The international newsletter on HIV/AIDS prevention and care

# AIDS action

Asia-Pacific edition

Issue 36
July-September
1997

# Reproductive Tract Infections

Mention RTIs and even health professionals will think of respiratory tract infections. The other group of RTIs – reproductive tract infections – is only now receiving attention in public health and even then, much is still needed to educate both professionals and lay people.

This issue of *AIDS Action* features the highlights of the 2nd Asia-Pacific Regional Meeting on Reproductive Tract Infections convened by Health Action Information Network (HAIN) in May 1997. This consultation, held in Caylabne Bay (Ternate, Cavite, the Philippines) brought in a group of biomedical and social scientists from India, Bangladesh, Vietnam, Thailand, China, Indonesia, the Philippines, Fiji and Vanuatu. The participants were also multisectoral, coming from government, NGOs and the academe.

The Caylabne consultation provided a venue for a systematic review of past and current activities relating to the prevention and control of RTIs, a rather broad category of illnesses that includes HIV/AIDS. The consultation showed how important it is to expand HIV/AIDS programmes to include other aspects of reproductive and sexual health. In particular, little is known about the social and behavioural aspects of RTIs.

The meeting also demonstrated the importance of regional sharing. Despite the diverse cultures represented, there was amazing similarity in experiences and lessons to be learned.

In this issue we feature excerpts from an overview of the biomedical aspects of RTIs, followed by an article looking into approaches in preventing RTIs. This is followed by a review of "where we are" today and recommendations for the future. It was not easy compiling these highlights, considering that many important issues remain unresolved. Many of the presentations were quite provocative, challenging many current assumptions about RTI prevention. An example of such a contentious area is that of the syndromic management of STDs.

Editing the discussions was difficult because they were so rich with facts and insights. What we feature in this issue of *AIDS Action* may not always do justice to the speakers' presentations but we hope this distilled version will at least stimulate *AIDS Action* readers to ask more questions and to share experiences and ideas.

IN THIS ISSUE



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# RTIs: An Update on Biomedical Issues

(Edited excerpts from a plenary lecture by Dr Christopher Elias, The Population Council)

## DEFINITIONS

There are three main categories of RTIs: (a) sexually transmitted infections or diseases (STIs, STDs); (b) endogenous infections caused by an overgrowth of organisms normally present in the vagina and (c) iatrogenic infections, which are infections associated with medical procedures, in particular transcervical medical procedures such as with the insertion of intrauterine devices (IUDs).

It is important to distinguish the different kinds of RTIs because these have different implications in terms of understanding causality, as well as in terms of defining the most appropriate intervention strategies. The prevention of sexually transmitted infections depends primarily on the regulation of sexual behaviour, whereas reducing the number of endogenous infections relies on improving the quality of medical services.

## SEXUALLY TRANSMITTED INFECTIONS

At last count there were at least 27 different diseases caused by different viruses, bacteria and other microorganisms. STDs are common but they are not necessarily the most prevalent among the different RTIs.

## ENDOGENOUS INFECTIONS

Endogenous infections are often called minor or nuisance infections, when in fact they are responsible for significant levels of morbidity among women. Bacterial vaginosis (BV) for example, is perhaps the single most common cause of RTI. They are often asymptomatic but in many cases, they can be quite symptomatic and uncomfortable.

Men are also susceptible to candida infection and particularly uncircumcised men may develop yeast infection under the glans, essentially the equivalent of endogenous infection among men and maybe associations with a disturbance, if you will, of the local flora or ecology of the uncircumcised man. Normal flora in males is very poorly studied.

## IATROGENIC INFECTIONS

These are usually caused by dirty instruments that are improperly sterilised. The infection is usually due to gram-negative organisms, the kind you would get in a wound infection. *Trichomonas* and *Candida* are not generally infections of the upper reproductive tract. If they are introduced into the upper reproductive tract it would be unlikely that they can cause an infection.

## CONSEQUENCES OF RTIs

A number of pregnancy-related complications have been associated with one or more of the different RTI pathogens and there are significant associations with fetal wastage, low birth rate and congenital infections with different RTI pathogens.

