around 0.1%, and again using our crude estimates of a complete loss of their contributions, the GNP would be reduced by only 0.012%.

This is not to underplay the impact of HIV when it affects overseas workers. As we will see in our discussion of the micro-impact, each overseas worker who is infected can mean serious dislocations for individuals and households.

5.2 Impact on Life Expectancy

There has been a tendency to exaggerate the potential impacts of HIV/AIDS on life expectancy, with dire predictions that populations will actually drop. No doubt, in African countries that have been hit hard by the epidemic, life expectancy did drop significantly. A UNAIDS report observes: "Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS." (UNAIDS 2000). The decreases in life expectancies of these countries have been responsible for the rapid drops of their Human Development Index. Botswana, for example, ranked 71 in the 1996 HDI; by 1999, its rank was 122.

Note, however, that life expectancy in some of these countries was already quite low to begin with, mainly because of poor health infrastructure. The impact of HIV on life expectancy in other countries with stronger health systems may not be as severe.

Certainly, large numbers of HIV infection will increase over-all mortality rates, especially among younger age groups (which then decreases life expectancy). In the worst-case situations, such as in sub-Saharan Africa, there is a change in population distribution toward what is called a "chimney" pattern. Over time, because the young are dying out, the population will have a larger population of old people who do not have the young to care for them. This will pose great strain on social services.

In the Philippine context, HIV could contribute to greater mortality in an indirect way, and this is through a further increase in our already high tuberculosis (TB) incidence. TB is a common opportunistic infection in HIV disease. Even without high HIV prevalence, TB has been consistently among the leading causes of death in the Philippines for the last 50 years. TB kills about 25,000 Filipinos each year and the numbers are likely to increase as the HIV epidemic spreads. People with HIV are more prone to developing TB, especially if they are already latently infected with the tubercle baccili, as is the case in the Philippines.

The TB problem in the Philippines is further complicated by the high prevalence of MDR (multi-drug resistant) strains. This is due to incorrect use of the anti-TB drugs, including incomplete treatment, or prolonged use of "preventive" doses of the anti-TB drugs (mainly isoniazid, ethambutol and rifampicin). Today, there are bacilli strains that no longer respond to these medicines.

Perhaps a more important issue is not just life expectancy but healthy life expectancy. Over the years, the World Health Organization (WHO) has been refining measurements such as DALYs (Disability-Adjusted Life-Years), emphasizing that the effects of disease should also be measured in terms of quality of life. Thus, mental illnesses, while infrequently a direct cause of death, are still considered serious enough as a leading cause of morbidity because they are so debilitating, affecting people's normal course of life. HIV and its opportunistic infections – TB for example – greatly decrease the quality of life, and burden is heavier in poorer countries because of the lack of access to care (see Gwatkin, Guillot and Heuveline 1999).

WHO (2000) has just released "healthy life expectancy" figures, also known as DALE or Disability-Adjusted Life Expectancy. DALE summarizes the expected number of years to be lived in full health. Among 191 countries, the Philippines ranked 113th with a DALE of 59 years. This figure is low compared with many countries, and could decrease further if HIV/AIDS becomes more widespread since the opportunistic infections that come with AIDS cover a wide range, and complications can include such problems as malnutrition and dementia, all of which are debilitating.

VI. Sectoral Impact

6.1 Impact on Labor Sector

Because HIV mainly affects people in what could be their most economically productive years, there are fears that HIV can have adverse impact on the labor sector. The studies, however, are clear that unless HIV becomes a major epidemic, it is not likely to have large-scale impact on the labor situation. In a study just recently published by the International Labour Office (ILO 2000b), the estimate is that in countries with prevalence rates of greater than 10%, the labor force will shrink by 10 to 22 percent by the year 2020. In countries with prevalence rates of lower than 10%, the labor force would shrink by 3 to 9%. Thailand, with an adult prevalence rate of 2%, is projected to have a 1% contraction of its labor force by the year 2020. The Philippines, with an adult prevalence rate of 0.07% does not come anywhere close to the figures cited by ILO.

The ILO does point out there is greater adverse impact on countries that are dependent on extractive industries (e.g., mining) or on export agriculture because a decrease in the labor supply for such sectors would mean reduced foreign exchange. In this sense, the Philippines could have added vulnerability because we do have such sectors that are important for foreign exchange. However, the adverse impact will come only with high HIV prevalence, and as infections enter rural areas.

There are other repercussions that could emerge as HIV spreads. Sehgal (1999) notes: that "the age and sex distribution of the labour force is likely to change, due to growing number of widows and orphans who would seek employment. Moreover, the fact that a large proportion of the HIV-infected population is in the age group 20-49 years means greater pressure for an early entry of children into the labour force and early retirements of infected persons due to morbidity."

The ILO study notes that AIDS-related illnesses and deaths of workers could affect employers by increasing costs and reducing revenues. Employers may have to spend more for health care, burial, training and recruitment of replacement employees.

Another possibility is that if there are large numbers of HIV cases, companies may move even more toward the use of contractual and short-term labor, to

avoid having to pay for sickness benefits. Insurance companies and health maintenance organizations (HMOs) may also be reluctant to provide workplace policies when HIV incidence increases, because of the fear of having to pay large claims. Another possible response is that insurance premiums may increase. Even without an HIV problem, this is already the trend right now with local HMOs. If HIV incidence rises and HMOs have to start shouldering these costs, the premiums could rise to the extent that they would be even more inaccessible for many Filipinos.

There has been concern about the impact on HIV on overseas workers. We have already discussed in an earlier section that overseas workers are at risk for HIV. However, even if prevalence rates increase among these overseas workers, it is unlikely that the sector will be severely affected. One possible scenario is that if the Philippines is perceived as being of high HIV prevalence, countries might avoid recruiting Filipinos but this is probably not likely to happen. Again using Thailand as an example, despite their high HIV prevalence, they are still able to export large numbers of overseas workers. The sad fact remains that there is a large reserve force of unemployed so even if more overseas Filipino workers are infected, there will always be more Filipinos waiting to be recruited.

6.2 Impact on Tourism

A search through the literature did not yield any studies looking into the area of tourism and HIV/AIDS. However, we can look again to neighboring Thailand for some insights. Despite widespread knowledge that Thailand has one of the highest HIV prevalence rates in Asia, its tourism continues to boom, with some 6 million visitors annually, compared to 2 million for the Philippines. Our negative image abroad – because of the kidnappings and violence in the country – is more likely to adversely impact tourism than HIV/AIDS.

6.3 Impact on Health Care System

The health care system will be adversely affected by HIV even without high prevalence. To understand this, we have to look at structure of health expenditures in the Philippines. In 1997, the latest year for which health care expenditures in the Philippines have been analyzed, total health spending reached P88.4 billion, or about P1,262 per person (estimated at a population of 70 million in 1997). A breakdown of expenditures is given in Table 6.

Table 6: Sources of Health Expenditures, 1997

Out-of-pocket	46.3%
National government	21.1%
Local government expenditures	17.5%
Social insurance (mainly PhilHealth)	7.2%
Other private sources (private insurance, HMOs, etc.)	7.9%

Source: Solon et al. 1999

From the figures we can see that the bulk of health care costs are still shouldered by government and out-of-pocket sources (i.e., family savings). Such funds are severely limited, which explains why total annual health expenditures remain so low.

Much of the financial burden for the care of people with HIV/AIDS will come, as it is right now, from government agencies, mainly the DOH, which itself faces severe limitations. In 1999, the DOH budget was only P14.1 billion. The budget for HIV/AIDS program amounted to P45 million, hardly enough to shoulder costs of medicines.

