2005 Philippine HIV and AIDS Country Profile

HIV and AIDS
COUNTRY PROFILE

PHILIPPINES 2005

PRODUCED BY
HEALTH ACTION INFORMATION NETWORK

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Health Action Information Network (HAIN)

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Preface

For years now, the Philippines has been able to describe its HIV and AIDS prevalence as "low and slow." And indeed it is—into the third decade of the HIV and AIDS pandemic, our prevalence rate in the adult population is still less than one percent. That is very low compared to many countries in the region (for example, Thailand, with a prevalence rate of 1.5 percent) and is certainly a long way off from the rates in some southern African countries, where one out of every three adults is infected.

But our low rates should not be a reason for complacency. The Philippine National AIDS Council (PNAC) now speaks of a "hidden and growing" HIV and AIDS epidemic in the Philippines, alarmed by the increasing number of HIV infection cases each month, as well as other danger signs such as a high prevalence of sexually transmitted infections (STIs), low condom use, a relatively young sexually active population, and prevalence of misconceptions on HIV and AIDS.

The reasons for the alarm go beyond HIV and AIDS as a disease. Even with the currently low prevalence rates of HIV and AIDS, the costs of caring for people with HIV and AIDS are already becoming a burden on the already over-stressed health care system. The lowest cost for antiretroviral drugs, used to slow down the course of HIV disease, is PhP 24,000 per patient per year—one which the Philippine government is not able to subsidize at this point.

There are other costs that come from this epidemic. For example, as more overseas workers are affected, there could be wide-reaching implications on the Philippine economy given that it is so dependent on the dollar remittances of these overseas workers.

More than a medical or public health issue, HIV is a development concern. Its future trajectory—whether kept low and slow or increasing rapidly—will have great impact on Philippine society. Conversely, the state of development in the Philippines affects the course of HIV and AIDS. For example, with a small budget available for health, HIV and AIDS information and education campaigns are neglected, which could put many Filipinos at risk. The present brain drain of health professionals, especially of doctors and nurses, has also affected the way we care for people with HIV and AIDS. Many hospitals are losing their older, more experienced health care providers, which means the training of younger ones are becoming substandard. HIV and AIDS care, already a field avoided by many health professionals because of stigma, suffers more than many other medical specializations.

This country profile—the third produced by Health Action Information Network (HAIN)—was commissioned by UNAIDS to help in providing information for the development of the 4th AIDS Medium Term Plan.

The country profile focuses on HIV and AIDS as development issues, with the first chapter devoted to many facts and figures taken from the national as well as global situation to help us understand where we are, and where we might be headed. Many of these statistics may not always seem directly related to HIV and AIDS but, when analyzed more deeply, can actually serve as indicators to help establish a prognosis on HIV and AIDS. The framework used here hews closely to that of the Millennium Development Goals (MDGs) adopted by the Philippines as part of its development program.

The second part of the report is also important—for the first time, we are featuring good practices related to HIV and AIDS. The good practices suggest replicable models for government, civil society and the private sector that we might want to emulate to keep the prevalence of HIV and AIDS low and slow.

The final chapter looks at what we know and what we have done for the Philippines in relation to the UNGASS (UN General Assembly Special Sessions) Declaration of Commitment on HIV/

AIDS, which was signed in June 2001 as a global battle plan against HIV and AIDS. We also had the "Three Ones" action framework first proposed in 2004 by UNAIDS to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management. Lastly, we pose new questions that need to be answered if we hope to keep HIV and AIDS prevalence low and slow.

HIV and AIDS Timeline

1984	First HIV infection reported in the Philippines
1988	Establishment of the National AIDS/STD Prevention and Control Program (NASPCP) and AIDS Registry
1988-1990	USAID supports projects for the strengthening of laboratories and communications programs.
1988-1993	First AIDS Medium Term Plan (AMTP) is developed and implemented as guide in forming national strategies and interventions needed given the prevailing HIV and AIDS situation
1992	Establishment of the Philippine National AIDS Council (PNAC), a multi-sectoral advisory committee responsible for HIV and AIDS policies, by virtue of Executive Order 39
1993-1999	Second AMTP is developed and implemented
1993-2003	USAID pilots AIDS Surveillance and Education Project (ASEP) in 10 Philippine sites
1994	Establishment of Pinoy Plus Association, the first organization of people living with HIV and AIDS (PLWHAs) in the Philippines
1995	Japan International Cooperation Agency (JICA) supports STI/AIDS Central Reference Laboratory
1995	First Filipino movie with HIV theme: *The Dolzura Cortez Story*
1995	Bahay Lingap (Halfway Home of Asymptomatic Filipino PLWHAs) is inaugurated
1996	Creation of HIV/AIDS Core Teams (HACT)
1997	Philippines hosts the 4th International Congress on AIDS in Asia and the Pacific
1997	Another Filipino movie with HIV theme, *The Sara Jane Salazar Story*, was shown in theatres
1997	Establishment of STI/AIDS Cooperative Central Laboratory (SACCL)
1998	Enactment of Republic Act 8504, or The Philippines AIDS Prevention and Control Act of 1998
2000-2004	Third AMTP is developed and implemented Local AIDS Councils are created in some cities, institutionalizing LGU and NGO partnerships at the city level. Local AIDS ordinances including provisions for budgetary allocations for HIV and AIDS activities are also enacted.
2001	UNGASS Declaration of Commitment on HIV/AIDS. The Declaration details various strategies to address 11 broad areas in the battle against HIV and AIDS with clear targets and timelines.
2004	UNAIDS adopts the "Three Ones", calling on countries to each adopt a common action framework, a national AIDS coordinating authority, and a country monitoring and evaluation plan.
2005	Development of the Medium Term Philippine Development Plan (MTPDP) Development of the fourth AMTP

Chapter

I

HIV and AIDS in the Philippines: **The Development Context**

Introduction

HIV and AIDS prevalence in the Philippines has been described as "low and slow" with a prevalence rate of less than one percent in the country's general population. However, experts now talk about the country's HIV and AIDS situation as possibly being "hidden and growing." The Philippine National AIDS Council (PNAC) reports that HIV infection in the country has been significantly picking up pace since 2000. With an average of 20 people being infected with HIV every month, the current rate of new case reports is at least twice that observed in the 1990s. The second trimester of 2005 saw 2,354 documented HIV infections, 30 percent of which are AIDS cases.

The recent evidence portrays a new picture of HIV and AIDS in the Philippines and comes as a timely challenge to our current understanding its extent in the country. It is a good opportunity to step up vigilance and awareness of the epidemic, expand local responses, and analyze its implications to development. Still, the fact remains that the country was able to sustain a fairly low level of the epidemic for a significant number of years. This is attributed to early recognition of the epidemic, exemplified by multi-sectoral responses by government agencies and non-government organizations to increase public awareness and fight discrimination.

This Country Profile on the HIV and AIDS situation in the Philippines documents significant responses to the HIV and AIDS epidemic. This report presents and reviews key development indicators affecting the response to HIV and AIDS, and includes vital statistics on the socio-economic situation and the health care system. It then outlines good practices of organizations in the areas of advocacy, prevention, and care and support.

A. HIV, AIDS and Development

A 2000 study conducted by the Health Action Information Network (HAIN) reveals that HIV and AIDS have significant implications on development in the Philippines. It reports that the interaction between HIV and AIDS, and development is a two-way process: lack of development increases susceptibility and vulnerability to HIV and AIDS; conversely, an unmonitored spread of HIV and AIDS can put significant stress on the country's meager resources and cripple its poverty reduction strategies.

The Millennium Development Goals (MDGs) was first developed by the United Nations and has since been adopted by governments throughout the world as a guide for development planning, as well as to monitor and evaluate a country's progress. The Philippine government recognizes the importance of HIV and AIDS prevention and care as a development issue, with HIV and AIDS prevalence as one of the key indicators for measuring progress in attaining the MDGs as reflected in its Medium Term Philippine Development Plan (MTPDP) for 2005-2010.

Table 1: Millenium Development Goals: Rate of Progress

Millenium Development Goals	Baseline (1990 or year closest to 1990)	Current Level (2002/ 2003)	Target by 2015 1/	Average Rate of Progress (1990-2002/	Required Rate of Progress (2002/ 2003-2015)	Ratio of required Rate to Average Rate (1=b/a)	Probability of Attaining the Targets 5/
Eradicate Extreme poverty and hunger							
Proportion of Population below :							
subsistence (food) threshold	24.3a/	13.8 f/	12.15	-0.88	-0.14	0.16	High
poverty threshold	45.3a/	30.4 f/	22.65	-1.24	-0.65	0.52	High
Proportion of families below :							
subsistence (food) threshold	20.4a/	10.4 f/	10.2	-0.83	-0.02	0.02	High
poverty threshold	39.9a/	24.7 f/	19.95	-1.27	-0.40	0.31	High
Prevalence of Malnutrition among 0-5 year old children (% underweight)- Based on international reference standards	34.5	27.6	17.25	-0.53	-0.86	1.63	Medium
Proportion of households with per capita Intake below 100% dietary Energy requirement	69.4b/	56.9	34.7	-1.25	-1.85	1.48	High
Achieve Universal Primary Education							
Elementary Participation rate 4/	85.1a/	90.05	100	0.45	0.77	1.70	Medium
Elementary cohort survival rate	68.4a/	69.8	83.3/	0.13	1.04	8.16	Low
Promote gender equality and empower women							
Number of girls per 100 boys:							
Elementary education	95.8c/	101.8e/	100	1.00	-0.14	-0.14	High
Secondary education	104.5c/	115.9e/	100	1.90	-1.22	-0.64	High
Reduce child mortality							
Under-5 mortality rate(per 1,000 children)	80	40	26.7	-3.08	-1.11	0.36	High
Infant mortality rate (per 1,000 live births)	57	29	19	-2.15	-0.83	0.39	High
Improve maternal health							
Maternal mortality rate	209	172 d/	52.2	-4.63	-7.05	1.52	Medium
Increase access to reproductive health services							
Prevalence of men and women/couples practicing responsible parenthood	40 b/	48.9	70	0.89	1.76	1.98	Medium
HIV prevalence	< 1%	<%	< 1%	0.00	0.00	0.00	High
Halt and begin to reverse the incidence of malaria and other diseases							
Malaria morbidity rate (per 100,000 population)	123	48	242	-5.77	-1.83	0.32	High
Provide basic amenities							
Proportion of families with access to safe Drinking water (percentage)	73.7 a/	80	86.8	0.57	0.52	0.91	High

Notes:
a/ 1991: Uses the old methodology considering special rice in the menu and using regional prices; family size is six
b/ 1993
c/ 1996
d/ 1998
e/ Based on preliminary estimates of DepEd
f/ 2003: Uses ordinary rice; and uses provincial prices; family size is five
1/ 2015 target is based on 1990 estimate or the closest year where data is available
2/ Target by 2010 based on MTPDP 2004-2020
3/ Based on DepEd – Education for All (EFA) target
4/ Beginning SY 2002-2003, participation rate was derived based on the age group consisting of 6-11 years old for elementary and 12-15 secondary whereas the previous system used 7-12 and 13-16 years old for elementary and secondary, respectively. Hence, SY 2002-2003 data cannot be compared with that of the previous years.
5/ The criterion used in determining whether the target and the current annual rate of progress, the rating correspond to ranges if rate given below:

Rate needed to reach target/Current rate of progress

<1.5	High
1.5 to 2.0	Medium
>2.0	Low

Sources: Medium-Term Philippine Development Plan 2004-2010; 2004 UNDP Human Development Report; Family Income and Expenditures Survey 2003 as cited in Second Philippines Progress Report on the Millenium Development Goals 2005

The socio-economic impact of HIV and AIDS may seem minimal because of the low prevalence rate of HIV in the country. However, because of our large population, even at a low prevalence the management and treatment of HIV and AIDS may pose serious impediments to poverty reduction and economic development. As it is, even without the heavy burden of HIV, government funds for social services and health care are already very limited.

The impact of HIV and AIDS in the Philippines is more pressing at the micro-level than at the national level. Poor households are affected most due to inadequate access to basic social services, medical care and expensive HIV and AIDS medication. Results from the 2003 National Demographic and Health Survey (NDHS) suggest that poorer and less educated people are at a greater risk for reproductive health problems. They have less access to health care and reproductive services, have less knowledge on HIV and AIDS prevention methods, and are more likely to engage in unprotected sexual activity at an early age.

Moreover, HIV's impact on households, families and communities is significant enough to threaten social cohesion and solidarity. Studies have shown that there is still much stigmatization and discrimination associated with HIV and AIDS even among family members. Results from the NDHS 2003 reveal that only 31.5 percent of its respondents are willing to provide home care for a relative with AIDS.

Table 2: Key Development Indicators

Indicator	Values	Year
Estimated Population Size	85.5 million	2005
Population Size	76,498,735	2000
Population Growth Rate	2.11%	2000-2005
Human Development Index (HDI), HDI Rank	0.753	2002
Gender Development Index (GDI), GDI Rank	0.751, 66th	2002
GDP per Capita (US$)	1,025.98	2004
NG Tax Revenue/ GDP	12.34%	2004
Investment /GNP	15.89%	2004
Total Outstanding NG Debt/ GDP	76.99%	2004
Public Debt (% of GDP)	101%	2003
External Debt (% of GNP)	61.9%	2004
Social Sector Expenditures (as % of total Expenditure)	42.81	2003
Share of poorest quintile in income or consumption	4.7%	2003
Share of richest quintile in income or consumption	53.3	2003
Life Expectancy at Birth (in Years)		
Male	67.2	2003
Female	72.5	2003
Unemployment rate	10.9%	2004
Underemployment rate	16.9%	2004
Poverty headcounts ratio (% of families below national poverty line; preliminary)	24.7%	2003
Percent of population with access to safe water supply	80%	2002
Proportion of underweight children (0-5 years old)	32%	2003
Simple Literacy Rate	93.9%	2003
Elementary Participation rate	90.05%	2002
Under 5- mortality rate (per 1,000 children)	40	2003
Maternal mortality rate (per 100,000 live births)	172	1998

Sources: Medium-Term Philippine Development Plan 2004-2010; 2004 UNDP Human Development report; Family Income and Expenditure Survey 2003 as cited in Second Philippines Progress Report on the Millenium Development Goals 2005

Population

The Philippines has an estimated population of 85.5 million. Growing annually at 2.11 percent, the population is projected to reach 102.8 million by 2015. As of the 2000 census, the country had a population density of 255 persons per square kilometer.