It appears that the presence of certain reproductive pathogens may significantly increase the likelihood of HIV transmission. Certainly this was first defined for genital ulcers syndrome, which were found to have very high correlation with significant transmission rate of HIV. More recently data suggests that even the non-ulcerative RTI syndromes may be associated with an increase in the likelihood of HIV transmission. Given that those non-ulcerative infections are actually more prevalent than the ulcerative diseases, they may actually represent more of an attributable risk for HIV transmission.

There are a number of consequences associated with infection of the upper reproductive tract. A significant proportion of lower RTI caused by STDs progress to upper reproductive tract pelvic inflammatory disease (PID), and this has been

associated with significant increase in the rate of infertility and ectopic pregnancy and the development of chronic pelvic pain.

Much has been made of initial impact of RTIs on family planning programmes. There is an association with this problem with contraceptive service delivery. First by compromising fertility, pregnancy outcome and child survival, RTIs may decrease demand for contraception. Similarly when perceived as side effects of contraceptive methods. RTIs may result in a discontinuation of contraception, and finally real and perceived associations between RTIs and particular methods of contraception may result in reluctance to accept methods.

## REVISITING SYNDROMIC MANAGEMENT

(Editor's Note: Syndromic management involves the use of signs and symptoms to diagnose and treat diseases. This has been recommended for RTIs, particularly STDs.)

What has emerged in the last two years is a better understanding of some of the limitations of standardised case management approaches, the use of syndromic algorithms. Historically, these algorithms were developed based on data from places with high rates of STDs and were recommended for more general use. Several studies have looked at how well these algorithms have performed, and they generally found that in low prevalence settings, algorithms have actually been very poorly predictive of the presence of STDs or of RTIs in general. This often results in significant amount of overtreatment. There has been growing concern in the last couple of years about the costs of the overtreatment, not only in terms of dollars spent on antibiotics but also the potential cost of widespread antibiotic use on emerging microbial resistance.

Unfortunately, while there has been progress in the diagnostic sphere in the last two years, it has yet to realise itself in terms of available diagnosis for use in programmes today. Some exciting possibilities are urine-based diagnostics, which allow broader screening of both males and females. If there is a less invasive diagnostic procedure to conduct screening, this may be a way to screen more women for potential infection and guide therapy more specifically.

The most common RTIs are bacterial vaginosis, candidiosis, trichomoniasis. Together those three infections typically account for 75% of RTIs in a community. Simple laboratory tests will allow one to reliably distinguish between those three most common syndromes. Some investment in infrastructure in the form of light microscopes and simple gram staining preparation and wet mount preparation, and a lot of training, will develop capacity to distinguish between the most serious infections.

*We would like to acknowledge The Ford Foundation for supporting this 2nd Asia Pacific Regional Conference on Reproductive Tract Infections (RTIs). The consultation was enriched by the contributions of our two resource persons: Dr. Christopher Elias and Dr. Vera Paiva.*

*Finally, we wish to acknowledge the valuable contributions from all the participants in the consultation.*

### ***RTIs**: Different Languages, One Meaning*

การติดเชื้อในระบบสืบพันธุ์ — Thailand

प्रजनन संबन्धित बिमारियां — Hindi, North India

గర్భసంబంధిత వ్యాధులు — Telugre, South India

जननेंद्रियातील जंतूंचा — Marathi, Central India

生殖道感染 — China

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# Different Models for RTI Prevention

*(Excerpts from a lecture by Vera Paiva, Associate Professor, University of Sao Paolo, Brazil.)*

I would like to share our experiences in HIV/AIDS prevention in Brazil, particularly our work with young people to see what we can use for RTI programmes. My approach here is to analyse four different approaches to prevention: (1) the behaviour change approach, (2) the self-empowerment approaches, (3) the community oriented approach, and (4) the social transformation approach.

## Behaviour Change

If you review the literature on behaviour change, you find most theories come from the psychobiomedical field. Basically the key point is that you give people information and knowledge. If you can access intentions and attitude, you would change behaviour and the final action. Most theories of behavioural change are not theories on behaviour change, but theories on behaviour. They rarely look at how the change has begun exactly.

## Self-empowerment

An improvement of the behaviour change model is the self empowerment model. Here, modeling is not enough. We need to foster awareness, give people skills training. More than information, intentions and attitudes you should make space for people to improve and to feel empowered to perform such behaviour. The most popular method of doing this is to offer workshops, for example, to deal with race prejudice, gender empowerment, etc. The focus here is on the individual but this approach still does not take into account the structural barriers.