The most expensive component of HIV care is the use of antiretroviral drugs, also sometimes referred to as Highly Active Antiretroviral Therapy (HAART). These drugs do not cure a person of HIV disease or AIDS, but it does slow down the multiplication of the virus, and may even reduce the viral load. But HAART is expensive, reaching up to P30,000 a month, or P360,000 a year. Below are lists of anti-retroviral drugs, together with their costing and dosage (see Tables 7 & 8):

Table 7. Costing and dosage of non-protease inhibitors

Name of Drug	Unit	No. of Units Per Bottle	Cost Per Bottle (PhP)	Dosage
Retrovir (AZT)	100 mg	100 capsules	4,488.00	2 capsules , 3 x a day
Zalcitabine (HIVID/ DDC)	375 mg	100 tablets	4,200.00	2 tablets, 3 x a day
Didanosine (Videx/ DDI)	50 mg	60 tablets	2,509.24	3 tablets, 2 x a day
Lamivudine (EPIVER/ 3TC)	150 mg	60 tablets	9,000.00	1 tablet, 2 x a day
Stavudine (Zerit/ D4T)	30 mg	60 capsules	9,011.31	1 tablet, 2 x a day

Source: Research Institute for Tropical Medicine

Table 8. Costing and dosage of protease inhibitors

Name of Drug	Unit	No. of Units Per Bottle	Cost Per Bottle (PhP)	Dosage
Invirase (Saquinavir)	200 mg	270 capsules	10,800.00	3 capsules, 3x a day
Veracept (Nolfinavir)	250 mg	270 capsules	16,700.00	3 capsules, 3x a day
Crixivan (Indinavir)	400 mg	80 capsules	12,510.00	2 capsules, 3x a day
Retonavir (Norvir)	100 mg	84 capsules	13,500.00	*First 6 months:* 4 capsules, 3 x a day Second 6 months: 4 capsules, 2 x a day Remaining months: 2 capsules, 3 x a day

Source: Research Institute for Tropical Medicine

People on anti-retroviral therapy need to have their viral loads monitored and each test costs P7,000. Together with other laboratory tests, costs could run up to P50,000 a year. Moreover, once a PHA starts taking the drugs, they have to stay on the treatment for life. Stopping treatment midway would cause a surge in the viral load, as the virus multiplies rapidly in the body. For all these, anti-retroviral drugs do not eradicate HIV. At most, they are only able to prolong the patient's life for approximately 10 years.

Besides having to use antiretrovirals, people with AIDS have to deal with numerous opportunistic infections, and the treatment can again be very expensive (Table 9).

Table 9. Common opportunistic infections and treatment costs

Infection	Approximate treatment cost (in PhP)
Cytomegalovirus	2,000 per day
Herpes simplex	2,000 for five days
Tuberculosis	2,400 for six month short-course therapy
Cryptococcus	5,000 a day, with maintenance treatment for 300 a day

Source: Research Institute for Tropical Medicine

It should be pointed out the high costs of medicines are due to structural constraints. Medicines in general are expensive in the Philippines. The Health Department spends about P2 billion a year on medicines, and this is still barely enough to cover people's basic health needs.

The high costs of medicines are due to control of the pharmaceutical industry by a few companies. For as long as a drug is under patent, only the patent holder can produce the drug, which means they can dictate its price. Most of the antiretrovirals are still under patent. The Philippine government has been trying to break this oligopoly by exploring possibilities of parallel imports — sourcing cheaper sources on the globe market — but this may not be adequate. In several countries where HIV is a serious problem, governments have combined compulsory licensing and parallel imports. The former is an arrangement where a company must allow government to produce a drug even if it is still under patent. As a result of these governments' efforts to look for alternatives, the cost of HAART has dropped in some countries. In Brazil, HAART is available for about US$1,000 a year, still quite high but certainly much more affordable than the US$10,000 price tag in the United States.

As the HIV/AIDS problem becomes more serious, the DOH and other government agencies will have to make some hard decisions, given its rather scarce resources. For example, the Philippine Charity Sweepstakes Office (PCSO) donated P1.9 million last year to RITM to help pay for antiretrovirals. At P360,000 for a year's supply, that amount can only support 5 individuals. One could argue that P1.9 million could have been used for other purposes, for example, to cover the costs of drugs for 790 patients with tuberculosis. The DOH and other social service agencies will have to make hard choices in the future. In principle, they should not have to choose, but the realities of scarce resources mean that painful decisions will have to be made later, and often, people with HIV will receive low priority in those choices.

VII. Impact on Communities and Households

We have stated, from the beginning, that the HIV/AIDS problem is not likely to have significant macro-impact in the Philippines in the near future, mainly because HIV is still "low and slow" in the country. Nevertheless, our research also showed that the impact on the micro-level, especially on families and households, can be devastating.

The vulnerability of households is due to the lack of social nets. The ILO (2000b) is more specific in pointing out the need for countries to strengthen its social protection and social security schemes. A definition of the two terms, adapted from ILO, is important:

Social security is the protection which society provides for its members through a series of public measures such as benefits for those who lose income from work resulting from sickness, death, employment injury, unemployment, invalidity, old age and death. **Social protection** is wider, including not just public measures but also private schemes, for example, mutual benefit societies or occupational pension schemes.

Both social security and social protection remain weak in the Philippines. We have given figures earlier on health care expenditures in the country, so severely limited by poverty so that total health care spending in the country is only about P1,200 per person per year, shouldered mainly through a family's savings and small government subsidies.

The situation is further complicated by the weak safety nets. As we will relate later in this report, a person who is infected with HIV/AIDS will often lose his or her job and have nothing to fall back on in terms of unemployment benefits and disability pay. Article IV Sec. 26 of R.A. 8504 has provisions for insurance for persons with HIV. However, this has yet to be implemented. At present, DOH, in cooperation with the Insurance Commission and other private and public insurance agencies, is conducting a feasibility study regarding this. The lack of safety nets affects the families of those infected with HIV/AIDS. If a person dies from HIV/AIDS, there is little that survivors can depend on in terms of old-age pensions, and support for orphans and widows.

Given the situation we have with social security and public sector expenditures, we can see why the impact of HIV/AIDS will be mainly at the micro-level, particularly families and households.

We have shown that on a macro-level, the impact of HIV/AIDS, for example on GNP, might be insignificant. However, behind each HIV infection there are families that are adversely affected. We use the plural to emphasize that in many cases, those who are in high-risk situations for HIV – overseas workers for example, or sex workers — are also those with the most dependents, not just their children but siblings, nephews and nieces, in-laws and others from the extended family. Geena, an HIV-positive woman, describes the ripple effect:

> "...di lang naman ikaw ang maapektado, siyempre pati yung pamilya mo, lalo na kung ikaw yung inaasahan ng buong pamilya. Parang siyang puno, pag namatay yung ugat, patay yung buong puno." *(You're not the only one affected, even your family is, especially if the entire family depends on you. It's like a tree, if the roots die, the whole tree dies.)*

Adverse impact on households will be economic and social. Based on our interviews with HIV-positive Filipinos, the following are the major negative consequences:

Economic:
- loss of jobs (unemployment or underemployment)
- depletion of savings
- increased debts
- medical costs
- funeral costs

Social:
- social exclusion/isolation
- children withdrawn from school
- social stigmatization and isolation
- AIDS profiteering

While the main impact of HIV/AIDS will be on families, we should look at the way the disease impacts on communities, towns, provinces and even regions. Looking at the case of overseas Filipino workers, for example, we find that some regions export more OFWs than others and this can mean differences in vulnerability (see Table 9). Note that within these regions, there will also be variations in OFW numbers, by provinces and even by towns. In our research, we found that small, poor towns may be more vulnerable because they are in fact more dependent on OFW remittances. In such poor towns, the houses of OFWs, especially seafarers, always stand out with relatively high incomes.

Table 9: Percentage of Families Depending on Overseas Remittances as Main Income Source, By region

Region	Total number of families	Number of families with overseas remittance as main income source	Percentage of families with overseas remittances as main income source
NCR	1,991,987	161,756	8.1%
CAR	259,033	17,131	6.6%
Ilocos	777,937	113,772	14.6%
Cagayan Valley	587,123	33,025	5.6%
Central Luzon	1,435,994	129,765	9.0%
S. Tagalog	1,938,287	151,312	7.8%
Bicol	968,877	24,705	2.5%
W. Visayas	1,249,979	89,502	7.2%
C. Visayas	1,046,159	42,896	4.1%
E. Visayas	751,367	22,624	3.0%
W. Mindanao	556,753	21,999	4.0%
N. Mindanao	528,138	13,790	2.6%
S. Mindanao	890,383	25,750	2.9%
C. Mindanao	449,538	15,696	3.5%
ARMM	356,087	4,847	1.4%

Base Source: Family Income and Expenditures Survey 1997 (NSO 1999)

7.1 Economic Costs

The most immediate adverse impact comes from loss of jobs. Even for those who are employed locally, there can be significant losses. Dong, a manual laborer, talks of his simple dreams, now shattered by HIV/AIDS:

> *Ako... Magkaroon ng tatlong anak lang para masubaybayan ang paglaki... pangarap ko sana mag-ipon ako ng pera. Tapos, kapag may puhunan na, magtatayo ako ng shop, vulcanizing shop gaya ng trabaho ko noon...* (Me, to have three kids to watch over till they're grown... I had hoped that I could save some money. Then, when I have enough capital, I would open a shop, a vulcanizing shop like the one I was working in before.)