Sixty percent of the population lives in urban areas (UNFPA, 2001), with a third of the total population living in the National Capital Region (NCR) and the adjacent Southern Tagalog Region. The NCR is the country's most densely populated region, with an average density of 16,091 persons per square kilometer.

Rapid population growth puts stress on the country's economic resources, slowing down economic growth and development. This negatively affects the delivery of social and health services, including those that directly affect HIV and AIDS prevention and care. Moreover, people often fail to see that rapid population growth has contributed to widespread unemployment in the Philippines, forcing many Filipinos to work overseas, where they often face risks for HIV.

Income, Poverty and Employment

On average, Filipino households have an annual income of PhP 148,616, or less than US$ 3,000. According to the 2003 Family Income and Expenditure Survey (FIES), 24.7 percent of Filipino families are poor. Using the World Bank international poverty line of US$1 per day, there is a slight decrease in the proportion of the population living below the poverty line (11.1 percent in 2003 compared with 13.5 percent in 2000; MDG).

Table 3: Average Annual Family Income 2003

		Income in Pesos
Philippines		148, 616
NCR	National Capital Region	274,529
CAR	Cordillera Autonomous Region	157,045
Region 1	Ilocos Region	102,596
Region 2	Cagayan Valley	97,945
Region 3	Central Luzon	136,548
Region 4	Southern Luzon	159,267
Region 5	Bicol Region	80,732
Region 6	Western Visayas	93,666
Region 7	Central Visayas	100,168
Region 8	Eastern Visayas	83,459
Region 9	Western Mindanao	76,805
Region 10	Northern Mindanao	89,592
Region 11	Southern Mindanao	97,505
Region 12	Soccsksargen	86,376
Region 13	Caraga	75,899
ARMM	Autonomous Region of Muslim Mindanao	68,212

Source: FIES 2003, http://www.nscb.gov.ph/secstat/d_income.asp

Table 4: Regional Poverty Incidence, by Family (in percent) 2003

		Poverty incidence (in percent)
Philippines		24.7
NCR	National Capital Region	5.0
CAR	Cordillera Administrative Region	24.8
Region 1	Ilocos	24.4
Region 2	Cagayan Valley	19.3
Region 3	Central Luzon	13.7
Region 4-A	Southern Tagalog-A	14.9
Region 4-B	Southern Tagalog-B	39.7
Region 5	Bicol	40.5
Region 6	Western Visayas	31.3
Region 7	Central Visayas	23.7
Region 8	Eastern Visayas	35.5
Region 9	Zamboanga Peninsula	44.1
Region 10	Northern Mindanao	37.9
Region 11	Southern Mindanao	28.1
Region 12	Soccsksargen	32.0
Region 13	Caraga	47.3
ARMM	Autonomous Region of Muslim Mindanao	45.7

Source: National Statistical Coordination Board (preliminary results)

In 2003, the poverty level in rural areas was higher at 36.3 percent compared with 12.7 percent in urban areas. Table 4 reveals a wide disparity of poverty incidence across the country. In Metro Manila, five percent of households live below the poverty line while Caraga has 47.3 percent of its households as poor.

In 2005, minimum wages were raised so the range now is from PhP170 to PhP300 a day depending on the region.

Table 5: Minimum Wage Rates (as of June 2005)

	Nominal Wage* (for non-agricultural workers)
NCR	300.00
CAR	205.00
Region I	200.00
Region II	193.00
Region III	243.50
Region IV-A	255.00
Region IV-B	196.00
Region V	194.00
Region VI	190.00
Region VII	208.00
Region VIII	195.00
Region IX	180.00
Region X	202.00
Region XI	209.00
Region XII	200.00
Region XIII	189.00
ARMM	170.00
* Highest Nominal Wage January-June 2005	

Source: National Wages and Productivity Commission, DOLE

As of 2004, unemployment remained high at 11 percent despite the 3.2 million jobs generated from 2001 to 2004. This indicates that the number of jobs generated had not been adequate to accommodate the influx of labor entrants. Moreover, underemployment seems to present a more serious problem at 17 percent in 2004.

Overseas employment has become the only option for many Filipinos seeking a decent life. A shortage of available jobs in the country has pushed an estimated seven million Filipinos to work overseas. Not only poor people are pushed into migration but also professionals seeking better opportunities. Since 2000, there has been a steady increase in the number of health professionals deciding to work abroad. The escalating migration of health professionals has serious implications to the country's health care system.

The increasing number of returning overseas Filipino workers (OFWs) who are HIV positive reveal that migrant workers are at great risk for HIV infection at various stages of the migration cycle. Studies have shown that low condom use, lack of access to information and health care services, inability to adapt to new environment, and difficult working conditions contribute to migrant workers' vulnerability to HIV and AIDS. The DOH reports that 33 percent of Filipinos infected with HIV are OFWs.

Literacy and Education

The Philippines continues to have a high simple literacy rate of 93.9 percent as of 2003, with only a slight difference between males and females; however, the functional literacy rate is only 85.1 percent. Literacy rates are higher in the urban areas, as people have more access to education compared with people in the rural areas. Metro Manila posts the highest literacy rate at 99.1 percent, while Autonomous Region of Muslim Mindanao (ARMM) has the lowest with only 70.7 percent.

Although literacy rates are high, completion rates in schools across the country are still low. The Department of Education reports that only 66.85 percent of those who begin elementary education actually get to finish it (elementary education in the Philippines has six grades). The situation is worse in ARMM where only 42.91 percent of those who begin Grade One actually get to finish Grade Six.

Survey results from the 2003 NDHS reveal that education is a notable variable in acquiring accurate knowledge about HIV transmission and prevention. Those who are better educated are more likely to have correct knowledge than those who are less educated. To illustrate, 44.3 percent of those who correctly rejected two most common misconceptions on HIV and AIDS have reached college while only 24.4 percent of those who reached elementary got the answers right. The number of years one stays in school is crucial in instilling HIV and AIDS prevention and education.

B. THE PHILIPPINE HEALTH SITUATION

Tables 6 and 7 give important health status indicators in the Philippines and the leading causes of morbidity and mortality in the country.

Table 6: Ten leading causes of morbidity 2003 (Rate per 100,000)

Causes	Number	Rate
1. Acute Lower Respiratory Tract Infection and Pneumonia	674,386	861.2
2. Diarrhea	615,692	786.2
3. Bronchitis/Bronchiolitis	604,107	771.4
4. Influenza	431,216	550.6
5. Hypertension	325,390	415.5
6. TB Respiratory	92,079	117.6
7. Diseases of the Heart	30,398	38.8
8. Malaria	28,549	36.5
9. Chickenpox	26,137	33.4
10. Measles	25,535	32.6

Source: FHSIS 2003

Table 7: Ten leading causes of mortality 2000 (Rate per 100,000)

Causes	Number	Rate
1. Heart Disease	60,417	79.1
2. Disease of the vascular system	48,271	63.2
3. Malignant neoplasm	36,414	47.7
4. Pneumonia	32,637	42.7
5. Accidents	32,355	42.4
6. Tuberculosis (all forms)	27,557	36.1
7. Chronic obstructive pulmonary diseases and allied conditions	15,904	20.8
8. Certain conditions originating in the perinatal region	15,098	19.8
9. Diabetes mellitus	10,747	14.1
10. Nephritis, nephritis syndrome and nephrosis	7,963	10.4

Source: Philippine Health Statistics, DOH (2000)

While many of the indicators show steady improvements over the years, progress has generally been slow. To illustrate, even though the infant mortality rate (per 1,000 livebirths) declined from 34 in 1993 to 26 in 2003, our current rate is still high compared to many of our neighbors.

Table 8: Infant and maternal mortlaity rates in Southeast Asia and China

	Infant Mortality Rate (per 1000 live births)	Maternal Mortality Rate (per 100,000 live births)
China	33	56
Cambodia	91	450
Indonesia	38	230
Lao PDR	84	650
Malaysia	10	41
Myanmar	71	360
Philippines	**26**	**200**
Singapore	3	30
Thailand	18	44
Viet Nam	28	130

Source: UNFPA, The State of World Population 2004

The poor performance of the Philippine health sector is partly due to our limited resources. The national government, saddled with chronic deficits, has not been able to allocate enough funds for social services, including health.

Table 9: National Health Expenditure on Health: The Philippines (Pesos)

Selected Indicators Health Expenditures	1998	1999	2000	2001	2002
Total expenditure on health as % of Gross Domestic Product	3.5	3.5	3.4	3.2	2.9
Government expenditure on health as % of Total expenditure on health	42.5	43.7	47.1	43.6	39.1
Private sector expenditure on health as % of Total expenditure on health	57.5	56.3	52.9	56.4	60.9
Government expenditure on health as % of Total government expenditure	6.5	6.5	7.0	5.8	4.7
Social Security funds as % of Government expenditure on health	8.9	11.5	14.9	18.2	23.4
Prepaid and risk-pooling plans as % of Private sector expenditure on health	15.5	18.0	18.0	17.0	17.9
Private households' out-of-pocket payment as % of Private sector expenditure on health	80.6	77.0	76.6	77.8	77.9
External resources on health as % of Total expenditure on health	2.8	3.7	3.5	3.7	2.8
Total expenditure on health per capita at exchange rate	32	36	34	30	28
Total expenditure on health per capita at dollar	163	164	169	163	153
General government expenditure on health per capita at exchange rate	13	16	16	13	11
General government expenditure on health per capita at international dollar rate	69	72	80	71	60

Source: World Health Organization

A significant proportion of health expenditures in the country comes out of family savings (out-of-pocket expenses), as shown in Table 9. In times of emergencies and catastrophic illnesses (including HIV and AIDS), not only are household savings wiped out, families also often go into debt.

Many problems on economic and political equity are reflected in the health care system; for example, there are more private hospitals than public hospitals in the Philippines. Of the 1,738 hospitals in the country, 1,077 are privately owned and only 661 are public hospitals. Moreover, hospitals are also unevenly distributed across the regions. While there are 178 hospitals in Metro Manila, the ARMM has only 14 hospitals.

In addition to hospitals, there are around 1,879 rural health units (RHUs) and 15,343 barangay health stations (BHS) in the country as of 2002. RHUs are usually staffed by a doctor, a nurse and a few midwifes. On the other hand, BHSs should have at least one midwife.

The country has seen a decline in the number of health personnel as many of them choose to work overseas where demand and pay is high. Those who remain, on the other hand, often choose to stay in the cities. Health professionals are unevenly distributed in the country, with a majority of government doctors and nurses practicing in urban areas, particularly in Metro Manila. Of the 3,021 government doctors, 658 work in NCR; in contrast, ARMM and CARAGA have to make do with only 69 and 79 doctors, respectively.

Table 10: Health Status Indicators

Indicators		Year
Life expectancy at birth (years) Female Male	 72.5 62.7	 2003
Crude death rate (per 100,000 population)	4.8	2000
Infant mortality rate (per 100,000 population)	29	2003
Under-five mortality rate (per 1,000 livebirths)	40	2003
Maternal mortality rate (per 100,000 livebirths)	172	1997
Births attended by health professional (%)	60	2003
Births delivered in health facility (%)	38	2003
Pre-natal care coverage (%)	94.1	2003
Malnutrition rate (% children under 5)	27.6	2003

Source: National Demographic and Health Survey 2003

Table 11: Health Care Indicators

Indicators		Year
Number of hospitals Private Public	1,738 1,077 661	2002
Number of barangay health stations	15,343	2002
Number or rural health units	1,879	2001
Hospital beds (per 1,000 people)	1.1	2002
Doctors (per 100,000 population)	11.5	2002
Nurses (per 100,000 population)	43.69	2002
Hospitals (per 100,000 population)	2.24	2000

Source: Philippine Statistical Yearbook 2004

Reproductive Health

The Philippine MDGs include a target that reads: "Increase access to reproductive health (RH) services to 60 percent by 2005, 80 percent by 2010 and 100 percent by 2015". The target associates reproductive health services mainly with antenatal check-ups, attendance by health professionals at delivery, and family planning.

Table 12: Reproductive Health Indicators 2003

Indicators	
Percentage of deliveries attended by health professionals	88
Percentage of pregnant women receiving post-partum check-ups (PPC)	72
Total fertility rate (wanted)	2.5
Total fertility rate (actual)	3.5
Contraceptive prevalence rate	49
Unmet need for FP of currently married women	17

Source: NDHS 2003

The Department of Health recommends that all pregnant women should have at least four antenatal check-ups (ANCs); however, the 2003 NDHS found that only 70 percent of women had four ANCs. To put it another way, around 30 percent of pregnant women have less than four ANCs, with some having none at all.

Family planning is a complex problem in the Philippines as some groups and sectors are aggressive in opposing family planning services. The 2003 NDHS found that the total fertility rate (TFR)—the average number of children a woman has in her lifetime—minutely decreased from 3.7 in 1996-1998 to 3.5 in 2001-2003.

Access to reproductive health services should not be limited to family planning; in particular, young people also need access to sex education, family planning and other reproductive health services. In discussions regarding young people, too much emphasis has been given to premarital sex (PMS) as a risk factor, often citing figures from the 3rd Young Adult Fertility and Sexuality Study (YAFS-3) showing that about 23 percent of unmarried young adults (aged 15 to 24) have had sex. Actually, the health risk is not so much of "PMS" per se than of unprotected sexual activity that could lead to early pregnancies and marriages, or sexually transmitted infections including HIV.

The 2003 NDHS reports that by the age of 19, 23.5 percent of Filipino women have already borne a child. This figure is rarely used as an indicator of the risks faced by young Filipinos. In fact, the number of young people having sex is actually quite low compared to many other countries; yet, many of the young women seem to get pregnant, indicating a lack of protection during sex. If HIV prevalence rates were higher in the country, young girls could also be expected to come down with the disease.

The focus on "PMS" as a risk factor also tends to suggest that sex within marriage is safe—an assumption far from reality. There is increasing concern that when HIV becomes more prevalent, many of those infected will be monogamous wives; that is, women who are sexually faithful to their husbands, but whose husbands have unprotected sex with multiple partners. The figures from YAFS are very clear in showing how males engage in far more risky sexual behavior than females.