## Community Oriented Approaches

With this approach, we emphasise needs assessment together with the community. You use focus group discussions to identify local language, how the culture works. The needs assessment is important for defining the community. For example, I was working in a community of ten blocks (defined by young people residing in area) in a small place in Sao Paolo with a lot of drug addiction. Later we found there were actually four subgroups of young people in the area. If we had used only one approach to HIV/AIDS with one language, some of the groups would not identify with the programme. Or if we had chosen one set of leaders, the other groups would not find themselves represented. It is important to define the community.

With this approach, you might find that people are interested in other topics. Rather than AIDS, for example, people may want to talk about drugs, or unwanted pregnancies.

## Social Transformation

With this approach, we recognise that not all people are equally vulnerable to HIV/AIDS. It could be that you are poor, a woman, a kid living in this district, which makes you more vulnerable.

We do not assume that there is a deficit on information and skills, or that the community needs training and intervention from outside. We assume people make choices, including risky behaviour, as part of their cultural situation. So what we do is to work with people, helping people to analyse and "decode" their own situation. For example, how do you talk about condom negotiation when people are in a situation where they share a room with several people. People need to describe these scenarios and talk about what they can do. Empowerment must come from real life experiences and only the people affected can do this.

# Preventing RTIs: Moving to the Future

## Where are We Now?

One discussion group at the Caylabne workshop on RTIs suggested that the answer to the question, "Where are we now for RTIs" should be: "We know that we know very little."

The answer may come as a surprise to many, considering that so much has been said about RTIs in the last five years. The Caylabne meeting in fact is only the latest in a series of meetings on RTIs. The first was held in Bellagio, Italy back in 1991. Other regional meetings have been convened since then.

The Caylabne meeting allowed participants to do a quick overview and inventory of the work that has been done. The result? Most studies concentrate on sexually transmitted diseases (STDs) and are often epidemiological surveillance reports for so-called high risk groups such as sex workers. Hardly any work has been done on endogenous and iatrogenic infections, even from an epidemiological perspective.

Even less is known about the social and cultural contexts of RTIs, whether STDs or endogenous and iatrogenic infections. What is not clear is how people perceive their reproductive health and risks for illnesses, and what they do in response to these perceptions.

Despite all these limitations, a number of insights emerged about where we are now vis-a-vis RTI prevention. Some common observations are listed here.

1) RTIs are a problem in all countries although the prevalence of particular infections varies by country and by population groups.

2) RTI prevention receives low priority compared to other programs such as those for HIV/AIDS or family planning.

3) Health professionals are still generally ill-informed about RTIs, tending to recognise only the STDs.

4) Popular knowledge about RTIs is a mixture of "traditional" and "modern" concepts, not necessarily one being "better" than the other. For example, a "modern" practice such as the use of antibiotics to "prevent" STDs – a myth that is causing many problems of resistance – is quite serious in several countries.

5) RTI prevention programmes tend to center on social marketing of condoms and on the production of IEC (information, education, communications) materials that may not always be culturally appropriate. In particular, fear tactics continue to be used widely, further increasing stigmatisation and discrimination and discouraging people from seeking help.

6) Syndromic management of STDs – the use of signs and symptoms for diagnosis and treatment – might be leading to overdiagnosis and overtreatment (see page 3).

7) The political environment for RTI prevention is important. For example, when governments withdraw free condoms, there may be adverse consequences for RTI prevention. In some countries, devolution and the privatisation of health services have resulted in a lack of consistent policies for RTI management, which may aggravate RTI prevalence.

8) RTI prevention programmes may sometimes lead to unexpected outcomes. For example, Thailand's massive promotion of condom use in brothels was quite successful but also led people to think that they should use condoms only with sex workers. Thus, unprotected sex in environments other than brothels (e.g., casual sex, or sex with free-lance sex workers) has led to new infections.

## Looking to the Future

The consultation on RTIs led to recommendations in three broad areas: policy formulation; information, education and communications (IEC) activities and service delivery. There were no formal recommendations but we have taken the liberty of organising the different points raised for a more systematic presentation.