The losses are even greater for those who worked overseas, who have more ambitious dreams. Once infected, a Filipino overseas worker is usually unable to leave again because many of the countries that "import" our workers require

therefore more severe for overseas workers. Note the wide differential between their potential salaries abroad, and locally. The minimum monthly wage now for a Filipino seafarer deployed overseas is US$385 or P15,400 while in Hong Kong, a domestic helper gets a minimum of HK$3,670 per month or about P18,350. Note that in many cases, the overseas workers are able to save much of what they earn because they do not have to spend for board and lodging.

The overseas workers' pay are equivalent to salaries of full-time associate professors at the University of the Philippines. They are also much more than the daily minimum wage in the Philippines, which ranges from P180 to P225 depending on the region.

Mar, a former seafarer, said he used to earn P20,000 a month. Had he not been infected, he would have earned even more, perhaps even reaching P40,000 or P50,000 if he got to higher positions. Today, he works for the NGO for about P6,000 a month. Just using Mar as an example, the difference between P20,000 a month as a seafarer and his current P6,000 monthly salary translates into P168,000 of lost income a year, a sizeable amount.

Note that the loss of income does not just apply to the HIV-positive individual. Eventually, when they develop AIDS, their partner or spouse will have to give up work as well to become a caregiver. This represents additional lost income.

As HIV infection moves on in an individual, the costs will increase tremendously, both in terms of expenses and in lost opportunities. Drawing on different cases in our study, we could present a hypothetical case involving a seafarer with and without infection. Table 10 shows what income could have come if a seafarer remained uninfected. Over the years, we presume an annual increase in monthly income of P5,000, which is quite reasonable given seafarers' rates. With the spouse working locally, we assume an initial annual increase of P500 for the monthly income, to increase to P1,000 as extra income is used for small businesses, quite often the case with seafarers' spouses. Without HIV infection, the seafarer and his wife could earn up to P6,258,000 in 10 years.

If, however, the seafarer is infected and is diagnosed in year 2, he will no longer be deployed and has to work locally. If he is lucky and does get a job, we presume the annual increases in his monthly wage will be only about P500. If AIDS develops in year 8, he will have to stop working and we presume zero income. His wife, on the other hand, faces reduced income even before AIDS develops in the husband because she will have to depend on wages, without capital to start small businesses. Eventually, when her husband develops AIDS,

capital to start small businesses. Eventually, when her husband develops AIDS, she will have to stop working as well. In this hypothetical case, the combined income for this couple will only be P1,704,000 over 10 years instead of P6,258,000.

The lost income over the 10 years is P4,554,000, an amount that could have meant purchase of a small but comfortable house, plus enough left over to put two children through private schools. With HIV infection, however, the couple would not only be unable to afford the house or private education but would need to shoulder extra costs from HIV, which have been outlined earlier (for example, P360,000 a year for antiretrovirals, an unthinkable cost for most Filipinos).

Table 10: Opportunity Costs of HIV Infection in a Seafarer

Without HIV					
	Seafarer		**Spouse**		**Total**
	Monthly	Annual	Monthly	Annual	
Year 1	20,000	240000	6000	72000	312000
Year 2	25,000	300000	6500	78000	378000
Year 3	30,000	360000	7000	84000	444000
Year 4	35,000	420000	8000	96000	516000
Year 5	40,000	480000	9000	108000	588000
Year 6	45,000	540000	10000	120000	560000
Year 7	50,000	600000	11000	132000	732000
Year 8	55,000	660000	12000	144000	804000
Year 9	60,000	720000	13,000	156000	876000
Year 10	65,000	780000	14,000	168000	948000
Total					5258000
With HIV Diagnosis in Year 2, AIDS in Year 8					
	Seafarer		**Spouse**		**Total**
	Monthly	Annual	Monthly	Annual	
Year 1	20,000	240000	6000	72000	312000
Year 2	25,000	300000	6500	78000	378000
Year 3	6,000	72000	7000	84000	156000
Year 4	6,500	78000	7500	90000	168000
Year 5	7,000	84000	8000	96000	180000
Year 6	7,500	90000	8500	102000	192000
Year 7	8,000	96000	9000	108000	204000
Year 8	0	0	9500	114000	114000
Year 9	0	0	0	0	0
Year 10	0	0	0	0	0
Total					1704000

We give these numbers reluctantly and again wish to point out that the costs of suffering cannot be quantified. We used a seafarer as an example to dramatize

with lower salaries, would suffer less if they got HIV. Bobby, who is not an overseas worker, talks about how all his dreams disappeared:

> *Wala akong bahay, as in... wala nga akong bank account ngayon. Meron, pero walang laman, tinapon ko na yung card.* (I don't have a house, and I don't even have a bank account now. I have one but it is empty, I threw away the card.)

Once the opportunistic infections come in, medical expenses soar. We have cited these expenses earlier. The costs are tremendous and families have to sell or pawn their assets. Others go into debt, creating a vicious cycle of payments and new debts.

We were requested by NEDA to compare expenditure patterns before and after HIV. What was striking was that in several of the cases, particularly among the sex workers, there was really no significant difference. Contrary to popular perceptions, sex workers do not earn large amounts of money. In fact, in some cases, earnings were really paltry. The women have no choice because low educational attainment offers them few options for jobs. Sex work pays miserably, and after they are infected, the misery of life is added on mainly when new expenses, meaning the medical expenditures, come in. A case in point is Ana, who says her expenses before and after HIV are quite similar: 300 pesos a week for the family's food, 200 pesos for laundry, 160 pesos for children's *baon* (allowance) and transportation, and 100 pesos for her personal use.

The point is that HIV's impact will be most adverse on populations such as overseas workers, who would stand to lose the most with an infection. Because HIV tests are mandatory for their jobs, they are diagnosed early and banned from further overseas work.

The impact on non-overseas workers will be more diffused. Ironically, because many will not be diagnosed for HIV, they will actually escape stigmatization and continue to work in the low-paying jobs they already have. It is only when AIDS develops, several years after infection, that medical expenditures come in to drain family coffers.

We know that the adverse impact is greater on those whose needs are greater. Jim, one of the HIV-positives we interviewed, had a sizeable income of about P1 million a year before he was infected. Now that he has HIV, his medical expenses are tremendous but he still lives very comfortably because he is still able to earn a living, and has enough savings. Poorer families, even those from the middle

class, are much more vulnerable because when HIV strikes, savings are wiped out quickly, and without other income opportunities, they rapidly become destitute.

7.2 Social costs

The most adverse impact of HIV/AIDS, even at this early stage of the HIV/AIDS epidemic in the Philippines, is its social effects. One can talk of this impact in terms of a deterioration in "social capital", defined by Barnett and Whiteside (2000a) as "stored trust, understanding and knowledge". This does not just include skills but also social ties and the solidarity and trust so important in the functioning of societies. Social capital is difficult to measure, but from the stories of our people living with HIV, we can see how it is slowly being eroded.

An example of this loss of social capital comes with our overseas workers. Most of them are college graduates so for each individual who is infected with HIV, there are losses for the family, the community or even the country in terms of investments in their education, and eventually, the loss of skilled labor and professional expertise.

The losses are inter-generational. Several of the HIV-positive Filipinos we interviewed said they had to withdraw some of their children from school. C.A. talks about her children:

> *Ngayon nga yung isa kong anak tumigil eh. Third year na siya. Tumigil dahil minsan may project, di namin masuportahan yung ano niya. Kawawa naman yung bata kung hindi maano yung project, di siya papasa. Yung ibang anak ko naman, first year highschool, grade 4, grade 3. Puro public school sila; di ko kayang magpa-aral ng private. Yung isa naman, kinder dapat pero tumigil din...* (In fact, at present, one of my children stopped schooling. She's already in third year. She stopped because one time she had a project and we could not support her. It's so pitiful for the child not to finish her project [because] she won't pass. My other children, they are in first year, grade 4, and grade 3. All of them are in a public school; I can't afford to have them study in a private school. Another one was supposed to be in kindergarten but he also stopped.)

This is an example of the erosion of social capital, as children, even the very young, lose their opportunities to a better life.