Table 13: Commercial and extramarital sex behavior among sexually active youth

	Male (in percent)	Female (in percent)	Both (in percent)
Ever paid for sex	19.1	(.05)	10.4
Ever been paid for sex	11.3	(0.7)	6.4
Used condom when receiving payment for sex	53.3	(88.9)	53.8
Used condom when paying for sex	56.1	(84.6)	56.9
Used condom with extramarital sex	8.0	3.2	4.4
** figures in parenthesis less than 30 cases*			

Source: YAFS 2002

C. HIV and AIDS IN THE PHILIPPINES

With an overview of Philippine social and economic indicators, as well as the health care system, we can now look at the HIV and AIDS situation in the Philippines.

By end of 2004, UNAIDS estimated that 38 million adults and children worldwide are living with HIV. In 2003, 4.8 million new infections were recorded and an estimated 2.9 million adults and children died. Over 20 million people have died of AIDS since 1981.

The Philippines has a relatively low prevalence rate, with less than one percent of the adult population infected. This is low compared with other countries.

Table 14: Estimated HIV infection in selected countries

	Estimated number of infected Adults and Children	Adult infection rate (%)
Botswana	350,000	37.3
Zimbabwe	1,800.000	24.6
Cambodia	170,000	2.6
Myanmar	330,000	1.2
Thailand	570,000	1.5
United States	950,000	0.6
Malaysia	52,000	0.4
Vietnam	220,000	0.4
Singapore	4,100	0.2
Australia	14,000	0.1
Indonesia	110,000	0.1
China	840,000	0.1
Philippines	**9,000**	**<0.1**

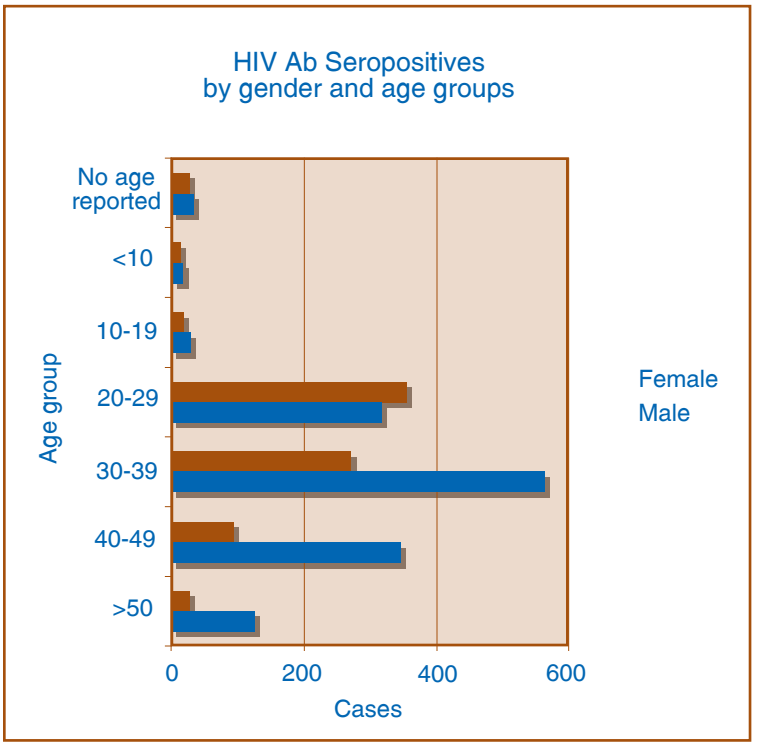
Source: UNAIDS 2003

Table 15: Reported number of people with HIV/AIDS in the Philippines, 1984 to September 2005

Cumulative Number of HIV/AIDS cases	Total	2,354
	Male	1,457
	Female	823
	<19 years	77
Cumulative Number of AIDS cases	Total	702
Number of AIDS Deaths	Total	273

Source: NEC HIV/AIDS Registry

Fig 1. HIV Ab Seropositives by gender and age group



Source: NEC HIV/AIDS Registry

The Department of Health is concerned that rates might be picking up, and that we may have a hidden and growing epidemic. Until recently, an average of 10 new cases were being reported each month. In 2004 and 2005, however, the average number of reported cases has gone up to about 20 each month. As of September 2005, the cumulative number of reported HIV cases was 2,354. Some important patterns in the reported cases are:

- Most of the reported infections (86%) are from sexual intercourse. Injecting drug use, which has been a major factor in accelerating the spread of HIV and AIDS in other Asian countries, does not seem to be a major cause of infection yet in the Philippines.

- Categorizing by sex, the proportions of reported infections is 64 percent male and 36 percent female. Significantly, the highest proportion of females infected fall within the 20-29 age group, while for males it is in the 30-39 age group. This pattern might be due to the way tests are conducted in the Philippines—Social Hygiene Centers routinely test female sex workers, who tend to be in their late teens or early 20's.

- Overseas workers account for about a third of total reported HIV cases considering that most of the OFWs are required to take an HIV antibody test by their recruitment agencies. Of the 797 reported infections among OFWs, 282 (35%) were seafarers, 132 (16%) were domestic helpers, 69 (9%) were employees, 62 (8%) were entertainers and 56 (7%) were health workers (nurses, caregivers, health educator, medical technologist, pharmacists, physical therapist, dentist and physician). Seventy-five percent of OFWs who tested positive were males, and the leading mode of transmission among OFWs is sexual intercourse.

- Access to treatment among HIV positive Filipinos remains low. The problems of access to treatment are related to the high costs of medicines, particularly antiretroviral drugs. The costs for HIV treatment are not, however, limited to antiretroviral drugs. There are many other medicines needed for all kinds of opportunistic infections to which PLWAHs are vulnerable. For instance, Azithromycin, an antibiotic used for some of the opportunistic infections, costs PhP 225.00 a tablet.

HIV Serologic Surveillance (HSS)

The DOH monitors HIV and AIDS infection in the country through the National Epidemiology Center (NEC) that currently employs two types of surveillance systems. NEC's HIV and AIDS Registry is a surveillance system that logs Western Blot-confirmed cases reported by hospitals, laboratories, blood banks and clinics. To augment the limitations inherent in a passive surveillance, the DOH established the HIV Serologic Surveillance (HSS) to monitor HIV prevalence among identified risk groups across 10 cities in the country. Particular populations groups are monitored and regularly tested for HIV and other sexually transmitted infections (e.g., registered and freelance female sex workers, men having sex with men, and injecting drug users).

In 2003, the HSS reported that, at the national aggregate, HIV seroprevalence among the risk groups is 0.03 percent. Syphilis rates, however, were consistently high among the risk groups ranging from one to four percent.

The figures may still be low but results from behavioral surveillance surveys indicate that the risks of infection among the said groups are high. For instance, in 2003, regular condom use among these groups was low with less than 30 percent consistently using condoms. Moreover, condom use has been generally declining from 2000 to 2003, except for MSMs.

Table 16: Proportion of risk groups consistently using condoms (in percent)

	2000	2001	2002	2003
Registered female sex workers	37	34	30	28
Freelance female sex workers	32	30	30	26
Men who have sex with men	12	16	12	19
Injecting drug users	3	2	3	2

Source: 2003 HIV/AIDS Technical Report

Other Sexually Transmitted Infections

Sexually transmitted infections (STIs) are co-factors for HIV transmission since the risk for HIV infection increases among individuals with STI. Thus, STI prevalence rates are used as primary indicators of sexual behavior that makes one vulnerable to HIV.

The DOH monitors STI prevalence through the Sentinel STI Etiologic Surveillance System (SSESS), which is composed of combined data from social hygiene clinics and private clinics caring for STI patients. The SSESS reports a high incidence of STI among sex workers with prevalence rates of selected infections reaching more than 40 percent. Moreover, gonococcal resistance to penicillin, tetracycline and ciprofloxacin is also high.

Table 17: Reported STI cases among male and female consultations SSESS 2003

	Number of consultations	STI cases (number)	STI cases (in percent)
Female	213,864	19,829	9
Male	15,284	1,154	8

Source: 2003 HIV/AIDS Technical Report

Among monitored STIs, gonorrhea has the highest incidence for males with 23 percent, while non-gonococcal infection is highest for females with seven percent. On the other hand, national aggregate results show that the prevalence of syphilis, genital warts and herpes are still below one percent.

Table 18: Positivity rate of STIs

	Gonorrhea	Non-gonococcal infection	Trichomoniasis	Bacterial Vaginosis
Female	1%	7%	1%	2%
Male	23%	17%		

Source: 2003 HIV/AIDS Technical Report

While most STI monitoring and surveillance strategies are carried out among identified high-risk groups, a few other surveys have been conducted to give a more complete picture of STI cases in the general population. Survey results show that a significant proportion of STIs occur in the general population, proving that no one is immune from STIs and HIV. STIs do not only occur among people involved in sex work and can infect anyone who engages in unprotected sex. In 2002, Family Health International (FHI) reported a 5.6 percent prevalence rate for Chlamydia Trachomatis among women (Table 19); a higher proportion is reported among young females and males (7.7% and 9%, respectively).

Table 19: Prevalence of STIs in General Population, in selected sites in the Philippines

	Chlamydia Trachomatis	Neisseria Gonorrhea	Syphillis	Hepa B	Trichomonas Vaginitis	Candida Albicansi	Bacterial Vaginosis
Women	5.6	0.8	0.2	3.2	3.2	17.2	28.6
Men	4.4	1.1	0.2	9.6	-	-	-
Female youth	7.7	.7	-	-	-	-	-
Male youth	9.0	1.7	-	-	-	-	-

Source: Family Health International / Department of Health, 2002

Knowledge and Awareness on HIV and AIDS

Despite the low prevalence and slow rate of increase in the number of AIDS cases reported in the past, the preconditions for a full-blown epidemic are already present in the country. These preconditions include the high prevalence of STIs, low condom use, a relatively young sexually active population, and prevalence of misconceptions on HIV and AIDS.

Knowledge gaps and misconceptions on HIV and AIDS continue to persist despite years of information, education and communication campaigns. A large number of Filipinos still have inaccurate knowledge on effective prevention, transmission and treatment of HIV and AIDS. Moreover, the general attitude of HIV invisibility has greatly impeded the effective dissemination of reliable information on HIV and AIDS. Most Filipinos continue to believe that they are immune from the infection; thus, failing to recognize the relevance of any AIDS prevention program. Consistent condom use has yet to be done by many Filipinos, believing that condoms should only be used in the context of commercial sex.

Results from the 2003 NDHS and the 2002 YAFS-3 reveal that although there is almost universal awareness on AIDS, a sizeable proportion of Filipinos still have misconceptions. For instance, while 96 percent of men and 95 percent of women have heard of AIDS, only a third of them correctly rejected two of the most common misconceptions about HIV and AIDS (NDHS 2003). Respondents also scored low awareness ratings on other indicators such as mother-to-child transmission (MTCT), with only 64.5 percent of women knowing that HIV can be transmitted by breastfeeding.

In addition, the level of awareness varies across the country's regions, with men and women in some regions being less likely to have heard of HIV and AIDS. In ARMM, only 75 percent of women and 51.4 percent of men have heard of AIDS. An even lower percentage are aware of prevention methods, with only 67.3 percent of women and 46.7 percent of men believing that there is a way to avoid AIDS.

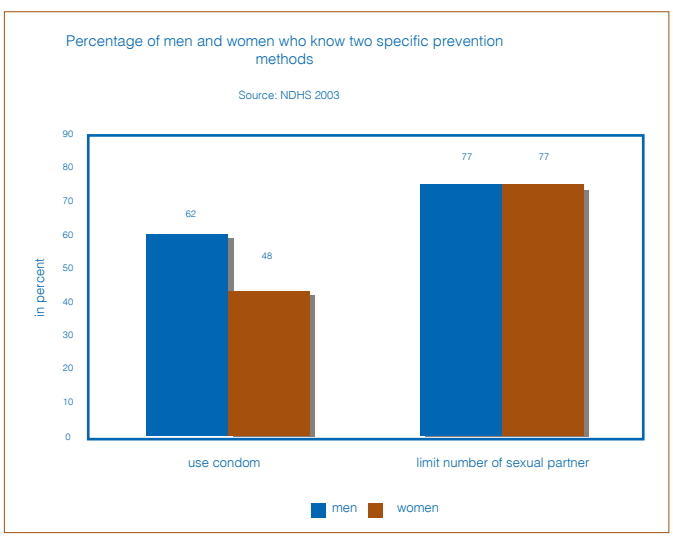
Table 20: HIV/AIDS Knowledge and Awareness (in percentage), NDHS 2003

Indicators	Men	Women
Have heard of AIDS	96	95
Believe there is a way to avoid HIV/AIDS	89	88
Know two specific ways to avoid HIV/AIDS	44.7	56.2
Condom use	62	48
Limiting sex to one partner	77	77
Correctly rejected two most common misconceptions about HIV/AIDS	29.6	36
Know that HIV can be transmitted during pregnancy	68.1	72.6
Know that HIV can be transmitted during delivery	60.5	62.9
Know that HIV can be transmitted by breastfeeding	60.3	64.5
Mother-to-child transmission of HIV can be reduced if mother takes drugs during pregnancy	20.7	20.2
Know that HIV can be transmitted during breastfeeding and that this can be reduced by taking drugs	18.1	17.7

Source: Family Health International / Departmentof Health, 2002

While 62 percent of women and 77 percent of men know that condoms can effectively prevent HIV infection, fewer females (48%) know that limiting sex to only one uninfected partner can reduce the risk of getting HIV.

Figure 2



Meanwhile, the same trend is observed among young people aged 15-24. In the YAFS-3 nationwide survey, 95 percent of youth have heard of AIDS, but only two-thirds of them are aware of other STIs. While almost all of the youth are aware of AIDS, their knowledge is still shrouded with misinformation. More than a quarter of the youth (27.8 percent) believe that AIDS is curable and 73.4 percent think that there is no chance of them getting AIDS in the future, illustrating the general attitude of AIDS invisibility among the young people.