## Research

While more research is needed to guide policy formulation, participants felt that it was time to move on from prevalence studies toward operations research, i.e., research integrated into actual prevention and management activities. Operations research is particularly important to assess the impact of existing programmes. For example, operations research is

needed to look at the way case management guidelines are being implemented, i.e., such as by checking how people follow the flowcharts.

RTI policies must look toward populations that have been left out by the "high-risk groups" approach. For example, population groups that need more attention include young people and older women.

Policy formulations need to consider the social, economic and cultural contexts of RTI prevention. In particular, this means a better understanding of (a) popular perceptions of risk situations (rather than risk groups) and (b) local knowledge, skills and experiences that respond to risk situations and reproductive health programmes.

Certainly, there will be room for specific research, including monitoring of antimicrobial resistance, or looking into the role of environmental factors and personal hygiene in relation to RTIs. (Although both health professionals and lay people generally believe that hygiene can prevent endogenous infection, there is actually little data to support the perception that "bad hygiene" causes RTIs.)

## IEC (Information, Education and Communications)

IEC materials have to be produced with adequate pre-testing and evaluation. This is quite time-consuming but necessary. Unfortunately, donor agencies often fail to recognise the time that is needed here. Projects funded for a year are not going to be able to produce good materials.

IEC materials should include guidelines on usage, especially for those working in service delivery. Health professionals often lack training for health education and therefore need suggestions on how materials can be adapted to local conditions.

IEC activities need to explore "new" methods, which could include the "old" communications methods such as story-telling, puppetry and other community-based activities.

The message that came through clearly is that information alone is not enough. Moreover, there is a need to move away from fear tactics. IEC materials tend to tell people what to do but do not necessarily make them think. IEC activities need to emphasise positive messages, empowering people to act. This also means that IEC activities and materials will need to address issues such as gender inequality.

## Service Delivery

There was concern over quality of services being delivered. A particular concern would be ways to improve the safety of contraceptive services. The country reports during the consultation showed that intersectoral cooperation and partnerships are the keys toward effective service delivery. This means getting government organisations, non-government organisations, academicians and community-based groups to work together.

## Paradigm Shift

Over-all, the recommendations from the consultations revolve around a recognition of the need to shift paradigms, away from the narrow focus of fertility control or HIV/AIDS prevention toward comprehensive reproductive and sexual health. This means a shift as well from strategies, away from targets, quotas and prevalence rates toward partnerships, community mobilisation, and empowerment.

The paradigm shift will affect the way programmes are evaluated. Indicators will have to change, away from the numbers of condoms distributed or workshops conducted toward more qualitative assessments for example, how communities have responded.

## Announcements

### HIV/AIDS Enquiry Services for the Asia-Pacific

Health Action Information Network (HAIN) encourages readers of ***AIDS Action*** Asia-Pacific edition to write to HAIN for additional information through our HIV/AIDS Enquiry Services. We provide bibliographic information services through an annotated database and resource lists. Some requests are also referred to other organisations through the Regional Information Reference Group (RIRG).

*If you have a specific information request, please contact:*
**HIV/AIDS Enquiry Services**
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**How to Request for Information**

1) You may request for information through telephone, email, post or fax.
Personal visits to the Resource Center are also welcome.
2) Photocopies of articles are given free of charge for developing countries. Bulk requests will be referred to the author/publisher.
3) Requests for information which HAIN cannot respond to will be referred to other organisations.
4) Materials cited in ***AIDS Action*** should be requested directly from the publisher. Addresses are provided after each citation.

**Full proceedings for the RTI consultation featured in this AA issue can be obtained free of charge for people working with non-profit organizations in developing countries. If you want to obtain copies please write and explain how you will use the proceedings.**

## Resources

**Challenging the culture of silence: building alliances to end reproductive tract infections.** 1994. Antrobus P; Germain, A; Nowrojee, S - proceedings of a women's conference on the issue of RTIs among women in the Third World with focus on women rather than the disease. Document no. PIP 100707[1]

**Economic impact of reproductive tract infections and resources for their control.** 1992. Piot P; Rowley J. recommends strategies to better estimate the resources needed for RTI prevention and control. Document No: PIP 120066[1]