Because the HIV/AIDS problem is still fairly mild in the Philippines, it might be difficult at times to grasp how social capital is eroded. We draw on neighboring Cambodia, where HIV prevalence rates now exceed those of Thailand, to give another example, still specific to the issue of children's education, of how social capital is eroded. This excerpt comes from an article that appeared in SEA AIDS, an electronic bulletin board, describing a recent celebration of International AIDS Memorial Day:

> The next speaker is a little boy, maybe 7 or 8 in his school uniform. His
> baby brother has come on stage, too. Dr Tia Palla (a doctor from the Cambodian Ministry of Health) is going to interview him. The little boy takes the microphone and begins to talk in a loud clear voice. But the baby brother follows him and cries. The boy stops, looking troubled. Dr Tia Palla takes the mike and the boy's school bag.
>
> "Look at this" he says, showing the dignitaries and the assembled people a school exercise book.
>
> "This boy is clever. Look at his marks. He got 10 out of 10 this day, and 10 the next, 10 marks again. Now 7, this is when his mother begins to get sick, now 5. Now 2. Now the pages are blank, his mother has died. He cannot go to school. But - see he has got 10 again because we helped him to go back to school."

The Cambodian example shows the tragedy of HIV/AIDS, but it also shows what people can do to overcome adversity. We are not sure how ready our families and communities are to assume new burdens such as those faced in Cambodia. In our research, we documented many instances of discrimination and isolation. For all the talk of the supportive Filipino family and community, there were instances of rejection of people living with HIV. Three people living with HIV share their stories:

> *Mahirap ang magkasakit ng ganito. Umaasa ka sa awa. Tapos, pinandidirihan ako ng mga half-brothers ko, kahit na yung mga pamangkin ko, alam mong iba ang tingin sa iyo. Although minsan, may mga pamangkin din ako, yung mga maliit pa, kini-kiss ako, naglalambing ba.* (It's hard to have this illnesss... My half-brothers despise me; even my nieces and nephews, you know that they look at you differently. Although sometimes, some of my neph-

ews and nieces, those who are still small, they kiss me and cuddle.) [Jojo]

Sila nga hindi nagpupunta roon. Nandidiri sila. Hindi kasi sila na-counsel. Akala nila nakakahawa. Pagkatapos ng counseling nila kay Doktor, mula noon dumadalaw na sila pero hindi pa rin katulad ng dating care nila sa kapatid nila nong hindi pa alam na HIV-positive siya, niyayakap nila. Nong nanghihina na ang asawa ko, dumadalaw sila pero hindi lumalapit sa asawa ko. (They did not come around, they loathed [her]. Because they were not counseled. They thought that it is contagious. After they received counseling from the doctor, they would visit, but their care for their sister was now different. They used to embrace her when she wasn't HIV-positive. When my wife was becoming weaker and weaker, they would visit, but they would not go near her.) [Gabriel]

Sa amin sa probinsya, hindi naman sa may narinig ako pero... kapag naglalakad ako sa kalsada, noon talagang okey lang. Ngayon, kapag nakikita kami ng mga nakakakilala sa amin, ang tingin sa 'yo parang sinusuri, mula ulo hanggang paa. Parang hinuhusgahan nila ako. (In our province, I don't hear anything...but whenever I walk in the streets, before it was ok. Now, whenever we are seen by those knew us, they look at you from head to toe, like they're studying you. Like they are passing judgment on me.) [Dong]

The HIV-positives we interviewed had many stories of violations of human rights, some beginning even with testing and diagnosis. Many of the HIV-positives we interviewed said their test results were disclosed to other people without their permission. Moreover, they were given their tests results without adequate explanations, and counseling, which meant they were left on their own to despair. Liza recalls what she did initially after discovering she was HIV-positive, and facing ostracism and ridicule from the media and from her community:

Dumaan ako sa punto na talaga patapon na yung buhay ko, wala akong pakialam. Nag-drugs ako, gabi-gabi nasa disco. Sarado pa ang disco nandoon na ako eh... Buti malakas ang family support. Kasi kung ako lang noon, magpapakamatay na ako, wala na akong pakialam! (There was a point when I was throwing my life away and I didn't care. I did drugs, discoed *every night. The disco was still closed but I was already there... It's good that I*

had strong family support. Because if it were just me, I would have committed suicide, I didn't give a damn!)

The initial shock after diagnosis gives way to living with HIV, but discrimination continues and can be quite vicious. Archie relates how he was treated by one television show host:

Kasi nag-guest ako sa TV. Kay _____ (a TV host). Bastos yung hayop na yun! ... Yung mga bato ng tanong niya eh talagang...o! HIV-positive ka pala, paano mo nalaman? Bakla ka ba? Nag-a-anal sex ka ba? Yung mga tanong na below the belt, which is hindi naman talaga dapat dun mapunta yung tanungan... (I was a guest on TV, with _____ (a TV host). The animal! It was my first TV interview. He started asking me all these questions. O, you're HIV-positive. How did you find out? Are you bakla? Do you engage in anal sex? Questions that are below the belt, which shouldn't be asked.)

Archie's story shows how HIV/AIDS can amplify old social prejudices, against homosexual men for example.

The HIV-positive people we interviewed said that they tended to be hurt much more if discrimination came from medical people, who they expect to have more knowledge about HIV/AIDS. Mar talks about how the testing of sex workers is in many ways forced upon them. Moreover, when they are found positive, they are subjected to even more degrading treatment:

Hindi ako naka pre- and post-test counseling. Yung mga tanong sa akin eh, nagpapakantot ka ba sa puwet? Anong style? Ilang lalake? Nag-blo-blow job ka ba? Which is...! Tapos pinik-up nila ako sa bar, ambulance, di ko alam kung ano yung kaso ko. Ang sabi lang sa kin, natapon yung dugo mo, kailangan ka uli kunan sa Maynila. Tapos habang daan, sinasabi na, papano kung may AIDS ka? Pagbalik mo, alam na ng buong bar. Actually, nung kinuha ako, hindi ko pa nga alam yung status ko. Eh nung na-diagnose ako 18 years old. (I wasn't given pre- and post-test counseling. Their questions were, well, did I get fucked in the ass? What style? How many men? Do you give blow jobs? Which is...! Then they picked me up at the bar, an ambulance, I didn't know what my case was. They told me, we spilled your blood, we have to take a new sample in Manila. And on the way,

they asked me, "What if you have AIDS?" When I got back, the whole bar knew. Actually, when they took me, I didn't know what my status was. I was 18 when they made the diagnosis.)

There is much bitterness in the stories of shabby treatment by medical people, especially when they had to be hospitalized. One woman said that when she was about to deliver a child, the doctor told her, "May *AIDS na kayo, pabuntis-buntis pa kayo.*" ("You already have AIDS and you still get pregnant.")

Even the children, even the newborn, are not spared from this discrimination, as Dong relates:

> *Yung pangalawang anak ko... grabe ang naranasan naming diskriminasyon sa PGH noong malaman na HIV-positive si M. Naawa ako sa anak ko.* Halos hindi na pinaliguan. Paglabas ng anak ko, diretso balot tapos pinauwi na kami. Pinahatid na kami kaagad sa ambulance dito sa San Lazaro. (My second son...we were really discriminated in PGH when they knew that M was HIV-positive. I pitied my son. They barely bathed him. When my son was born, they just wrapped him up and told us to go home. They sent us immediately to San Lazaro by ambulance.)

It is not just the hospitalization incidents that so hurt our HIV-positive Filipinos. There is, too, the day-to-day living with fears and doubts, especially the anxieties about being "discovered" as HIV-positive, and the gossip that would follow. Mar, our seafarer, says he has not told his peers:

> *Hindi alam ng barkada ko na positive ako. Di ko maplanong sabihin. Kasi di ba uso yung tagay-tagay, pag nalasing na, magkaakbayan na, isa lang yung iniinuman na baso... di ko tuloy alam kung ano ang gagawin nila... kung ok pa rin maglasing, kung ok pa rin magtagay-tagay.* (My peers do not know I'm positive. I don't plan to tell them. You know how we go when we drink. When you're drunk, you embrace each other, you drink out of one glass... I don't know what they'd do... if it'd still be ok to do toasting.)

The discrimination follows people with HIV up to the grave. At San Lazaro Hospital's AIDS Ward, there are still several boxes with the ashes of cremated AIDS patients. The staff talks about how they had contacted relatives but the ashes remain unclaimed. Even in death, people with AIDS are often left on their own.

7.3 AIDS Profiteering

What was most shocking in our research were stories from HIV-positive individuals of "AIDS profiteering", which we consider to be another aspect of the deterioration of social capital. Liza, one of the HIV-positives we interviewed, recounts how she was in a boutique shortly after her husband had died of AIDS and the shop-keeper, not knowing who she was, asked her to donate money for the widow of an Italian. A shocked Liza asked who had authorized them and they named an NGO.

Liza's story was not isolated. There were several stories from people living with HIV about how politicians, the media and even AIDS NGOs had used people living with HIV for fund-raising. One of the PHAs, during our FGD on human rights, lashed out at a quite well known case of "AIDS impersonation", where one person actually pretended to be HIV-positive to attend a conference.