Figure 3

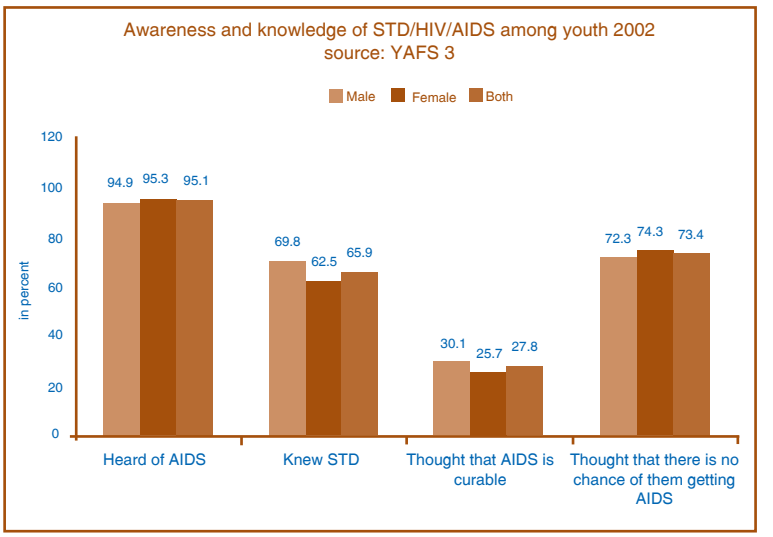
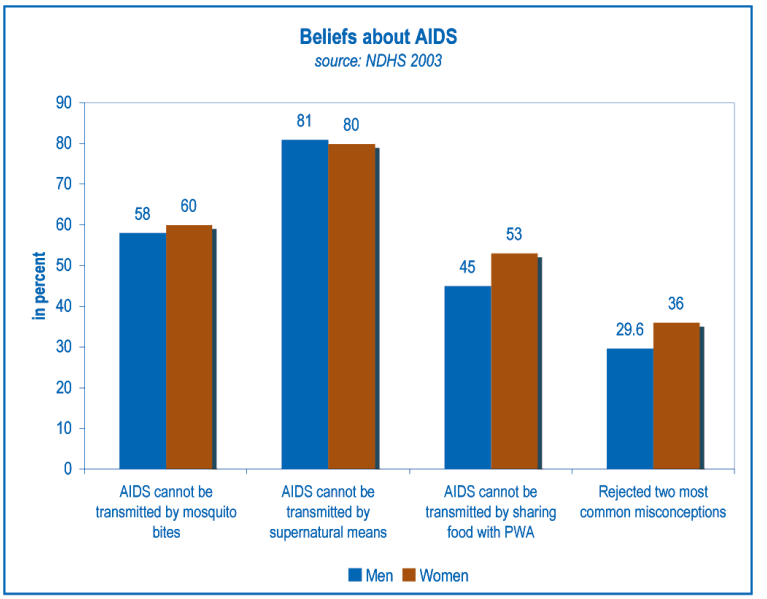


Figure 4



Comparisons from the 1994 YAFS survey indicate little change in STI/HIV/AIDS awareness among the youth, meaning awareness was already high in 1994. However, a notable difference has been observed in the percentage of young people who think that AIDS is curable, which doubled between the surveys. In 1994, only 12.5 percent of young people aged 15-24 thought there is a cure to AIDS; this number significantly increased to 27.8 percent in 2002. This deterioration in knowledge on HIV and AIDS raises serious questions about HIV information and education in the country.

Stigma and Discrimination

Misconceptions on HIV and AIDS transmission still persist in the Philippines, as revealed by the 2003 NDHS. Such misconceptions contribute to the discrimination and stigmatization against PLWHAs. Only 36 percent of men and 30 percent of women rejected the two most common misconceptions on AIDS such as transmission through mosquito bites and sharing food with a person who has AIDS. Beliefs about AIDS likewise vary across the country. And as earlier noted, better educated respondents and those in higher income groups are more likely to have correct and accurate knowledge than other respondents.

Stigma and discrimination have long been recognized as contributing factors to the rapid spread of HIV infection because such limiting attitudes threaten the successful implementation of prevention and control programs. In the Philippines, the low rate of infection is attributed to early recognition by government and civil society of the potential impact of AIDS. However, continuing stigma attached to AIDS has masked the real HIV and AIDS situation of the country. Experts agree that many cases of HIV and AIDS remain unreported due to the stigma associated with HIV—a factor that discourages disclosure.

A majority of the reported cases come from a skewed population, mostly representing individuals who have undergone mandatory HIV screening for work overseas. A study on stigma and discrimination conducted by Pinoy Plus Association among PLWHAs point out that 37 percent of them underwent HIV antibody testing for work-related reasons. Although Republic Act 8504 guards against discrimination against PLWHAs in various areas of social life, some of the receiving countries for OFWs do not have parallel laws that guard against mandatory testing for HIV. Most employment agencies abroad also require HIV and STI screening to determine one's "fitness to work."

Findings from the 2003 NDHS confirm a prevailing attitude of stigma and discrimination against HIV and AIDS. Only around four percent of men aged 15-49 have ever undergone voluntary counseling and testing for HIV, leaving a large proportion of presumably sexually active men who have never thought of getting tested for HIV. Furthermore, the survey shows that only 10.8 percent of men and 14.2 percent of women believe that an HIV-positive teacher should be allowed to teach, while 79.3 percent of men and 76.4 percent of women feel that the HIV-positive status of a family member should not be necessarily kept confidential. These results show that the prevailing stigma attached to HIV and AIDS is a contributing factor to the attitude of invisibility towards AIDS, with many feeling that AIDS has little relevance to their lives. Results also show that HIV and AIDS threaten social cohesiveness and is a source of social isolation. To illustrate, only 29 percent of men and 33.6 percent of women are willing to care for family member with HIV at home.

Table 21: Voluntary counseling and testing among men aged 15-49 (in percentage)

	percent
Ever tested	
received results	2.7
no results	0.9
Never tested	92.0
Don't know/missing	4.4
Percentage tested for HIV and received results in past 12 months	0.6

Source: NDHS 2003

Risk Behavior

As was earlier pointed out, although HIV infection may be seemingly low the preconditions for a full blown epidemic are actually present, such as the prevalence of risky behavior in the population. Promoting change in sexual behavior is an important component of many HIV prevention programs. Behavioral surveillance and other surveys show that while knowledge and awareness may seem to be moderate if not high, the gap between knowledge and actual practice is still wide.

Table 22 shows that condom use remains an inconsistent practice among sexually active youth aged 15-24 as condom use is mostly associated with commercial sex. Figures show that 53.8 percent of the youth used a condom when paying for sex while only 4.4 percent used condoms when they engaged in extramarital sex.

Table 22: Sexual risk behavior among young adults aged 15-24

	Male	Female	Both
Ever had sex	31.3	15.7	23.1
First sexual intercourse was something…			
Wanted to happen	46.0	34.9	42.1
did not want but went along	21.3	27.3	23.4
did not plan but happened anyway	31.8	33.7	32.5
happened against will	(1.0)	4.0	2.0
Practiced contraception…			
During first sexual intercourse	27.5	14.9	21.0
During last sexual intercourse	26.6	21.8	24.8
Used condom…			
During first sexual intercourse	43.0	38.0	40.5
During last sexual intercourse	45.2	23.3	38.2
Had sex with more than one partner	48.9	10.6	34.8
** figures in parenthesis less than 30 cases*			

Source: YAFS 3, 2002

Among men who have sex with men (MSM), the study shows that one in every three MSM have had STIs. In Metro Manila, 80 percent of the MSMs surveyed had multiple partners and 98 percent had anal sex, 56 percent of whom practiced unprotected anal sex. In Baguio City, 84 percent of MSMs reported to have practiced unprotected anal sex (CEMSHAD DoH USAID/FHI Philippines, 2005).

Another cause of concern among risk groups are male truckers—long-distance drivers and their assistants—who, by the nature of their work, are far from their families and are thus reported to frequent entertainment establishments along their routes. A study conducted among male truckers in Central Luzon found low usage of condoms among those who had sex with non-regular partners and with sex workers (Mateo, R., M.C. Lim-Quizon, and R. Magpantay, 2003).

Gender, Class and Risks

We end this chapter with some statistics related to reproductive health to show how risk in itself is related to issues of gender and class. As mentioned earlier, the 2003 NDHS shows that while the total fertility rate is 3.5 percent, the wanted fertility rate—what women actually want—is only 2.5 percent, meaning women generally have more children than they want. There are wide variations in these rates, between rural and urban areas, across regions, and among richer and poorer women. Again, it is poor, uneducated and rural women who seem to have least control over their fertility.

Table 23: Total Fertility Rates: Actual and Wanted

Wealth index quintile	Wanted	Actual
Lowest	3.8	5.9
Second	3.1	4.6
Middle	2.6	3.5
Fourth	2.2	2.8
Highest	1.7	2.0
Total	2.5	3.5

Source: National Demographic Health Survey 2003

Table 24: Other reproductive health figures, women aged 25-49

Wealth income quintile	Median age at first marriage	Median age at first intercourse
Lowest	19.7	19.5
Second	20.6	20.6
Third	21.5	21.5
Fourth	22.8	22.8
Highest	24.6	24.5

Source: National Demographic Health Survey 2003

Table 25: Men fertility: Mean number of children, by wealth index quintile

Lowest	4.3
Second	3.8
Third	3.5
Fourth	3.2
Highest	2.9

Source: National Demographic Health Survey 2003

The differences in reproductive health indicators give us glimpses into the risks that may be faced in relation to HIV and AIDS as they become more widespread. If women cannot protect themselves from unprotected pregnancies and if they lack access to information and services for family planning, then they will face much greater risks as HIV and AIDS becomes more prevalent.

Note, too, that the differences found across income quintiles are also present among men. Table 26 shows that men belonging to the richest 20 percent have an average of 2.9 children, compared to 4.3 for those belonging to the poorest 20 percent. More research is needed to probe into how much male "disempowerment" is involved here, or if this is another manifestation of women's disempowerment (i.e., the female partners of the poorest 20 percent of males are unable to protect themselves adequately).

Chapter

II

Good **Practices**

As the Philippines implements the 4th AIDS Medium Term Plan, this research reviews the country's past responses to HIV and AIDS. Twenty-four organizations with good practices are profiled to show how different sectors and communities have responded to HIV and AIDS. The critereia used in selecting these organizations include a) replicability; b) appropriateness to local conditions; c) involvement of communities and vulnerable populations; and d) evidence of beneficial impact.

These case studies are not meant to be full blown analyses of these organizations' practices and experiences; rather, they are meant to provide a broad glimpse into the various responses and strategies that they have employed. The case studies presented below cover three aspects of HIV and AIDS responses – advocacy, prevention, and care and support – and are outlined as follows:

I. Advocacy

- A. Non-Government Organizations
  - Human Development and Empowerment Services (HDES)
  - Wo/Men's Access to Vital Education and Services (WAVES)
- B. Local AIDS Councils
  - Cebu City Multisectoral STD/AIDS Council (CCMSAC)
  - Dagupan City AIDS Council
  - Laoag City AIDS Council (LCAC)
  - Local AIDS Council of San Fernando (LACSF), La Union
- C. Media: AIDS Society of the Philippines (ASP)
- D. Overseas Filipino Workers: Action for Health Initiatives (ACHIEVE)
- E. People Living with HIV and AIDS: Pinoy Plus Association (PPA), Inc.

II. Prevention

- A. Sex Workers
  - Free Rehabilitation, Economic, Education and Legal Assistance Volunteers Association (FREELAVA), Inc
  - Pearl S. Buck Foundation - Philippines (PSBP)
  - Kabalaka-Central Philippines University
- B. Men who have Sex with Men
  - The Library Foundation (TLF)
  - Bidlisiw
- C. Injecting Drug Users: University of Southern Philippines Foundation (USPF)
- D. Youth: Center for Promotion, Advocacy and Protection of the Rights of the Child (Lunduyan Foundation, Inc.)
- E. Workers
  - Department of Labor and Employment–Occupational Safety and Health Center (DOLE-OSHC)
  - Trade Union Congress of the Philippines (TUCP)
  - Employees Confederation of the Philippines (ECOP)
  - Amkor Technology Philippines (ATP), Inc.
- F. Fisherfolks: Social Health, Environment and Development Foundation (SHED), Inc.

III. Care and Support

- Positive Action Foundation of the Philippines, Inc. (PAFPI)
- Remedios AIDS Foundation (RAF)
- Precious Jewels Ministry

Case Studies of Various Organizations

I. Advocacy

Advocacy is the first step in any program intended to prevent or slow down HIV and AIDS in a given locality. It provides the platform from which awareness is raised, activities are conducted, and policies are enacted.

The following profiles give a short glimpse of some of the good advocacy practices conducted in the Philippines over the past few years. The focus of the advocacy programs, their activities, the level of participation, and their success are highlighted to provide guidance and inspiration for other organizations that may be facing the same circumstances.

The case studies presented in this section begin with the NGO sector's advocacy programs, followed by the local governments' responses to their local, as well as the country's HIV and AIDS situation. Advocacy programs for the media are also illustrated, followed by the programs targeted for specific populations – the overseas Filipino workers and people living with HIV and AIDS
.

A. Non-Government Organizations

Human Development and Empowerment Services (HDES)

The Human Development and Empowerment Services (HDES), established in 1998, is a key partner for HIV and AIDS information, education and advocacy work among the local government, other NGOs and the media. The strength of HDES' HIV and STI prevention lies on its strong and extensive networks with the most-at-risk groups (MARGs) – the sexually exploited children under sixteen (SECUS), freelance female sex workers (FFSW), registered female sex workers (RFSW), their male customers, and male sex workers (MSW).

HDES conducts one-on-one peer education activities among the MARGs and facilitates the establishment of organizations and associations among these populations. By closely working with these organizations, MARGs are mobilized and educated regarding HIV and STI prevention and control, and in the process, increasing the level of awareness among the general population.

In 2001, the organization effectively lobbied for the enactment of an HIV and STI prevention ordinance and the institutionalization of the multi-sectoral AIDS council in Zamboanga City with the passing of City Ordinance 234. The ordinance mandates the implementation, monitoring, and evaluation of five HIV and STI prevention policies; namely, 100 percent condom accessibility, compulsory HIV and STI education, universal access to STI health care, regular STI screening among entertainers, and non-hiring of minors in entertainment establishments. The local AIDS Council, wherein HDES sits as the Vice-Chair, was established to coordinate and monitor the implementation of these HIV prevention policies in the city.

Through its Barangay Legal Action Against Child Prostitution Project (BLACP), HDES raised public awareness on child trafficking, child prostitution, and sexual exploitation in Zamboanga City. Part of the project's success was the establishment of the Barangay Council for the Protection of Children (BCPC) in ten pilot barangays. HDES also lobbied for the passage of barangay resolutions strengthening the BCPCs, which eventually led to the enactment of a city ordinace establishing the BCPC in Zamboanga City's 98 barangays.