**Reproductive Tract Infections in Women in the Third World: National and International Policy Implications.** 1991- intends to encourage readers to break the "culture of silence" surrounding reproductive tract infections (RTIs) and to reduce the terrible burdens they impose on women and on health systems. Contains recommendations for action. *Copies may be requested from International Women;s Health Coalition, 24 East 21 St., New York, NY 10010 (212) 979-8500, USA.*

**Rural women and reproductive tract infections.** 1995. Bang, R & A.- summarises the experience of SEARCH, India, on the prevention of RTIs and STD management in rural areas. *AIDS Action Asia-Pacific ed., Jan-Mar (Issue 26): p11.*[2]

**Infection-free sex and reproduction.** 1997 - examines RTIs in both the developed and developing world: thier magnitude and dimensions, their determinant and consequences, the available means to prevent and treat them, and the strengths and limitations of possible intervention strategies. Unfortunately, the goal of infection-free reproductive health appears as far as it did 100 years ago and it concludes that a multifaceted public health approach is necessary to get closer to the goal of infection-free sex. *IN: Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions ed. by Tsui, AO; Wasserheit, JN; Haaga, JG. published by National Academy Press. pp.40-84.*[2]

**Understanding STDs and the public health approaches to their control: the appropriate role of family planning programs,** meeting proceedings held in Virginia, USA. *Write to Family Health International, PO Box 13950, Research Triangle Park North Carolina 27707, USA.*

**All About STDs,** *AIDS Action Asia-Pacific edition, Issue no. 26, Jan-Mar 1995.*[3]

[1] Free copies may be requested from Population Information Program, Center for Communication Program, Johns Hopkins School of Public Health, 111 Market Place, Suite 31-, Baltimore, Maryland 21202-4024, USA. Email: popline@hunix.hcf.jhu.edu

[2] Free Copies may be requested from HAIN, 9 Cabanatuan Rd., Philam Homes 1104, Quezon City, Philippines.




# AIDS action

*AIDS Action* is published quarterly in seven regional editions in English, French, Portuguese and Spanish. It has a worldwide circulation of 179,000.

The original edition of *AIDS Action* is produced and distributed by AHRTAG in London.

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**The Asia-Pacific edition of AIDS Action is supported by** The Ford Foundation, CAFOD, Christian Aid, ODA and JICA

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Registered charity (UK) no. 274260

**HAIN** (Health Action Information Network) is a Philippine NGO involved in research and information on health and development issues.
Registered with Securities and Exchange Commission 127593

ISSN 0117-908X

The international newsletter on HIV/AIDS prevention and care

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## Philippine Updates

July - September 1997

## Anti-HIV Drug Trials Stopped

Four out of five persons with HIV (PHIVs) have dropped out of the clinical trials for anti-HIV drugs being conducted by the Department of Health (DOH). The four patients, all of whom were female, had reported experiencing nausea, difficulty in breathing, and loose bowel movement as a reaction to "cocktail therapies" — a combination of three anti-HIV drugs. The fifth patient and the only male in the group involved in the drug trials, also experienced side effects but these could be tolerated.

The side effects experienced by the patients are common among those taking "cocktail therapies". While the efficacy of the drugs has been proven, questions have been raised regarding the safety of these drugs.

The five patients were taking the drugs Ritonavir, zidovudine and zalcitabine. Ritonavir is a protease inhibitor which prevents the spread on infection to healthy cells. Zidovudine and zalcitabine, both reverse transcriptase inhibitors, block the integration of HIV into host cells.

The drug trials started last July 16. Originally scheduled to start in April, the trials were put on hold when Health Secretary Carmencita N. Reodica asked the DOH Ethics Committee to give its approval, which the Committee granted in May.

Although the four female patients had backed out of the drug trials, the remaining male patient will continue with the drug therapies.

Sources: Philippine Daily Inquirer (PDI), July 23, 1997; Manila Times, July 23, 1997

## Phase-out of Commercial Blood Banks Extended

Republic Act 7719, known as the National Blood Service Act of 1994, mandates that commercial blood banks "shall be phased out over a period of two years after the effectivity of this Act, extendible to a maximum period of two years by the health secretary". The "grace period" allowed by the Act has already been extended, and will be extended again as the country faces a shortage of blood obtained from voluntary donors.