Our informants were particularly bitter about the way Sarah Jane Salazar was handled, first paraded around and then relegated to a mental institution to die. The politician who had handled her came under particular criticism as someone who had turned away from her when she needed help, and then surfaced again after she died, to bask in the limelight.

Such instances are only another aspect of the erosion of social capital, of how the epidemic may bring out the worst in the Filipino, not just in terms of discrimination but a ghoulish capitalizing on other people's suffering.

7.4 New Forms of Solidarity and Social Capital

We do not want to end the discussion on a sad note. We did find that the HIV/AIDS epidemic can be an opportunity for building up social capital. We have seen families rejecting HIV-positives, but we also saw how others do care for their relatives.

> *Hindi naman sila yung tipong 'anong sasabihin ng tao...' At least, sabi ko, suwerte pa rin ako na binigyan ako ng family na ganito, anak na maunawain, never ako nakatikim sa kanila ng salitang masasakit, wala yung 'eh kasalanan mo rin naman yan eh.' Kahit na tatay ko, sinasabi pa rin niya na mahal ko pa rin ang anak ko. Sabi niya, kahit anong sabihin ng tao, wala akong paki-alam basta hindi tayo magkahiwa-hiwalay. Kasi sa family namin,*

naranasan naming maghirap na sama-sama kami, naranasan din naming maginhawa na sama-sama kami. (They were not the type who would say 'what will people say…' At least, I told myself, I'm still lucky I was given this kind of family, even a child who is understanding. I never received any painful words from them. I didn't hear them say, 'It's your fault eh.' Even my father, he says that he still loves his daughter. He said, no matter what others will say, I don't care as long as we are together. You know, in our family, we have experienced going through sufferings together, we have also experienced good times together.) [Liza]

What helped me a lot was my family. I disclosed to my family immediately. I told them, look, I may not be able to help you financially now kasi I need my money, kasi I'm dying. They laughed, dying of what? So I told them, close the door, this is it, I'm infected with HIV. They got very quiet… My sister said, 'some people got cancer, they're still alive; people get HIV, doesn't mean you'll die tomorrow. You will have it for years. The thing is you have to look for yourself... we're here for you. We're family. Whatever happens, you're with your family.' [Joshua]

Other HIV-positive individuals talk about how friends sometimes become more supportive than relatives:

I told my friends first then my family. At first, they were shocked; little grief. Friends are always easier. Persons with the same feather. They are more knowledgeable about this. I was assuming more immediate acceptance, which is what happened. [Jim]

Then, too, there are instances where communities and neighbors express solidarity, sometimes to the surprise of the persons living with HIV:

Una kong pinagsabihan tungkol sa kalagayan ko mga kapatid ko, then mga officemates ko, ibang kapitbahay ko sa Tondo… Kilala naman nila ako. Naawa sila sa akin. Wala 'yong paninisi. Palagay ko 'yong stigma nasa akin, eh… Kapag hindi ako nakakapunta dun (Tondo), sinasabihan ng matanda 'yong mga kaibigan ko, dalawin niyo naman si Boyet gusto kong malaman kung anong kalagayan niya. (I first disclosed to my brother, then *to my officemates and some neighbors in Tondo… They knew me. They pitied me. There was no blaming. I think that the stigma is*

actually from me. Whenever I don't go there (Tondo), the old ones would tell my friends, 'Go and visit Boyet, I want to know how he is doing.) [Boyet]

The most inspiring stories, however, are those of HIV-positive Filipinos organizing themselves and learning to speak for themselves. Organizations such as Pinoy Plus and PAFPI have contributed to the well-being of HIV-positive Filipinos, mobilizing themselves for mutual help activities, and providing support for each other when a crisis strikes. When one of them is hospitalized, they also provide care and support. Geena echoes others when she says that she has found a "family" with other HIV-positives.

There is of course sadness when a fellow HIV-positive passes away. Yet, death seems to provide strength to go on, as Geena relates:

May pangako rin kasi ako kay Gigi. Yung anak niya kasi mag-isa sa probinsiya, kasama lang yung nanay niya na matanda na rin. Bago siya namatay, kausap ko siya. Sabi niya...gusto kong makita yung anak ko. Sabi ko, magpagaling ka muna para makauwi ka sa inyo, para makita mo yung anak mo. Sabi niya, gusto kong makita yung anak ko. Sabi ko, oo nga bakla, pero kung talagang oras na, kung gusto mo nang magpahinga, kahit papano, gagawan namin ng paraan. Tapos, nagpray pa kami, kasama namin yung nurse na mag-pray. Tapos, sabi ko, sige ah, punta muna ako sa labas, may titingnan lang ako, babalikan kita. Paglabas ko, medyo natagalan ako nun kasi may nakalamay din nun. Pag pasok ko patay na siya. Sabi ko, Diyos ko, sana magawa ko kahit papano yung mga sinabi ko sa kaniya. Ang daling sabihin, pero ang hirap gawin. Lalo pa na wala kaming address, pero kung tutuusin, kung gusto mo talagang tumulong, madali mong makukuha yung impormasyon tungkol doon. Ang problema, hindi alam ng bata na ganoon ang ikinamatay ng nanay niya. Mabigat kasi para sa mga bata, lalo na hindi natin alam kung OK ba sila sa extended family nila, iba pa rin kasi yung magulang. Sana magawa ko. Maumpisahan man lang...

(I made a promise to Gigi. Her child is in the province, living with her mother who is already quite old. I was with her before she died. She said...I want to see my child. I said, you should get well first so that you can return to your home, so that you can see your child. She said, I want to see my child. I told her, yes bakla, but if it is time now, if you want to rest, we will try our best to

take care of it... Then we prayed, with the nurse we prayed. Then, I said, ok, I'll step outside, I have to attend to something, I'll be back. When I went out, I was delayed because I went to see another person who is also gravely ill. When I returned, she had passed away. I said, my God, I hope I could accomplish what I promised her. Easier said than done. I don't even have an address, but if you think about it, if you really want to help, it should be easy to get the information. The problem is, the child doesn't know why his mother died. It's difficult for children. We don't know if they're OK with their extended families, a parent is always different. I hope I'll be able to do it. At least to just start.)

Such stories remind us of all the tenacity of the human spirit, that the most adverse of situations also bring out the most noble in people. They are sad stories, there to offer whatever lessons we choose to recognize.

VIII. Reducing Susceptibility and Vulnerability : Recommendations

In coming with recommendations to alleviate impact, it is useful to return to the terms "susceptibility" and "vulnerability". On one hand, we need to reduce susceptibility in terms of the risk factors that increase the chances for people becoming infected. But going beyond susceptibility, we need as well to tackle vulnerability, which refers to the way HIV/AIDS will impact on the country, and on communities and households.

8. 1 Keeping HIV "Low and Slow"

Prevention becomes primary when we look at susceptibility. We have identified and discussed the factors that increase the chances of HIV/AIDS spreading in the Philippines.

1) Adopting an HIV and development framework for risk analysis

AIDS in the World II (1996:460) notes: "In the past, many national AIDS programs have sought to involve ministries other than health (education, communication, defense, etc.) in HIV/AIDS work. Too often, however, this has involved only superficial and token measures, such as including a few words about HIV/AIDS in an existing brochure published by another ministry. In contrast, the contextual approach required by vulnerability analysis demonstrates the human development dimensions of HIV/AIDS and creates the potential for synergy by focusing efforts of different sectoral groups onto the contextual issues of common concern. HIV/AIDS is no longer an addition to the development agenda; it signals where development efforts should focus and who should be their prime beneficiaries."

Prevention will entail more than IEC (information, education, communication) campaigns about the virus and the disease; instead, it must anticipate and deal as well with some of the structural problems, from gender inequity to the economic crisis. Such topics need to be discussed as part of HIV prevention programs.

2) Strengthening social/behavioral research.

The effectiveness of prevention programs will rest on the way it is guided by rigorous social and behavioral research. We have to move away from KAP (knowledge, attitudes, practices) surveys and look at the context of risky behavior. This includes looking at sexual networks, motivations for sex, mobility patterns and other factors that shape susceptibility. More attention needs to be given as well to looking into casual sex and how this might contribute to the epidemic in the future.

In terms of population groups, more research is needed for the groups at risk that have been mentioned: women, young adults, men who have sex with men, sex workers, and overseas Filipino workers. Such research is best done with the involvement of those concerned, e.g., gay men's organizations would be best equipped to handle MSM research. The research should avoid further stigmatization of marginalized groups and should help to bring out solutions.