Furthermore, HDES has successfully advocated for the allocation of a two million peso budget for STI and AIDS program in Zamboanga City, so far, the highest funding given by any local government unit in the country for STI and AIDS program.

HDES has effectively reached its goal of empowering socially disadvantaged sectors so that they may avail themselves of health services and participate in community development. Its projects and activities have resulted in changes in sexual behavior among high-risk groups—a fact evidenced by the increase in condom use and negotiation among the MARGs. Moreover, health-seeking behaviors such as regular checkups and smears have also notably increased among the MARGs.

Wo/Men's Access to Vital Education and Services (WAVES)

The Wo/Men's Access to Vital Education and Services (WAVES) played a pivotal role in the successful passage of the Davao City AIDS Ordinance during its AIDS surveillance and education project (ASEP) with PATH. Together with the Davao Entertainment Industry Association (DEIA), Inc., WAVES lobbied for the enactment of five HIV and STI prevention policies, namely: (1) mandatory AIDS and STI education for entertainers; (2) improved medical examinations for entertainers; (3) establishments' health policy for workers; (4) nonhiring of minors; and (5) condom availability and 100 percent use in registered establishments. Although they have been generally successful in their lobby work, their proposition was met by considerable public opposition, particularly with regards to the condom policy.

Only four of their five proposed policy provisions eventually passed with the blocking of the 100 percent condom use policy.

To facilitate the development and passage of an ordinance that mandated the abovementioned policies, the project identified local "champions" on HIV and AIDS issues from various sectors to lead the policy and advocacy efforts. These "champions" come from the government, particularly the City Council, the media, and private sector. They take part in activities intended to enhance their understanding of the issues and help them develop practical approaches to address HIV and AIDS prevention in their locality. The activities include exposure visits to other sites and consultations with other stakeholders, such as people in the entertainment industry.

The project relied on simple persistence to encourage the champions to push for the ordinance. The project staff's strategies included daily follow ups, visits to the City Hall, meetings with the stakeholders, informal visits at home, and leaving IEC materials in the hope that they would reach the mayor or councilors. As a result of their lobbying, the Davao City AIDS Ordinance was enacted in 2002, promulgating policies and measures for the prevention and control of STI, HIV and AIDS in the city, and at the the same time, strengthening the Davao City AIDS Council.

B. Local AIDS Councils

Cebu City Multi-Sectoral STD/AIDS Council (CCMSAC)

Cebu City could be considered as a hot spot for HIV transmission. Being a metropolis and the center for trade and commerce in the south, the city attracts a lot of tourists and businessmen. Cebu city has 80 entertainment establishments, with approximately 3,000 registered female sex workers, catering to these men. At the same time, the city has a large population of freelance sex workers. Furthermore, other most at risk groups are also present in the city, including men who have sex with men and injecting drug users.

On the other hand, Cebu City has a very active network of organizations working on HIV and AIDS. The relationship among these various stakeholders is characterized by that of collaboration and partnership, especially while the AIDS surveillance and education

project (ASEP) was in implementation in the city. Towards the end of ASEP, however, the need for the institutionalization of HIV and AIDS prevention efforts became apparent; thus, the Cebu City Multi-Sectoral STD/AIDS Council (CCMSAC) was created.

As the central advisory, planning and policy making body on the prevention and control of HIV and AIDS in Cebu City, CCMSAC prepares the short-, medium-, and long-term plans for HIV and AIDS prevention in the city. It also spearheads prevention campaigns in different communities and barangays especially in the red light districts, in close coordination with two NGOs – Bidlisiw and FREELAVA. The council also initiates the conduct of HIV and AIDS information, education and communication activities, and condom provision and distribution.

In addition, the council, in coordination with the Social Hygiene Clinic (SHC) and the Department of Health, conducts an annual STI/HIV/AIDS serological and behavioral surveillance among at risk groups such as female registered and freelance sex workers, their male clients, men who have sex with men, and injecting drug users. From its annual budget, CCMSAC provides financial assistance in the form of small grants to finance HIV and AIDS activities of NGOs. At the same time, it extends technical assistance to the different Barangay AIDS Councils in the city, supporting them in their work and financial planning.

Dagupan City HIV/AIDS Council

In June 2002, the Dagupan City HIV/AIDS Council was created to respond to the threats HIV and AIDS pose to the city. Being the capital and business center of the province of Pangasinan, Dagupan City attracts local businessmen and tourists to spend the night and relax at the city's numerous entertainment establishments.

The council is composed of different city government units and non-government organizations, including associations of club owners and guest relations officers (GROs). The city government allocates an annual budget of Php500,000 for the programs of its local AIDS council.

Through its "HIV/AIDS sa Barangay," the council takes the lead in conducting massive information drives on HIV and AIDS prevention in all of the 31 barangays of Dagupan City. It also conducts seminars on STI, HIV and AIDS and distributes IEC materials to vulnerable groups like sex workers, entertainment establishment staff, policemen and firemen.

HIV and AIDS issues are integrated in parents' classes, primary health care seminars, pre-marriage counseling, barangay health workers training, and women's education program. From time to time, the council also conducts sex and health education campaigns in private and public schools, as well as among out of school youth.

The council ensures the availability of condoms and information materials for the prevention of STI and HIV at entertainment establishments, hotels, motels, lodging houses, sauna parlors and similar establishments. It implements the 100 percent condom use policy among the registered sex workers and their clients. Condoms are distributed for free if supplies are available.

The council maintains close coordination with the various associations of club owners and organization of GROs to ensure the implementation of the 100 percent condom use policy. It holds regular meetings to give updates on relevant issues and provide livelihood skills training for the GROs. It also ensures regular inspection of entertainment establishments and puts up IEC materials within their premises.

The city's SHC offers free pap smear services and voluntary HIV antibody testing for sex workers and anyone who wishes to be tested. Pre- and post-test counseling are also provided at the clinic.

Laoag City AIDS Council (LCAC)

The Laoag City AIDS Council (LCAC) was created on May 31, 2002, bringing together the police, city social welfare, tourism and education councils, and the City Health Office (CHO) in working towards preventing the spread of STI, HIV and AIDS in the city. The move was not surprising, considering that Laoag already had policies that prevented the spread of STI, HIV and AIDS as early as 1983.

The biggest boost for the fight against STI, HIV and AIDS came in 2003, with the enactment of City Ordinance No. 2003-023, which promulgated policies and prescribed measures for the prevention and control of HIV and AIDS in Laoag. To achieve these, the ordinance instituted a citywide HIV and AIDS IEC program, established a comprehensive monitoring system, and strengthened the LCAC.

Because of the ordinance, registered GROs and sex workers regularly undergo mandatory urinalysis, stool exam, VDRL/RRR, and physical exams every six months; pap smear twice a week; and a chest X-ray every six months to detect tubercolosis. Periodic HIV antibody testing is also conducted on a voluntary basis.

With an annual allocation of only PhP 100,000, the LCAC utilizes its close relationship with the Discolandia Owners and Managers Association, which provides financial support, as well as human resources for the training of peer educators in the bars. A partnership was also formed with the Philippine National Police, which monitors the implementation of the city's 100 percent condom use policy.

For 2005, the LCAC intends to specifically deal with most at-risk groups that continue to evade its efforts, including MSM and tricycle drivers. A one-hour slot on DWFB Radyo ng Bayan is already in the offing to advocate the prevention and control of HIV and AIDS through tri-media, which reaches the biggest number of the local populace. The Laoag HIV/AIDS Hotline was also established with the City Hall Press Corp on a trial run for a year.

Local AIDS Council of San Fernando (LACSF), La Union

San Fernando, La Union is a fairly busy city with an abundance of institutional magnets: 51 government offices, 5,044 business establishments, 68 educational institutions, six bus terminals, the Poro Point Economic Zone, an airport and seaport, and 35 entertainment establishments that house over 200 registered sex workers. As these bring in more people, the threat of the entry of HIV and AIDS spreading in the city looms large. Moreover, a growing number of overseas Filipino workers come from San Fernando (over 1,000 annually), adding to the city's vulnerability.

To face these vulnerabilities, the Local AIDS Council of San Fernando (LACSF), La Union was established in 2002 by virtue of an executive order from the mayor to strengthen the SHC and to implement and evaluate STI, HIV and AIDS prevention and control programs," Rilloraza said. The SHC also offers counseling to clients, IEC dissemination, and networks with other GOs and NGOs involved in STI and HIV prevention and control.

For its end, the LACSF ensures the prevention and control of HIV and AIDS via the dissemination of IEC materials, and helps in institution-building through regular trainings, seminars and consultations on local responses to HIV and AIDS. Since 2001, LACSF had overseen activities that ranged from basic HIV and AIDS training and counseling, to STI laboratory diagnosis, etiological surveillance, and monitoring.

Though considered to be still in its infancy stage, San Fernando's effort nonetheless thrives because of a highly supportive political environment. Although the budget allocated for the LACSF was initially set at PhP 200,000, incumbent Mayor Mary Jane Ortega is already eyeing the possibility of increasing its budget. Moreover, support from NGOs allows LACSF to reach a wider audience by teaching community leaders to look after their own communities.

C. Media: AIDS Society of the Philippines (ASP)

In order to educate the masses and reduce the amount of inaccurate information regarding HIV and AIDS, the AIDS Society of the Philippine (ASP) has convinced the media of the relevance of proper HIV and AIDS reporting. To ensure that the industry's eye is constantly trained on pertinent issues, ASP came up with a strategy that appealed to Philippine media's collective psyche.

After consulting with the media practitioners themselves, ASP instituted the AIDS Media Awards (AMA). Taking off from the initial undertaking of the DOH in 1997, ASP recognizes exemplary works in the tri-media so as to set a benchmark. The competitive atmosphere it fosters also serves to drive up the standards each year. Additionally, ASP finds it easier to get exposure about the issues it wants to air since it has already forged ties with various organizations within the industry, such as the National Press Club. To further make sure that all possible audiences are reached, the AMA annually introduces special categories—among them have been a novelette, a children's story, and an editorial cartoon.

Alongside the awards are workshops that continually build on HIV and AIDS reporting skills. Ethical issues are raised and debated during these workshops so that when faced with a situation where protecting the rights of an individual conflicts with the society's right to know, media practitioners have a set of guidelines that will allow them to find a middle ground in their work – a way of presenting stories that is fair to all parties involved. This way, sensationalism is reduced and responsible reporting is encouraged.

D. Overseas Filipino Workers: Action for Health Initiatives (ACHIEVE)

Action for Health Initiatives (ACHIEVE) has taken the task of protecting the overseas Filipino workers (OFWs) from HIV and AIDS as they have been identified as one of the most vulnerable groups.

Among the OFWs, ACHIEVE has taken special interest in seafarers. ACHIEVE is pragmatic in fulfilling its objectives—instead of taking to the streets to point out the national government's weaknesses, it has partnered with the Department of Foreign Affairs to improve the state of OFWs. One of the accomplishments ACHIEVE has had is the inclusion of a module on HIV and AIDS in the mandatory Pre-Departure Orientation Seminar (PDOS) given to OFWs. ACHIEVE also facilitates the training of foreign service personnel, such as those who work in embassies, upon request. The workshops aim to equip them with the necessary skills to handle on-site situations with sensitivity.

Linkages with other government agencies, such as the Social Security System (SSS) and Overseas Workers Welfare Administration (OWWA) are also being strengthened to ensure that OFWs with HIV are able to claim their benefits with minimum red tape. As of now, informal channels are in place within these institutions, but ACHIEVE trusts that in the future, policy changes will be made to uphold the rights of OFWs with HIV.

ACHIEVE has also tapped seafarers as resource persons in their advocacy projects. Being OFWs themselves, they are perceived to be more compelling and credible. The organization handles workshops that give volunteers the confidence to speak in front of an audience. It also provides the seafarers a venue to share their stories with other OFWs. These discussions make listeners realize that HIV and AIDS are real threats and that efforts to prevent their spread must be taken seriously.

E. People Living with HIV/AIDS: Pinoy Plus Association (PPA) Inc.

Pinoy Plus Association, Inc (PPA). the only Filipino NGO run by people living with HIV and AIDS (PLWHAs). Being the sectoral representative of PLWHAs in the Philippine National AIDS Council (PNAC), PPA responds to the care and support needs of the HIV positive population while upholding their human rights, and contributes to HIV and AIDS prevention and control efforts in the country.

Considering that the PPA president is concurrently the Philippine representative to the Asia Pacific Networks of PLWHAs (APN+), the organization is the principal authority on PLWHAs issues in the country. Thus, the organization has several programs that complement the overall goals of the Philippine government via its PNAC/DOH/NASPCP programs. However, more focus is given to two components: (1) care and support services that highlight the meaningful involvement of PLWHAs and their affected families; and (2) strong networking and advocacy initiatives particularly at the international level.

PPA's initiatives are consistent with its goal to empower PLWHAs to help their fellow PLWHAs. Since 1994, the association has completed several projects that benefited PPA members and most at risk groups, projects on livelihood and skills enhancement, the promotion of multi-sectoral and participatory approaches, the development of IEC materials, and AIDS education among sex workers, out of school youth and students.

PPA successfully fought for the their representation of PLWHAs in the PNAC in 1994. The organization also helps in increasing HIV and AIDS public awareness through their personal testimonials in various workshops and gatherings – a strategy they use to put human face to the issue of HIV and AIDS.

One of the main challenges for PPA nowadays is the pushing for the universal access to treatment of PLWHAs. It hopes that all PLWHAs could have access to anti-retrovirals and treatment to opportunistic infections.

II. Prevention

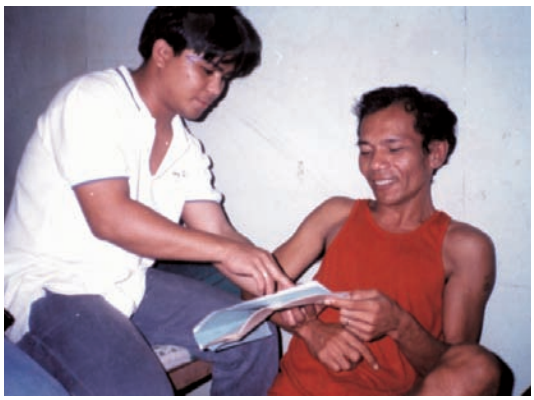
After setting the platform and the right conditions under advocacy, HIV and AIDS prevention is the necessary next step. Although there are no medical vaccines or prophylactics for HIV, communities, particularly, the most at-risk groups, can effectively use prevention programs to protect themselves from the spread of the infection – a social vaccine to the disease, as one may say.