The deadline, which was originally set for August 1996, was first extended to December 1996. Yet another extension of the phase-out period was set for August 1997. The third extension will cover the period up to August 1998 — or four years after the Act was signed into law.

Dr. Eduardo Janairo, director of the Department of Health's (DOH) voluntary blood donation program, said that the phase-out period had been extended because "we're not yet ready to serve the (blood) needs of the nation". About 60 to 70 percent of the country's blood supply is provided by commercial blood banks.

Commercial blood banks had earlier questioned the capability of the government to provide an adequate blood supply obtained from voluntary donors. Operators of these blood banks had urged that instead of closing down the blood banks, these should instead be regulated by the DOH.

At the Second National Blood Donation Congress held in Subic last July 18, Janairo announced that commercial blood banks will be allowed to continue their operations even after August 1998 provided that they are accredited with the government.

Accreditation means that "they are ready to comply with the principle of the national voluntary blood donation program". The commercial blood banks will have to collect blood on a purely voluntary basis from a list of donors to be provided by the voluntary blood donation program of the DOH. The blood banks will be allowed to sell screened blood at a lower price which will be set by the government. The fee will cover expenses incurred by blood banks in the screening, testing, and storage of blood.

Sources: Manila Times, July 18 and 19, 1997; PDI, July 19, 1997

## 375,000 Filipino Women & Kids Are Into Prostitution

The United Nations Children's Fund (UNICEF) reported that there are 300,000 women and 75,000 children in the Philippines who are mired in prostitution. The survey was conducted by the Coalition Against Trafficking in Women-Asia Pacific.

Violence against women and children is the most pervasive violation of human rights in the world today. According to UNICEF, majority of the one million children prostitutes in the world are Asians. Most of them are victims of incest and child sexual abuse. Many of them are aged 15 to 20 who come from semi-rural and urban backgrounds.

In the Philippines, those who are driven into the sex trade are mostly street vendors or their children who are lured by leaders of sex rings. Many of these children are runaways from home or are pushed into prostitution by their own parents. In some instances, young girls are recruited from the provinces to serve as domestic helpers, only to find themselves trapped in white slavery.

In 1996, 492 out of 3,776 reported cases of child abuse involved pornography, prostitution, pedophilia and trafficking. The Department of Social Welfare and Development, through the Bantay Bata hotline, recorded 8,335 cases of child abuse from 1991 to 1996.

According to a report from the University of the Philippines-Center for Women Studies and UNICEF, 96 percent of victims of child abuse were young girls. Majority of them or 58 percent belong to the 11-17 age group. More than half the number of cases involved some form of sexual abuse, with incest accounting for more than 3 out of 10 cases. The perpetrators were mostly father (29 percent), uncle (16 percent), or stepfather (13 percent). Sexual abuse among children generally occurred in the home.

In a related story, the International Organization of Migration has reported that white slavery in Japanese cities is increasing. In a paper entitled "Trafficking in Women to Japan for Sexual Exploitation: A Survey of the Case of Filipino Women," it said that many Japanese men fear being infected with HIV. Because of this, the demand for younger sex workers has increased and that many Asian women, including Filipinos, are forced into white slavery.

Hiring of Filipino entertainers in Japan started since the 1970s. About 150,000 Filipino women are hired by Japanese companies annually. Most of them work as entertainers. The study said that only 11 percent of the women respondents confirmed that they are sex workers. But 80 percent said they were forced into prostitution.

Recruiters often lure women by offering cheaper and easier processing of travel papers, which are usually forged. Most of these women become easy prey to Japanese employers who blackmail and force them to work or face arrest.

Most women stay in windowless rooms with poor heaters, are not allowed to leave unescorted and have at least 75 percent of their income witheld by their employers.

Illegal migrants are also vulnerable to many forms of abuse. About 50 percent have suffered physical and psychological abuse. More than 30 percent work in night clubs run by the yakuza.

Many Filipinas returning from Japan had been dismissed from their jobs when they got pregnant and some had been suffering from sexually transmitted diseases such as HIV infection.

Sources: PDI, 26 July 1997; Today, 31 August 1997

Contribute to *AIDS Action Philippine Updates* and let readers know more about your work and learn from your experiences. Please contact us at:

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