3) Monitoring impact of HIV prevention strategies

While we have emphasized, in this report, the impact of HIV/AIDS, we forget that much needs to be done in terms of monitoring and evaluating the impact of anti-HIV strategies. Put another way, we have not asked enough, "Are we making a difference?" and "Are we 'cost-effective' in trying to make a difference?"

Issues of cost-effectiveness have been described at great length in a UNAIDS document (UNAIDS 1998) with emphasis on quantitative measures. It is important we conduct such analysis, and in a rigorous way. Previous local evaluations that have appeared over-emphasize such measures as "numbers of workshops conducted" or "numbers of condoms distributed". These are measures of operational efficiency of a program, but say little about actual impact on people's awareness, knowledge, attitudes and behavior and, ultimately, whether their risks for HIV have been reduced or not.

Qualitative indicators need to be developed, recognizing that human behavior cannot always be quantified and that "behavior change" is a long process.

4) Expanding multisectoral involvement

One strength of the Philippine response to HIV/AIDS has been its multisectoral approach. This approach needs to be maintained especially in relation to prevention programs. The private sector needs to be mobilized in these

efforts. For example, having identified seafarers as a population at risk, programs should be initiated through such labor unions as Associated Marine Officers' and Seamen's Union of the Philippines (AMOSUP).

Besides the private sector, NGOs remain a potent force, especially those that are organized by marginalized groups themselves, such as gay men's organizations. Such organizations as Pinoy Plus and PAFPI need to be drawn in to play more active roles in policy-making and in prevention programs and in linking up with other groups. The gay men's organizations meeting in one of our FGDs, for example, has already asked if gay HIV-positive individuals could "come out" in meetings and workshops with gay men, if only to emphasize that HIV has began to affect gay men.

Another sector that remains untapped are the religious groups. It is too easy to presume that the religious are conservative and will not support HIV/AIDS programs. The Protestants and Muslims are not opposed to condoms and even among Roman Catholic clergy and sisters, there are those who recognize that condoms can be life-saving. Those opposed to condoms can still be tapped for support and care activities.

5) Involving local government units (LGUs).

The relationship between HIV and development needs to be "mainstreamed", especially for LGUs, who may feel the threat is too remote. Facts and figures about HIV/AIDS and how certain local areas might be more susceptible and vulnerable need to be disseminated.

We have mentioned some areas are more dependent on overseas workers. If these areas are truly concerned about protecting their "investments" in terms of overseas workers, they should be looking into HIV/AIDS programs for the OFWs and their families.

This is not to say that only areas with OFWs should be involved. Here, risk analysis is again important. We have named the different factors that should be considered. Geography, for example, reminds us that HIV could enter through the country's back door, Mindanao. Priority needs to be given to areas that are susceptible and vulnerable.

There is no sense reinventing the wheel. The DOH and NGOs can guide LGUs so they can avoid such counter-productive measures as the use of mandatory testing, or the use of scare tactics in the production of IEC materials.

Unfortunately, local government units (LGUs) often do not recognize the importance of health issues, especially for HIV/AIDS. It would be unfortunate if LGUs are eventually mobilized only when the epidemic has spread and has affected them adversely. Providing LGUs with the capabilities for IEC campaigns on HIV/AIDS could be the most cost-effective mechanism for getting a national campaign off the ground.

6) Sustaining information, education and communications campaigns.

Several of our Delphi panel members expressed concerns about the donor dependence of our HIV/AIDS initiatives, both on the part of government and NGOs. Thus, several commented that they had not seen new materials in the last two or three years. This is especially important because IEC materials seem to be produced only when there are donors giving out grants. Ways have to be found to sustain IEC campaigns through local resources, including LGU funds; otherwise, the IEC efforts will be short-lived.

Future IEC campaigns should be planned more carefully so they are linked to existing infrastructure. It is not enough to tell people there's a problem; they need to be able to go to a place where they can get services. A corollary here is that campaigns need to have a judicious mixture of mass media (which only raises awareness) and interpersonal approaches (which give the intensive education). "Maintenance" programs are sorely needed to follow through the effects of the campaigns and to keep people motivated to protect themselves.

7) Incorporate gender issues in HIV/AIDS education and training.

We have seen how susceptibility to HIV/AIDS is affected by gender inequality, with women and gay men put at risk. It is therefore important that training materials and workshops incorporate gender issues. Moreover, training materials should be reviewed thoroughly to screen out pictures or text that might actually reinforce anti-women and anti-gay attitudes, for example blaming women or gays for the spread of the epidemic.

8) Respecting human rights

In our report, we have shown that respect for human rights is not a luxury, or a "western" concept imposed from the outside. The respect for human rights is a necessary prerequisite for reducing the adverse impact of HIV/AIDS. The evidence from countries throughout the world, developing and developed, is overwhelming in showing that respect for human rights – from the ban on man-

datory testing to the protection of people with HIV/AIDS – enhances the effectivity of prevention programs. Note, too, that a respect for human rights includes providing access to education about HIV/AIDS. Blocking young people's access to sex education is in a sense a violation of their rights as well, one that puts them in dire danger.

8.2 Alleviating Impact

We have tried to show through this study that even with low HIV prevalence, we are already beginning to feel the impact of HIV, especially at the level of the family. Some of the measures that can be taken to reduce vulnerability include the following:

1) Strengthening the social protection system, i.e., safety nets in both the public and private sectors. Even with scarce resources, government and the private sector need to look at how they can respond to the needs of people living with HIV/AIDS, and their families. There is, already, an ongoing feasibility study for health insurance coverage commissioned by the Philippine National AIDS Council (PNAC) but similar initiatives are needed for the public sector, primarily PhilHealth. Other support services, including alternative livelihood strategies and retraining programs, will be needed to help people living with HIV.

2) Strengthening research in relation to clinical care.

We are not in the position to do basic research in HIV/AIDS but there is much that can be done in terms of clinical care. We need to be able to evolve treatment regimens appropriate to hospitals, communities and homes, using local resources. The model of Bahay Lingap, a center within San Lazaro for people living with HIV, needs to be reexamined. The center has often been counterproductive, isolating the patients and yet exposing them to the media looking for sensational stories. In other countries, home- and community-based care have been developed. This needs to be done as well in the Philippines. Such strategies help to keep people with HIV integrated in their social milieu, and may actually help to educate families and communities about HIV.

Quality of care issues will be important here, and people living with HIV will be vital partners for identifying the parameters to be used.

It is also important to identify the patterns of opportunistic infections, and to educate health professionals throughout the country so they can make an early diagnosis of AIDS and provide the necessary support or referral.

3) Strengthening the National Drug Policy and the essential drugs program.

For the last 10 years, the DOH has enunciated a National Drug Policy (NDP) that includes increasing access to medicines. The NDP is anchored on the concept of essential drugs, providing medicines that are safe, effective and affordable. To do this, the NDP has its PQRST components: P for people's empowerment, Q for quality assurance, R for rational drug use, S for self-reliance and T for targeted procurement. These principles need to be applied as well to the medicines that people with HIV need, whether HAART or medicines for opportunistic infections. Other countries have shown that the use of generics, parallel imports and compulsory licensing can lower costs for treatment. The goal for a chronic disease like HIV should be sustained access to needed medicines.

4) Educating the public on human rights

Again, the issue of human rights figures prominently when we talk about alleviation of impact. The protection of the rights of people living with HIV is going to be more and more important as the epidemic spreads. People with HIV can continue to give many years of productive service to society, and should be allowed to do so, without stigmatization and isolation.

It is clear, too, that the continuing violations of the human rights of people living with HIV is keeping them "underground". If health institutions and health professionals become more caring and respectful of the rights of people with HIV, more of them will come out to seek help.

Government and NGOs must also be more vigilant about the many instances of discrimination and violation of human rights that occur even among organizations working on HIV/AIDS. In some instances, these may be unintentional, and can be easily corrected, such as providing more training for staff members to become more sensitive to the needs of people with HIV.

5) Stop AIDS profiteering

The strong words of PHAs about AIDS profiteering point to the need to stop such activities, which shamelessly exploit other people's suffering for individual gain. Like government corruption, AIDS profiteering affects many people's lives, reducing the resources available for HIV prevention and care. In the long run, such forms of corruption will affect the entire AIDS network as donor agencies withdraw support for local programs.