The following profiles give a short glimpse of some of the good prevention practices conducted by various organizations over the past few years. The responses, risk-reduction strategies, contexts and successes are highlighted to provide guidance or inspiration for other organizations that may be facing the same circumstances.

The case studies presented in this section are arranged according to the various groups' target populations, i.e., sex workers, MSM, IDUs, youth and children, workers, and fisherfolks.

A. Sex Workers

Free Rehabilitation, Economic, Education and Legal Assistance Volunteers Association, Inc (FREELAVA)



FREELAVA (Free Rehabilitation, Economic, Education and Legal Assistance Volunteers Association, Inc) was established in 1983 by a group of volunteer lawyers in Cebu City to provide free legal services to poor and oppressed people during the martial law era. Because of their track record in working with people in poor communities and in promoting and protecting human rights, ASEP tapped FREELAVA to take part in its AIDS project in 1995.

People in prostitution (PIP), being highly vulnerable to discrimination and abuses, have become one of the main beneficiaries of FREELAVA in its HIV and AIDS prevention and advocacy activities. Working with PIP and other groups of marginalized people, FREELAVA promotes HIV and AIDS issues as development and human rights concern, not just providing legal aid, but also raising their awareness on STI and HIV prevention, condom use, STI treatment, and educating them on human rights. FREELAVA also serves as a "bridge" for freelance workers to access services at the SHC, which usually only provides services to registered sex workers.

With their outreach workers and peer educators, FREELAVA worked in pilot barangays that are classified as red light districts because of the presence of entertainment establishments. Collaborating with the associations of establishment owners and GROs, FREELAVA regularly conducts symposiums and workshops in these communities. It also distributes IEC materials (and sometimes condoms whenever there are free supplies) in entertainment establishments. FREELAVA also invites freelance workers, pimps and male clients to attend their lectures, and fields peer educators and outreach

workers among these hard-to-reach sectors to provide free condoms and information materials. At the same time, the organization has also established a referral system for their clients.

Furthermore, FREELAVA has served as the prime mover in the creation of the Cebu City Multisectoral STD/AIDS Council and the several Barangay AIDS Councils in the city. It also serves as a lead advocate in the passage of several local ordinances at the city and barangay levels.

Pearl S. Buck Foundation

The Pearl S. Buck Foundation-Philippines (PSBP) was initially set up to help Amerasian children—often the abandoned offspring of US servicemen with Filipino girlfriends or sex workers—in their humanitarian needs. Later on, the organization branched out to the wider social problem of HIV and AIDS.

The first prong of PSBP's response to HIV and AIDS is advocacy, influencing local leaders at both the city and barangay levels. In this regard, one of the organization's successes is the promulgation of Angeles City Ordinance 106 series of 2000, or the AIDS Prevention and Control Ordinance, calling for mandatory AIDS education for the city's sex workers. PSBP also pushed Angeles City local government to allocate a portion of revenues from box office sales towards social hygiene clinics, ensuring the maintenance of HIV and AIDS, and reproductive health services in the city.

PSBP's activities among sex workers include education on STI and HIV prevention, training and capacity building (i.e., safer sex negotiation), condom distribution and referral system. These are often done by community health outreach workers (CHOWs) with the help of peer educators. The peer educators are sex workers who are trained in HIV and AIDS prevention, communication skills and counselling.

The project staff establishes rapport with freelamce sex workers by first approaching the pimps and walking the streets. Without bar owners or managers to enforce rules, pimps serve as the de facto enforcers on the ground, making sure that the sex workers under their wing have their regular gram staining. Peer educators are also essential in overcoming this challenge, as they are able to pinpoint and convince their fellow sex workers of the benefits of regular STI check-ups.

However, even before confronting problems on monitoring and enforcement, encouraging and convincing sex workers that they need STI and AIDS education, and check-ups is the necessary first step. To do this, PSBP presents sex workers with a simple cost-benefit table—one side shows the costs of check-ups and pap smears, while the other side shows the medical and opportunity costs of acquiring a sexually transmitted infection, demonstrating that prevention is indeed less costly than a cure. This simple and practical cost-benefit approach in demonstrating the need to incur check-up costs has proven to be very effective in convincing not only sex workers but also pimps and club owners.

Kabalaka-Central Philippine University

The Kabalaka Reproductive Health Center is the outreach program of the Central Philippine University's College of Nursing. Established in 1972, it has provided nursing students with practical knowledge on reproductive health concepts, STE IVand AIDS management and prevention, and family planning. Through the years, it has established a credible reputation in the delivery of efficient STI and reproductive health services, and has been instrumental in the prevention and control of STI and HIV in Iloilo City through the constant publication and distribution of IEC materials.

Kabalaka's programs focus on various levels of intervention, with the primary aim of increasing STI, HIV and AIDS awareness among the general population through the publication and dissemination of information and education materials. One-on-one counseling, focus group discussions and peer education activities are also conducted for registered female sex workers, their male clients, male sex workers, MSM, and sexually exploited children under sixteen.

Kabalaka has successfully set a good example for future health professionals in Iloilo City by strongly encouraging community service among its students, exposing them to relevant health and development issues while in school. Hoping that as their students become professional themselves, they will be able to deal with such issues in a responsive and sensitive manner. They are not wary about bringing their students to the "seedy" parts of the city; instead, nursing students are encouraged to immerse themselves in the red light district of the city, providing relevant STI counseling to registered sex workers. Students also intern at the social hygiene clinics, harnessing their skills in speculum examination, specimen collection for STI screening, management and risk-reduction, and counseling.

Recognizing the sporadic nature of funding for NGOs, Kabalaka ensured the sustainability of prevention and control programs by pushing the city government to create the Iloilo STI/AIDS Council in 2002. This ensures that HIV and AIDS programs are supported by the local government once funding for NGO projects have ended.

B. Men who have Sex with Men

The Library Foundation

As a gay men's community-based non-government organization, The Library Foundation (TLF) provides STI and HIV prevention services to men who have sex with men (MSM). TLF also seats as the sectoral representative for MSM at PNAC.

Since 1991, TLF has implemented HIV and safer sex workshops for MSM. Conducted over one weekend, the Healthy Interaction and Values (H.I.V.) workshop consists of participatory, peer-facilitated activities that focus on basic information about STIs, HIV and AIDS, issues on homosexuality, and community building. Initially conducted among young professionals, TLF extended the workshops to school and community-based MSM aged 15 to 24 in Metro Manila. In addition to STI, HIV and AIDS information, the subsequent workshop included discussions on social issues relevant to MSM, as well as training on peer education and community organizing skills.

Learning from these previous undertakings, TLF embarked anew with a project that aims to improve behavioral change, communication and STI management among MSM through a community developmental framework. The project utilized participatory assessment and planning among local MSM communities and stakeholders, involving formal and informal leaders from the areas in identifying local needs and mapping out sexual and social risks within the community. Local government officials were also consulted in order to gain access and support from the communities. The project aims to form community self-help groups among MSM by mobilizing and organizing them towards prevention of STI and HIV, and the promotion of human rights. A series of capacity development activities were conducted to train peer educators, outreach volunteers and peer counselors on safer sex negotiation, basic counseling, and community organizing.

To promote positive sexuality, as well as sexual health and rights among MSM, outreach and health promotion activities in identified MSM-frequented areas and events were organized to improve the STI, HIV and AIDS awareness and life skills of the MSM communities. Peer educators provided the clients with STI and HIV information,condoms and lube packs. The project also conducts multi-sectoral dialogues, including local officials and law enforcement officers, on issues concerning the MSM community.

Bidlisiw

Bidlisiw, a non-government organization based in Cebu City, has been working with the MSM community, starting in 1995 under the AIDS surveillance and education project (ASEP). The project specifically aimed at MSM practicing risky sexual behaviors, encouraging condom use, partner reduction, health-seeking behavior, and utilization of available STI treatment services.

The project utilized the twin strategies of community outreach and peer education in reaching this at-risk population, relying heavily on community health outreach workers (CHOWs) and volunteer peer educators (PEs) who were selected for their influence within the MSM community. CHOWs and PEs worked with clients through a series of one-on-one contacts and guided group interaction to encourage the development of skills for condom use, safer sex negotiation, and seeking appropriate STI treatment

The PEs initiate contact with the clients, usually in their communities or cruising sites, by providing them information on STI and HIV. In subsequent sessions, they provide clients with more in-depth counseling and individualized prevention information, including STI referral. Clients who were found to be engaging in risky sexual behaviors, are placed in preventive case management (PCM), wherein they were helped to establish a risk reduction goal. MSM clients are encouraged to reduce sexual partners, use condoms consistently, and seek care for symptoms of STI. During each repeat contact session, the CHOWs and PEs provide educational materials and monitor the progress of the client towards his personal goal.

C. Injecting Drug Users: University of Southern Philippines Foundation (USPF)

With a long history of community work, the University of Southern Philippines Foundation (USPF) started its work on HIV and AIDS by educating entertainers in Cebu City. However, the most remarkable outreach program of the organization is its advocacy among injecting drug users (IDUs), promoting HIV and AIDS prevention, establishing programs on IDU intervention, and harm reduction.

USPF has initiated a clean up drive to end the indiscriminate disposal of used syringes and introduced the idea of rotating the placement of injections to minimize infections. It teaches proper use of needles and offers counseling services to IDUs. It also distributes free needles and syringes whenever these are available. It has mobilized and trained groups of harm reduction advocates among IDUs to work in various community outreach and peer education activities.

An IDU who graduates from USPF seminar-workshops receives a kit, which contains condoms, syringes, swabs, alcohol and information materials, all of which can be replenished when they return to the clinic for testing and follow-up counseling. Also discussed in the seminar-workshops are topics on safe sex, Hepatitis C and health care.

In dealing with the IDUs, the foundation's approach is to promote self-esteem to these drug users who feel that they are social outcasts. USPF educates IDUs in a non-coercive, non-judgmental and highly confidential manner. The foundation empowers IDUs by inviting them to join advocacy activities such as the World AIDS Day celebration. It organizes its own parades and street-based fun activities to raise public awareness on harm reduction and HIV prevention.

USPF educators use the topic on Hepatitis as an entry point to discuss HIV and AIDS in the community. Almost 90 percent of the IDUs there are positive for Hepatitis C and several of the IDUs have died of these diseases.

D. Youth and Children: Center for the Promotion, Advocacy and Protection of the Rights of the Child (Lunduyan Foundation, Inc.)

Observing that the issues of affected and infected children are often sidelined during discussions on Filipinos living with HIV and AIDS, the *Lunduyan Para sa Pagpapalaganap, Pagtataguyod at Pagtatanggol ng Karapatang Pambata* (Center for the Promotion, Advocacy and Protection of the Rights of the Child), decided to come up with a project specifically targeting children living with HIV and AIDS (CLWHAs).

To determine the level and magnitude of the problem, Lunduyan began its project by identifying the exact number of CLWHAs and the issues confronting them. Although accurate figure on CLWHAs are hard to come by, the organization was able to develop its capacities to provide services to CLWHAs.

Under Lunduyan's care, CLWHAs are given structured learning sessions that provide needed skills for people with HIV and AIDS. Among other things, the children study various communication arts such as painting, drama and music, encouraging them to discuss their issues and concerns in their art. These works are then developed into advocacy tools so that the children's issues can reach a wider audience.

Most of Lunduyan's workers are volunteers who provide services, even using their own resources, to help Lunduyan sustain its efforts. The organization uses four criteria to judge the success of its undertakings; namely, the child's survival, child development, child protection, and the child's participation.

"It has been tough but we've had breaks," says Lunduyan President Irene Fonacier-Fellizar. "We've had policies passed that somehow address children more vulnerable to HIV and AIDS. We may have convinced a lot of our colleagues in the network to take this issue on. We are in the process of making sure that a national policy for children is written, passed and executed, and implemented all over the country."

The organization also seats at PNAC to represent the children and youth.

E. Department of Labor and Employment-Occupational Safety and Healtch Center

Created 1987, (DOLE_ OSHC) is the national authority for research and training on matters pertaining to safety and health at work. More specifically, it is mandated to promote workers' welfare though the effective implementation of occupational safety and health programs that will enhance productivity, and subsequently contribute to national economic development efforts. In 1996, OSHC's Bureau of Health was tasked to deal with HIV and AIDS in the workplace through AIDS education for government and private employees.

However, given real world constraints, innovative approaches have been used by the government agency to continue its functions despite limitations. For one, DOLE-OSHC's Bureau of Health has an annual budget of only PhP 150,000. With an estimated 35 million Filipinos in the workforce, relying on that budget alone would severely limit the project's success. Moreover, there are only 30 people tasked to run the center's projects, which are limited to STI, HIV and AIDS. Despite the difficulties, OSHC has been holding a minimum of five seminars per month on occupational safety and health, though for this year only two seminars specifically dealth with HIV and AIDS.

To deal with these limitations, DOLE-OSHC has integrated HIV and AIDS with its existing training courses, particularly those dealing with substance abuse and lifestyle related diseases. Also, funding has been sourced from the private sector, such as Amkor, which provided P200,000 for OSHC as part of its corporate social responsibility.

Moreover, since OSHC largely focuses on the private sector, the center has been pushing for the involvement of the Civil Service Commission to respond to the needs of the 1.5 million-strong government workforce, seeing that only the military has been actively promoting HIV and AIDS awareness in its ranks. Networking has also been seen as the best way to also service the informal sector, which is also largely ignored. Lastly, for workers who have been misplaced by HIV and AIDS, the OSHC is trying to provide them with alternative livelihood.

Employers Confederation of the Philippines (ECOP)

The Employers Confederation of the Philippines (ECOP) has two efforts directly addressing the reproductive health concerns of employees. First, there's the development of training modules on HIV and AIDS risk assessment and case management for the human resources (HR) personnel and clinic service provider. Second is the establishment of an extensive in-plant referral system to include NGOs, medical organizations and pharmaceutical companies.