6) Development to alleviate HIV/AIDS

We end our recommendations a bit uneasily, by citing the need to look at macro-solutions for the alleviation of the impact of HIV/AIDS. Over (1998) observes: "From the evidence. . .a country that improves per capita income and reduces inequality, for example, by implementing broad pro-growth investment policies that will generate jobs, will reduce its risk of suffering an AIDS epidemic or help to minimize an epidemic already under way. If, in addition, the country acts to close the literacy and urban employment gaps between men and women, HIV will have even more difficulty spreading. . ."

The passage is self-explanatory, but we use it with some reservations because it also reminds us how daunting HIV/AIDS is. If indeed we need to look into improvement of income and "pro-growth investment policies" (coming from the World Bank, that would mean even more liberalization), then the outlook is not too bright for the Philippines.

Nevertheless, we use the passage to emphasize that the whole framework of HIV and development is crucial for understanding HIV/AIDS and for the formulation of responsive policies.

IX. Conclusions

To end our report, we return to the theme of HIV and development. Dr. Roderick Poblete of the DOH laments, "Gasgas na yung, 'It's not only a health issue, it's an economic and social issue, a development issue. . .It's still a numbers game. Kung hindi umuusok yung bulkan, walang evacuation, walang response." Unfortunately, the need to produce more numbers in each study becomes almost a fetish, because after the numbers are all in, the economists and statisticians and epidemiologists still wonder about p-values and the significance of those numbers.

We have tried to balance the quantitative and qualitative in our report, and want to emphasize there is no way we can quantify human suffering. The statistics are there only to complete the picture, but we hope they will not be the only guide for policy-making.

In a box at the end of this report, we have certain key messages which we feel can be used to develop future strategies and campaigns. They are not new, but our report provides the data and information that can be used to add flesh, and life, to those messages.

We end here with a projection. During our interviews, we noticed how quite a few of our Delphi panelists would refer to TB. Perhaps that was inevitable since TB is itself a disease of development. We still have one of the highest rates of infection in the world, but we cannot blame it all on poverty alone since many countries poorer than we are have come to control it. One can blame individual habits, environmental sanitation, the lack of political will. It will be the same kind of finger-pointing as HIV spreads. Dr. Ma. Concepcion Roces suspects we may eventually get to a point where HIV will be like TB, "creeping", not out of bounds but still a serious problem affecting many Filipinos. The impact will be mainly on the health care system, and on families, still invisible because it will infect mainly the poor, yet gnawing away at scarce resources and at people's lives. Dr. Poblete also refers to TB and asks if HIV might yet produce another "epidemic of depression." It is not a pleasant prospect but that quite succinctly summarizes all the fancy terms we use in relation to impact.

Is there hope then? We believe there is. The DOH's Dr. Loreto Roquero repeatedly used the phrase "It's a matter of time" as we interviewed him. It's an intriguing statement. On one hand, it offers us a warning that the "low and slow" epidemic will not always be so, and that with time, a critical mass will eventually be reached. On the other hand, time may be on our side. We had an early start with prevention campaigns, and they may have made some difference. Time is on our side, too, in that we learn from the experiences of other countries, both their successes and failures. "It's a matter of time" should be taken positively. The investments we have put into HIV prevention, and our openness to learning from own accomplishments and shortcomings, are also important to avert the disaster that would come with a serious HIV/AIDS epidemic. In time, we will see the fruits of our labor.

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Appendix 1

Participants in Delphi Process
(In Alphabetical Order)

A note on the selection of the panelists: We chose the members with the intention of balancing the following criteria: (a) disciplinary background, including academic training and work experience; (b) gender; (c) sectoral representation (NGO, GO, academe) and (d) geography. We intentionally included people who were not necessarily in the AIDS sector but who had expertise that would be useful, in order to bring in fresh insights on HIV/AIDS in the country. Note that because NEDA funded this project, we could not tap NEDA economists as part of the panel.

Dr. Cecilia Acuin, medical doctor and medical anthropologist. Presently a Program Officer of Population Council, a visiting research consultant of De La Salle University Angelo King Medical Research Center, and consultant of Research Institute for Tropical Medicine. Has done extensive work in reproductive health, mainly reproductive tract infections.

Dr. Fernando T. Aldaba, economist. A professor at Ateneo de Manila University. Executive Director of Ateneo Center for Social Policy and Public Affairs. Was part of the team that reviewed the country situation on and response to HIV/AIDS.

Marie Christine Bantug, psychologist, social worker and researcher. Currently a program coordinator of HASIK, an NGO concerned with women's and young people's issues.

Dr. Nina Castillo-Carandang, health social scientist. Presently connected with the Department of Clinical Epidemiology, College of Medicine at the University of the Philippines in Manila. Also teaches at the University of the Philippines in Los Banos.

Maisie Faith Dagapioso, social worker. Currently freelance but formerly working with women's organizations and development groups in Zamboanga, with particular focus on cultural minorities and Muslims.

Dr. Manuel Dayrit, medical doctor and epidemiologist. Former Assistant Secretary of the Department of Health and director of the Field Epidemiology

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Dr. Mari Rose Aplasca delos Reyes, medical doctor. Former Head of the AIDS Research Group at the Research Institute for Tropical Medicine. Has been involved in various AIDS/STD activities such as care and support, training and research on STDs and AIDS education.

Dr. Sylvia Estrada-Claudio, medical doctor and psychologist. Assistant Professor in the Women and Development Program, College of Social Work and Community Development, University of the Philippines in Diliman. Chair of the board of LIKHAAN, an NGO providing reproductive health services to urban poor women.

Dr. Alejandro N. Herrin, economist. Professor at University of the Philippines School of Economics, Diliman, and a member of the WHO Technical Advisory Group on Health Sector Development in the Western Pacific Region. Has a number of publications in the field of population, development, gender and health.

Dr. Margarita Gosingco Holmes, psychologist and sex therapist. Noted for her 14 books and newspaper columns giving advice on issues of sex and sexuality.

Yasmin Busran-Lao, psychologist and social worker. President of Al-Mujadilah Development Foundation, a Marawi-based organization working with Muslim women. Currently involved in projects on reproductive health, gender and sexuality, community organizing, peace-building and advocacy.

Dr. Joseph Anthony Lim, economist. Professor, UP School of Economics. Expert in development economics, econometrics, macro-economics. Most recent projects include a study of drug pricing, and the impact of the Asian economic crisis on women.

Dr. Consorcia Lim-Quizon, epidemiologist and medical doctor. Resident Advisor of the National HIV Sentinel Surveillance System, Field Epidemiology Training Program, Department of Health.

Dr. Virginia Miralao, sociologist. Executive Director of the Philippine Social Science Council. Headed the team that evaluated the country situation and response to HIV/AIDS.

Dr. Ofelia T. Monzon, medical doctor. President of the AIDS Society of the Philippines and consultant of Research Institute for Tropical Medicine. One of the pioneers in AIDS work in the Philippines, Dr. Monzon also has conducted numerous epidemiological and clinical studies on sexually transmitted diseases.

Dr. Victor Mari SD. Ortega, medical doctor. Currently heads the UNAIDS office in the Philippines. Former consultant of the Senate Committee on Health and Demography, as well as the "architect" of the Republic Act 8504 or Philippine AIDS Law of 1998.

Dr. Roderick Poblete, medical doctor. Secretariat and Technical Officer of Philippine National AIDS Council. Heads the Policy Section of the National AIDS/STD Prevention and Control Program at the Department of Health.

Dr. Ma. Concepcion Roces, medical doctor and epidemiologist. Director of the National Epidemiology Center of the Department of Health. Also Program Manager of the National HIV Sentinel and Surveillance System, as well as the Infectious Disease Surveillance and Control Project of FETP-DOH.

Dr. Loreto B. Roquero, medical doctor. Director of the National AIDS-STD Prevention and Control Program, Department of the Health. Also Chairman of the ASEAN Task Force on AIDS. Former Head of the Family Planning and Reproductive Health Program.

Dr. Vicente Salas, medical doctor and public health specialist. Former HIV Program Manager of the UNDP, Philippines. Presently working with the International HIV/AIDS Alliance in London. Has worked extensively on migration and health, as well as HIV/AIDS program development, technical support and evaluation.

Rosena Sanchez, economist. Faculty member and researcher connected with Ateneo de Davao University. Coordinator of the Ateneo Task Force and Mindanao Health, Gender and Sexuality. Active in women's advocacy in Mindanao, especially concerning reproductive health, gender policy and planning, and violence against women.

Dr. Ofelia Saniel, epidemiologist. Associate Professor at the College of Public Health, University of the Philippines, Manila. Currently the Principal Investigator of a study on STD Case Management, as well as Co-Investigor of a study comparing the HIV epidemics in different countries in Asia.