These efforts are formulated to address the concerns of two groups: young adult workers (18-24 years old), including the new entrants into the labor force who are still in their late adolescent years, and middle age workers (25-40 years old), who are the emerging new leaders and have time for career advancement. The program aims to gain the support and commitment of major company stakeholders, as they are responsible for changes in company policies and their implementation. Its implementation includes a survey of HIV and AIDS, and RH services among companies, comprehensive training for HR and clinic personnel, in-plant training sessions, and periodic monitoring and evaluation.

ECOP Project Director J. Nomer Macalalad admits that the "funding is too small considering the large constituency in the workplace." ECOP has a membership base of 500 large corporations and 50 industry associations (national, local and foreign chambers of commerce and industries, etc). "But we make do with what we have," he adds.

The project aims to have workplaces establish HIV and AIDS prevention and management programs for employees, including services such as non-discriminatory procedures in HIV and AIDS risk assessment, confidentiality, established referral system for the management of suspected cases, continuous workers' HIV and AIDS education program, as well as the dissemination of IEC materials and commodities for HIV and AIDS prevention.

"The workplace is just one of the many areas where development work, such as preventing and eliminating the scourge of HIV/AIDS, can bear much gains," says Macalalad. In the end, ECOP hopes to help build the capacity of employers to sustain the program at the enterprise level, so that, when replicated and multiplied, it will contribute to the benefit of the larger society.

Trade Union Congress of the Philippines (TUCP)

Recognized by the government as the voice of the laborers, the Trade Union Congress of the Philippines' (TUCP) is primarily focused on improving the living and working conditions of Filipino laborers. As part of its campaign, TUCP is touching on issues such as reproductive health and STI, HIV and AIDS. In 2004, TUCP linked up with the Packard Foundation for its Intensifying RH Programs in the Workplace, which is expected to finish in December 2006.

The effort is actually a follow-up on the Demonstration Project on the Promotion of RH in the Workplace, which accomplished, among others:

- The establishment of the Workplace Reproductive Health Coalitions, which was able to mobilize the support of management and employees, reaching 400 companies all over the country with a total combined reach of around 80,000 workers.
- The formulation and consequent promulgation of the DOLE National Policy pronouncement strengthening its Family Welfare Program, and making RH as one of the priority components.
- The provision of innovative and comprehensive RH/FP services for workers through the TUCP Family Welfare Clinics (FWC), which serves almost 45,000 clients.
- The strengthening of enterprise-level delivery of RH information and services via the training of peer educators in workplaces, as well as development of materials on RH for dissemination in workplaces.

The goals of Intensifying RH Programs in the Workplace are specific—first, it wants to enhance the delivery of RH information and services to 100,000 workers and employers. Second, it aims to increase the current client load of TUCP-FWCs to 40 percent through the sustained provision of quality RH care services. Third, greater focus on young workers and union members. And fourth, it should enhance the leadership capability of 80 local unions to negotiate for the integration of RH in collective bargaining agreements.

To achieve these goals, the project builds on the approaches that proved effective in the earlier project, particularly strengthening the multi-sectoral practices. The newer addition to the program is its focus on the youth sexual and reproductive health needs, through the provision of face-to-face counseling, and installation of YAPE (young adult peer educator) boxes in participating companies, so questions anonymously raised by the youth can be answered by experts. TUCP expects that the needs of at least 80 percent of the young union members could be met.

Amkor Technology Philippines (ATP), Inc.

When Amkor technology Philippines (ATP), Inc., one of the world's largest firms for semiconductor packaging and testing, started its operations in 1989, its commitment to its employees' safety and health (ESH) was already in place. With 69 percent of its 10,000 workforce being female, 51 percent of whom are below 30 years old, Amkor realized the need to protect this vulnerable group; thus, a policy on HIV and AIDS in the workplace was called for. In 2003, ATP began the implementation of its HIV/AIDS in the Workplace Policy, working with the Philippine Business for Social Progress (PBSP) to conduct HIV and AIDS awareness program in the company.

ATP's efforts go beyond its predominantly female employees, covering their dependents and the communities where their employees live. Aside from giving HIV and AIDS orientation to new employees, ATP is also providing HIV and AIDS awareness programs and offering free clinic services to its adopted communities in Muntinlupa and Biñan.

ATP's effort is further strengthened in 2005 with the implementation of A Decade of HIV/AIDS Awareness Program, which will institutionalize the company's various programs by including them in the ATP Medium and Long Term Development Plan until 2015. After 10 years, ATP hopes that it would have served at least a million beneficiaries and prevent the spread of the disease.

Acknowledging that everyone is vulnerable to HIV because of the high-risk behaviors of others, ATP believes that everyone should be involved in its prevention. This way, especially in the workplace, all sectors can help fight stigma and discrimination, and improve education to reduce their vulnerability to HIV and AIDS. Summing up the intended effect of the program, ATP hopes that each employee who participated in the program will be able to share his or her knowledge on HIV and AIDS prevention to their dependents, providing a larger scope of prevention.

F. Fisherfolks: Social Health, Environment and Development (SHED) Foundation, Inc.

The Social Health, Environment and Development (SHED) Foundation, Inc. is an NGO engaged in HIV and AIDS advocacy, education, information dissemination and training in General Santos City. Its target populations include fisherfolk, sex workers, injecting drug users (IDUs), men who have sex with men (MSM), and prostituted children.

One of the city's important most at risk groups is its large population of fishermen, among whom a mixture of mobility and disposable income makes for a tinder pot of risk. Moving from port to port, General Santos' fishermen are faced with the combination of loneliness and temptation, raising the possibility of patronizing sex workers abroad. On the other hand, with much disposable income at hand, returning fishermen become ready clients for the city's sex workers; in fact, interviews with local sex workers reveal that a significant number of their clientele are local fishermen. This risk is then transmitted to fisherfolk communities when these fishermen return to their wives, the damage exacerbated by misconceptions and false beliefs about the transmission, prevention and cure of HIV and other STIs.

SHED was influential in the successful passage in 2003 of General Santos City Ordinance Number 8, An Ordinance Requiring Compulsory Reproductive Health Education for Fishermen/Fisherfolk in General Santos City, requiring fishing companies to provide their employees with a one-day city-approved seminar on reproductive health. To enforce this requirement, the ordinance states that the seminar is a condition for the renewal of the fishing company's business license. Given the vulnerability of the fisherfolk to HIV and AIDS, this ordinance could go a long way in reducing the risks of HIV transmission among the city's mobile fisherfolk. Moreover, by educating the city's large population of fishermen, this ordinance could

help further slow down the spread of infection in the city.

To reach the fisherfolk communities, coordination with the barangay officials is needed. However, talking sex, AIDS and reproductive health with fishermen and their families is not an easy task. The problems SHED initially encountered was the lack of interest and the unwillingness of the community to talk about the subject. In this case, rapport with the barangay officials is most important as the local leaders are in a position to persuade the community to sit down and listen. Eventually, the fishing communities became more aware of the problem and took time to listen to SHED's lectures and seminars. Meeting in community plazas, gymnasiums or health centers, these seminars discussed STIs, HIV and AIDS, and their prevention. Misconceptions regarding STIs are corrected, and, if needed, those who are infected are referred to health centers or hospitals for treatment.

The biggest challenge for SHED at this point is self-reliance. To meet this challenge, SHED is studying the prospects of being a self-sustaining organization. One avenue toward this goal is to provide services for a fee. For example, since fishing companies are now required to conduct annual reproductive health seminars for their employees, SHED could offer to conduct those seminars for a fee. Another prospect involves conducting seminars or conferences on reproductive health. In other words, operating the organization like a sound firm – not for profit but for sustainability, security and self-reliance.

III. Care and Support

Despite advocacy campaigns and prevention measures, one should still expect a certain portion of the population to get infected by HIV. This is where care and support for people living with HIV and AIDS (PLWHAs) come in – to provide treatment, shelter and counseling. Care and support should also be extended to the families, friends and communities of PLWHAs to help them cope with the disease and to provide a nurturing environment for the patient.

Three organizations that provide care and support for PLWHAs and their families are profiled in this section, illustrating their focus, strategies and efforts to foster supportive families and communities that can adequately address PLWHAs special concerns.

Positive Action Foundation of the Philippines, Inc. (PAFPI)

The Positive Action Foundation of the Philippines, Inc. (PAFPI) was founded in 1998 as a community-based organization providing care and support services for PLWHAs, with several members of their staff being PLWHAs themselves. Recognizing the importance of the peer-

to-peer approach in education and counseling, the organization is fully aware of the need for greater involvement among PLWHAs, encouraging its members to become productive members of society by providing them opportunities to work or engage in its advocacy and HIV prevention projects.

Aside from PLWHAs, PAFPI also extends its education and counseling programs to members of the PLWHAs families and their partners who are also emotionally affected by the disease. Recognizing the difficulty of disclosing one's HIV status to one's family, PAFPI provides counseling for PLWHAs to smooth the progress of their disclosure. It also reaches out to PLWHAs living in the provinces who usually do not have a support system. Its peer educators and staff visit families of PLWHAs to acquaint them regarding symptoms management, and to give emotional support.

PAFPI trains the PLWHAs to become peer educators and public speakers so they may provide testimonials to various advocacy activities participated by PAFPI. Most of the PLWHA speakers of PAFPI are called "positive speakers" for having the courage to relate their stories to other people. PAFPI members often give testimonials during pre-departure orientation seminars given to overseas Filipino workers.

Since PAFPI's primary mission is to facilitate support responses to the needs of PLWHAs, it faces limitations in providing drugs and treatment to all of its PLWHA members. To meet this challenge, it established a referral system and takes great effort to maintain close linkages with various institutions (e.g., Research Institute for Tropical Medicine) which could help their members to have access to free or subsidized drugs and treatment. It also seeks funding from foreign donor institutions, which provide funds for drugs and treatment of PLWHA patients. PAFPI also facilitates the informal procurement of generic antiretroviral drugs from India since most of its PLWHA members could not afford high-priced branded drugs being sold by multinational companies.

PAFPI has established three drop-in centers, two in Manila (Abot Kamay Drop-in Center and Bahay Kanlungan Center) and one in Iloilo City. These centers provide home-based care training on how to deal with and attend to the needs of PLWHAs. The home-based care training includes counseling, prescribing practices and peer education.

Remedios AIDS Foundation, Inc. Community Support Center

To address HIV and AIDS care and support in the country, the Remedios AIDS Foundation (RAF), Inc. Established its Community Support Center (CSC) in 2001, a halfway house for PLWHAs to give them access to services, develop their potentials, train caregivers to deliver home-based care, and offer accommodation to PLWHAs coming from other parts of the country. Remedios currently has two CSCs, one based in Metro Manila and the other in Cebu City.

A relevant part of RAF's program is the expansion of care and support services to the communities, with the aim of creating a supportive and enabling environment for PLWHAs. To achieve this, RAF builds community-based coordinating teams – composed of community workers, local government leaders, social workers, and medical practitioners – for care and support services, information dissemination, home-based care, and referral systems. The volunteers undergo three levels of training on treatment including alternative therapies. The training aims to prepare the community, and provide skills to PLWHAs and their families.

While there is no documentation on its exact number of beneficiaries, RAF has identified indicators in monitoring how beneficial their CSCs are, such as monitoring the number of clients reached, a client satisfaction survey, counting number of people recruited and taking antiretrovirals, and participation in different activities.

Instead of scrutinizing the figures, however, RAF Executive Director Jose Narciso Melchor Sescon would rather look at the success of CSC via its "impact in terms of reaching family members with positive loved ones, in making them realize that life doesn't end after HIV positive diagnosis." "We've reached a lot, so we consider that somehow as a measure of success," he adds.

Precious Jewels Ministry

To provide care and support for children, particularly in reducing the impact of chronic and terminal illnesses, such as HIV and AIDS, the Precious Jewels Ministry (PJM) has been developing holistic models of care that respond to the emerging needs of these vulnerable children.

PJM is currently a partner of the DoH, San Lazaro Hospital (SLH) and the World Health Organization in implementing the pilot of Extended Child Care Programme (ECCP) in the Philippines. Since 2002, PJM has been responsible for the overall program and services of SLH's Extended Child Care Center (ECCC), which has an innovative program that recognizes the need of children to receive ongoing stimulation, nurture and protection while they or their parents are in the hospital. ECCP attempts to minimize the impact of hospitalization on a family by enabling the children and parents to remain together during times of crisis and illness.

With ECCP, PJM intends to develop a framework and associated plan of action for the development of extended community interaction between hospitals and selected communities when dealing with priority public health needs

More recently, Crossing Borders (CB) was formed as an initiative to develop a strategic plan of action for integrated care for children and families affected by HIV and AIDS through a collaborative partnership among medical practitioners and child welfare advocates.

CB unites the efforts of the SLH, Research Institute for Tropical Medicine (RITM), the Philippine General Hospital (PGH), and the Precious Jewels Ministry. While the PGH, SLH and RITM have been providing care and support services for PLWHAs, the special needs of children affected by HIV and AIDS is still largely unaddressed. PJM fills this imbalance in the equation.

CB initially targeted 50 families, with 20 children given anti-retroviral therapy (ART) in its first year of application, with the figure increasing by 25 families for the next two years. In a way, monitoring of these families is an indicator used to measure the project's success, along with training of service providers and caregivers, clinical care management with CRC, counseling of pregnant or post-partum HIV infected women, following up on children below 18 months born to HIV infected mothers, setting of database, establishment of referral system, and developing policy guidelines on the care and treatment of affected children in the Philippines.

Other PJM efforts include the opening of a respite care home in 1995 to specifically respond to children affected by HIV and AIDS. This program, developed to satisfy the needs of children confined in SLH, provided temporary shelter, medical treatment, special education, and play therapy to children whose families were in crisis due to chronic or terminal illnesses or medical emergencies. At the same time, PJM started providing hospice care through bedside care, as well as offering emotional support and counseling to family members, which, in the long run, resulted to the holding of the annual Summer Kids Camp for vulnerable children. Another program that continues to this day are the workshops on AIDS education and prevention for various groups.

"Ultimately, it is the children who draw us together. They want to laugh, play, (and) go to school. (And) they look to us – doctors, nurses, social workers, families and friends – trusting that we will care for them and help them to live," says Lorraine Anderson, PJM Executive Director. "The challenge… is to work and learn together, share our resources and experiences to help create a world fit for children."

Chapter

III

What We Need to Know and Do

The first two chapters of this Country Profile outline what we know about HIV and AIDS in the Philippines, and the responses that constitute "Good Practices" in the areas of prevention, advocacy, treatment and care. Clearly, there are still many gaps in what we know, and what we need to do. This chapter emphasizes the areas that will need more attention as we try to keep the pandemic within manageable limits.