Dr. Jose Narciso Melchor C. Sescon, medical doctor. Executive Director of the Remedios AIDS Foundation. Involved in diverse projects on HIV/AIDS and reproductive health, mainly with young adults, with sex workers in an urban poor setting.

Dr. Carolyn Sobritchea, anthropologist. Professor at the UP Asian Center and Director of the UP Center for Women's Studies. Noted feminist scholar. Has done extensive research and consultancy work on the fields of women and development, reproductive health, as well as Philippine peasantry and agrarian issues.

Dr. Sandra Tempongko, public health specialist. Professor at the College of Public Health, University of the Philippines, Manila. Regional Expert of SEAMEO-TROPED CHASPPAR. Most recently conducted studies among OFWs in Hong Kong and sexual behavior in different parts on the Philippines.

Dr. Teodora C. Wi, medical doctor. Resident Advisor of Family Health International. Has worked with AIDS programs for several years, conducting research on risk factors and sexually transmitted diseases among female sex workers.

Appendix 2:

Recommendations for a Dissemination Strategy on HIV and Development in the Philippines

This is a brief paper accompanying several reports related to HIV and Development in the Philippines, prepared by Health Action Information Network as part of the NEDA project "Increasing Awareness and Understanding the Development Implications of HIV/AIDS (DEV/AIDS). The main findings of the study are found in our report, "A Matter of Time: HIV/AIDS and Development in the Philippines".

We first cite recommendations in relation to how the dissemination campaign might be conducted and then give key messages that emerge out of our findings.

Conducting the dissemination campaign

1. Identifying targets

Targets need to be prioritized. While ideally, one would like to reach all government groups, NGOs and the private sector, particularly groups that may be more receptive to the theme of HIV and development:

Government: Among government agencies, the Department of Health needs to be reached with the messages because our studies show very clearly how the health sector is, even now, being adversely affected by HIV. Reaching the different bureaus of the DOH is important so that HIV becomes "mainstreamed" even within the department.

Other government agencies that need to be reached first are those involved in social services (DECS, DSWD), as well as those related to social protection (GSIS, SSS, etc.)

NEDA itself needs to be a priority target because of the theme of development, hopefully with training to make staff more sensitive to the importance of non-quantitative indicators.

Local Government Units: In our consolidated report, we emphasized the need to mainstream HIV and development issues and to reach LGUs with the key messages. LGUs can be prioritized by looking at susceptibilities and vulner-

abilities, for example, those that "export" many overseas workers may be more receptive to HIV prevention if they understand the repercussions of their constituents being infected while working abroad.

NGOs: Many NGOs are already aware of the HIV/AIDS-development link, especially those involved with communities. Unfortunately, it is the AIDS groups or agencies limited to reproductive health that tend to lack an orientation toward development, concentrating their education on biomedical aspects of HIV/AIDS. It is not surprising that some of these groups lack gender awareness and sensitivity, one very basic feature of the HIV/AIDS-development paradigm. Such groups need to be reached with the messages of development and HIV/AIDS so that their campaigns can become more effective.

Religious Groups: A dialogue needs to be maintained with religious groups, with emphasis on the adverse impact of HIV/AIDS on society and especially social services. The potential impact of HIV on the religious groups' own services, for example hospitals and orphanages, need to be highlighted. HIV's erosion of social capital – including the breakdown of social cohesion – needs to be brought to the attention of religious groups.

Private sector: There are several groups already working with the private sector on HIV/AIDS – Philippine Business for Social Progress (PBSP), Remedios AIDS Foundation and the Trade Union Congress of the Philippines (TUCP). They can be key partners for further work on HIV and development. Other partners can be explored for sector-specific work, e.g., for seafarers, the various seafarers' unions such as Associated Marine Officers' and Seamen's Union of the Philippines (AMOSUP).

2. Use positive messages.

Avoid using alarmist and fear-arousing messages. The work in health education shows this just does not work. We have also seen how all the dire predictions of an AIDS epidemic in the Philippines may now be backfiring because the HIV problem remains "low and slow". Emphasize that this is no time for complacency, and that there are factors that could speed up the epidemic, but that we also still have time to act.

3. Use both statistics and qualitative information for education. Bring in the human interest angle.

Too many statistics can be numbing, and can get people confused. The practice of DOH releasing new HIV infection figures each month should be re-

viewed – people are no longer listening. The human interest angle, especially stories from people living with HIV, are important especially for drawing people's attention to what could happen to individuals and families.

4. Use metaphors and analogies.

We have used several metaphors and analogies in our report, comparing it to a typhoon and the traffic situation to illustrate vulnerabilities and risks. Especially since HIV is still low and slow, people have to understand why we need to launch prevention now.

5. Present cost comparisons and analyses.

When numbers are used, it is good to show what the costs of HIV are, and what is sacrificed when an infection happens. We have several examples in our report.

6. Avoid modeling and projections.

We have seen how previous modeling projections have fallen apart. The projection of 100,000 HIV cases by the year 2000 was lowered to 38,000 and now to 13,000. Avoid presenting these projections to the mass media since they become meaningless when not accompanied by explanations. Doomsday predictions are like the case of the boy crying wolf – people are no longer listening to the warnings.

7. Avoid hypothetical scenarios.

We have also avoided hypothetical scenarios because there are so many diverse situations that affect HIV impact. Someone who is wealthy and becomes infected with HIV will not be as vulnerable, economically, to the adverse impact of HIV. Attempts to compare income and expenditures are not always useful since the very poor have paltry earnings with or without HIV. What needs to be brought out are "true stories" from people living with HIV that convey some statistics, but which also carry the human interest angle.

8. Always explain technical terms. Avoid vague terms like "development", "reproductive health" and "reproductive rights".

Many words are thrown around without adequate explanation. Even a word as basic as development needs to be reviewed in relation to local situations. How does HIV/AIDS relate to "kaunlaran", when kaunlaran tends to be more of a

macro process. Would "pag-aasenso" be more relevant? These are concepts that have to be reviewed before a dissemination campaign starts.

9. Incorporate "DEV AIDS" into existing information and education modules.

Instead of launching a new "flavor of the month" as has happened with HIV/AIDS and reproductive health, incorporate the HIV/AIDS-development issues into existing programs. AIDS 101 modules that talk only of the biomedical aspects can now incorporate some of the facts and figures we have for HIV and development. "DEV AIDS" issues can go into community health curricula, or even gender-sensitivity programs. There are many entry points that can be used, depending on the target group.

10. Emphasize the human rights aspects.

DEV AIDS is a matter of human rights as well. The relationship between human rights and development needs to be emphasized, i.e., respecting human rights is a necessary component for an effective HIV prevention program, in the same way that it relates directly to economic development. Mandatory testing and quarantine are needless and unscientific expenditures that drain our already limited resources needed for HIV prevention and care.

Since people living with HIV/AIDS are going to be crucial partners in DEV AIDS education, extra effort needs to be taken to avoid their being used in the process. They should not be there for display, or for moralizing lectures. People living with HIV/AIDS are in the best position, if they are assured safety and protection, to talk about what HIV has meant for their lives, and how it will in the long run affect an entire nation's development.

11. Play on the theme "a matter of time".

We explain, in our report, why we used "A Matter of Time":

We have the advantage of an early start with HIV prevention programs.
It is a matter of time – our current efforts – to keep HIV low and slow.
It is a matter of time before HIV/AIDS becomes serious in the country.

KEY MESSAGES

To summarize our report, we are presenting the key messages that should be considered as well in future information and advocacy campaigns.

1. The HIV/AIDS "epidemic" in the Philippines is "low and slow" for now, and is likely to remain slow for the next five years.

2. "Low and slow" only means we have not reached a critical mass of infections. This could change in the future and once the critical mass is reached, the epidemic could take off.

3. The economic impact of HIV is still minimal, and will remain so until the epidemic becomes serious.

4. HIV/AIDS can be kept low and slow through multisectoral efforts involving government, NGOs and the private sector.

5. Some populations are at greater risk than others because of social and economic factors. Special attention is needed to reach such populations.

6. HIV is a development issue. Our development policies affect people's vulnerability and susceptibility. On the other hand, HIV itself impacts on development.

7. Because HIV is a development issue, responses need to be broad-based and multisectoral, involving those most affected, including people living with HIV/AIDS.

8. At this stage, HIV is already adversely affecting the lives of many Filipino individuals and families, economically and socially. It is also beginning to strain our already overworked health care system.

9. A respect for human rights is the most scientific way of dealing with HIV/AIDS, both to prevent it from spreading as well for alleviating impact.