Epidemiology

Some of the more cynical observers of HIV and AIDS in the Philippines attribute our "low and slow" prevalence to under-reporting. But many of the observers are unaware that there is in fact quite widespread testing in the Philippines, with about 600,000 tests conducted each year, according to the Department of Health. Of these 600,000 tests, 75 percent are conducted by private institutions, mostly among overseas workers. Government HIV testing is conducted mainly by Social Hygiene Clinics among female sex workers. It would be useful to the HIV and AIDS networks if we know how many tests are conducted by these different agencies and how many positive results are produced, with a breakdown by age, sex and occupation and the probable means of transmission.

Since many of the tests are conducted among groups that do face higher risks for HIV transmission (e.g., sex workers), it would also be useful to have antenatal testing to assess the extent of infections in the general population. Such testing is expensive—up to one million pesos per site per year for a sample of 300—so it has been discouraged for countries with a low prevalence, but we may get to the point where such tests will be needed as a monitoring tool.

Social and Behavioral Studies

In our review of the literature for this country profile, we found a serious dearth of socio-behavioral studies relating to HIV and AIDS. Ongoing behavioral surveillance yields some data but these are limited to general knowledge and awareness about HIV and AIDS and the use of condoms.

What we sorely lack is information around the circumstances of risk behavior, and what people do to reduce their risks. The lack of information is particularly strong in certain areas, described below:

Substance abuse. The main concern with substance abuse, in relation to HIV and AIDS, has been injecting drug use because this is a mode of direct transmission for HIV. There are sporadic reports of injecting drug use in Cebu and General Santos involving Nubain (nalbuphine) and Sosegon, but it is not clear how much this is actually contributing to HIV and AIDS in the Philippines.

Much less attention has been given to the possible contribution of different forms of substance abuse to sexual risk behavior. Amphetamine abuse, mainly as shabu (crystallized metamphetamine), is a serious problem in the Philippines. The use of such drugs could affect judgement, inducing users to take greater risks. Shabu also delays ejaculation and suppresses pain—factors that could contribute to anal sex. Moreover, there are now reports of shabu being injected, the crystals mixed with intravenous fluids (sodium chloride in water). If this practice spreads, it could become a new route for HIV transmission.

Men who have sex with men. Because of the tendency of scapegoating gay men, many programs have emphasized that HIV and AIDS is a "heterosexual" epidemic. This has been counter-productive in the way it denies the needs of gay men and men who have sex with men. About a fifth of reported HIV and AIDS cases are associated with men who have sex with men. The term itself is used to refer to the rather ambiguous situation, where even *lalake* ("straight men") will have sex with the *bakla* (often mistranslated as "gay", when in fact *bakla* is a distinct gender category referring to effeminate men). FHI recently studied MSM networks and found these to be rather elaborate, extending across many private and public places, yet little effort has been made to reach people in these settings.

Overseas workers. A third of reported HIV cases come from the ranks of overseas workers. We see from the figures that these are not limited to the usual stereotypes of seafarers and women sex workers. In its September 2005 monthly report, the government's HIV and AIDS Registry notes that of the cumulative total of 2,354 HIV seropositive cases reported to the government, 797 (34%) were OFWs, "of which 282 (35%) were seafarers, 132 (16%) were domestic helpers, 69 (9%) were local employees, 62 (8%) were entertainers and 56 (7%) were health workers."

The figures should lead us to question some of the stereotypes of HIV vulnerability, which among overseas workers tends to be perceived as one limited to seafarers and entertainers. The actual infection cases show that even domestic helpers and health workers are getting infected. We need to know why this happens, although Tan notes that there may be paradoxes involved here, where entertainers, precisely because they are sex objects, are actually protected because it is in the interest of their managers to make sure they remain free of infections. Seafarers, on the other hand, see sexual adventurism as part of machismo and their entitlement, and may therefore take greater risks.

Research into risk-taking behavior of overseas workers should take contexts into consideration. At the height of the Iraq war, there were still Filipinos smuggling themselves into Iraq despite warnings and bans on deployment to that country. When asked why they were doing this, they said the risk of being killed in Iraq was still worth it when compared to the risk of families starving back in the Philippines. Given such perceptions of risks, it should not be surprising that sexual risks are probably taken all the time, perhaps perceived as minor compared to the many other problems faced by overseas workers.

Transactional sex. Numerous studies have been done on sex work, especially those involving female sex workers. This usually involves women in establishments (e.g., bars, brothels, massage parlors) where the sex work involves financial payments. Yet there is reason to believe that much of the high risk sexual activities may be occurring outside of the formal sex work industry.

In a survey of over 1,200 men in health facilities in the Philippines, just six percent of adult men said they had bought sex in the past six months (Wi, Saniel et al., 2002). The six percent figure could translate to large numbers of men, but we also need to be more alert to transactional sex, which refers to a broader category of sex work where the favors may not be overtly financial, usually in the form of "gifts". People engaging in transactional sex may do this irregularly, such as students who need to pay their tuition (thus "prosti-tuition"), waitresses in some restaurants, or young men who want a night of drinks or extra money to spend and offer sex to the neighborhood *bakla*. Even if money is involved, note that the exchange is for "tuition" or for "drinks", and is not seen as actual payment for sex. Both clients and the person offering the sex may not think of their transaction as "commercial sex" and may therefore be less inclined to take precautions.

To some extent, there is overlap between financial sex work and transactional sex. A study revealed that women sex workers will sometimes go into a relationship with frequent customers. In such a relationship, they may not use condoms, looking at the customer as a "boyfriend". Similar relationships may develop with transactional sex, and open the parties involved to risks for HIV and other STIs.

Casual sex. This is an area about which we have almost no research at all. In the qualitative research of YAFS, some of the preliminary data suggest that casual sex is practiced by young people and often with no protection. In HAIN's research among young adults in an urban poor community, the young men consistently talked about "pok pok"—young girls who offer sex for free. They are known to have multiple sex partners but because the "pok-pok" is now differentiated from the "GRO" (guest relations officers) or sex workers, the men do not see a need to use condoms. Since casual sex is more accessible for young people than sex work, the risks for STIs and HIV may be higher than with commercial sex.

HAIN's research among young adults also found casual sex among urban migrants. For females, these include large numbers of domestic helpers and factory workers (especially in export processing zones). For males, these would be houseboys, drivers, security guards and construction workers. Free of their families and nosy communities, these young migrants are quick to establish sexual relationships. Whether casual or with some element of commitment, condoms are almost never used here because there are no sex education programs or reproductive health services for these migrants.

Again, it is important to look at how the contexts or settings determine whether or not precautions are taken. FHI's *AIDS in Asia* notes that "in Vietnam, most sexually active migrant workers in seven cities reported sex with 'lovers', and, although consistent condom use with sex workers was between 55 percent and 75 percent in most sites, condom use with 'lovers' was below 10 percent in all but one city."

Finally, mention should be made of the way the opportunities for casual sex in the Philippines (as in many countries) have increased with the advent of internet chat rooms, where people may feel more emboldened to make new contacts than if they were in a bar, a party or out in the streets. These chat rooms often provide opportunities as well for "eyeball" parties, where the participants can meet in person.

Nonconsensual sex. Little attention has been given to circumstances that force people to have nonconsensual sex. HAIN's research among young adults found young men boasting about their "tira-maid" exploits, meaning sex with domestic helpers (rural women who may be unable to refuse the sexual advances of their employers or employers' sons). These have on occasion led to cases of pregnancies and sexually transmitted infections.

There is a fine line between "consensual" and "nonconsensual sex". Again, in HAIN's research, a young woman may go into a committed non-sexual relationship with a boyfriend, with the boyfriend eventually insisting on sex. There may not be actual force here but the circumstances may limit the young woman's ability to refuse. Young males with more sexual experiences (read exposure to different partners) are more adept at this seduction, which further increases

Public Policy and Practice Issues

The UNGASS Declaration of Commitment on HIV/AIDS names 11 broad areas for action in the battle against HIV and AIDS:

1. Leadership at the national level
2. Prevention
3. Care, support and treatment
4. HIV and human rights
5. Reducing vulnerability
6. Children orphaned and made vulnerable by HIV and AIDS
7. Alleviating social and economic impact
8. Research and development
9. HIV and AIDS in regions affected by conflict and disaster
10. Resources
11. Follow-up

When planning for the good practices to be included in this Country Profile, we found the majority was in the area of advocacy and prevention. The areas of treatment and care and VCT (voluntary counseling and testing) were poorly represented simply because there aren't many groups working in these areas. Even within the domain of prevention, there is practically nothing being done in terms of prevention of mother-to-child transmission (i.e., giving antiretrovirals to pregnant women who are HIV positive, to prevent the transmission of HIV to the fetus). This may reflect the fact that we are still in a low and slow stage, but underscores the need to anticipate the epidemic by learning from the experiences of the groups that are already working in these areas. Some areas, such as caring for AIDS orphans and alleviating social and economic impact, are being handled quietly and on a small scale by one or two NGOs, again reflecting the still low and slow epidemic in the country.

The analysis here of good practices focuses on the three areas—advocacy, prevention, treatment and care—for which we have more case studies.

Prevention

From the good practices, we are seeing that prevention involves more than HIV and AIDS lectures. A package of services needs to be offered to tackle the contexts of HIV and AIDS. With overseas workers, for example, their concerns are still primarily work-related so education around HIV and AIDS needs to address those work-related issues.

The KAP gap, meaning the gap between knowledge and practice, is now well known. No longer can we be satisfied with reports claiming an improvement in knowledge levels. These levels can actually deteriorate with time, if information and education campaigns are not sustained. We have cited data from the Young Adult Fertility and Sexuality study (YAFS): during the 2nd round in 1994, they found that 12.5 percent of young people thought AIDS was curable, while in the 3rd round in 2002, they found the figure had increased to 27.8 percent. What probably happened here was that mass media was coming out with news about new antiretrovirals, which do not cure AIDS but slow down HIV replication. Without adequate information campaigns, this distinction between "curing" and "slowing down" is not reaching people, and is creating a false impression that AIDS can be cured.

The KAP gap can be very complicated as shown by a study of young Filipina migrants in Australia. Although family planning services are widely available in Australia, the study found that young Filipinas are still unable to access these services because they encounter barriers in discussing sex with their parents or other community members. The concern with family honor and shame means silence around sex, contraception and prevention of sexually transmitted infections; thus, the women are unable to get practical advice about services. (Lenore Manderson, Margaret Kelaher, Nicole Woelz-Stirling, Joy Kaplan, Kirsten Greene, 2002.)

The situation in the Philippines itself would be even worse because accompanying the silence in families about sexual issues is the lack of accessible reproductive health services. This problem of access could worsen with the increasing dominance of conservative politicians and policy-makers.

Family Health International (FHI), in its report *AIDS in Asia* (2005) identifies the following features of effective prevention programs:

1) They address the specific behaviors that are causing most infections and provide specific services to reduce the risk of those behaviors. Programs to encourage men to use easily available condoms in commercial sex are the most common of these, but there are encouraging examples of success in increasing the use of clean needles among intravenous drug users.

2) They provide access to information and services on a scale large enough to make an impact on HIV transmission. Prevention efforts are successful if they change behavior on a national or regional scale.

3) They ensure that the social, political and security environments support the provision of appropriate HIV prevention services to those most at risk, allowing them to adopt safer behaviors. People will not use prevention services if using those services puts them at risk in other ways—for example, being arrested or stigmatized in ways that threaten their livelihoods. Successful prevention programmes have worked with law enforcement, social services, sex industry power-brokers and others to ensure that those in need of services are supported in protecting themselves and others from HIV.

Voluntary Counseling and Testing

This is a very weak area in the Philippines given the way testing has been identified with almost mandatory testing, as with the permits obtained by “entertainment workers” from Social Hygiene Clinics. Nevertheless, it may be worthwhile looking at the experiences of these Social Hygiene Clinics, and whether the testing has been accompanied by counseling and education, to help sex workers become more conscious of their risks.

Wi, Ramos et al. (2003) offer some interesting insights into testing for STIs, noting that in the Philippine setting, investment in simple laboratory tests has improved diagnosis, reduced incorrect and unnecessary treatment, and contributed to a reduction in STIs. This is important given the strong tendency to over-diagnose (using generic terms like *tulo* for any urethral discharge) and self-medicate. Wi and her associates did in fact find that in Angeles City, there was no correlation between self-reported symptoms of STIs and

laboratory diagnosis among female sex workers; that is, "syndromic management" may not be appropriate. Access to more accurate laboratory tests would be more appropriate.

Treatment and Care

There is still much that needs to be done in terms of treament and care for people with HIV. For example, at present only one hospital in the entire country—the Philippine General Hospital—accepts mothers with HIV for delivery. In-patient facilities for patients with HIV and AIDS, on the other hand, are still limited to a few hospitals such as San Lazaro Hospital and the Research Intitute for Tropical Medicine (RITM) Hospital.

Access to medicines is a perennial problem for people living with HIV and AIDS. The medicines are not readily available and are expensive where they are in stock. The case of access to medicines highlights the need for community empowerment. There is a tendency to equate access with getting free drugs from government. As HIV and AIDS spreads, the limits of government will become more acute and people living with HIV and AIDS will have to find other ways of coping. This is already happening in the Philippines, with about 100 people with HIV working through Positive Action Foundation of the Philippines, Inc. (PAFPI) and Pinoy Plus Association to get their own supplies of antiretrovirals. The Department of Health is looking for antiretrovirals for another 500 patients, but this would cost 20 million pesos a year.

Using alternative and complementary medicine as support therapy also has potentials in reducing the costs of HIV treatment. Patients need to be educated on where to access medicines, especially generic ones, since the Department of Health offers lower-cost medicines in some of its hospitals.

We should be careful, though, not to use alternative and complementary medicine as the solution to the lack of access to antiretrovirals and other essential drugs. Issues of intellectual property rights, industry structure and government policies need to be confronted especially in the Philippines, where medicine costs are among the highest in the region. It is not surprising that Filipinos living with HIV and AIDS have had to establish their own networks and channels for obtaining low cost medicines, sometimes from countries like Thailand, where drugs are more affordable.

Advocacy

In the area of HIV and AIDS, the Philippines can pride itself with having strong multisectoral coordination, involving government, civil society and, to some extent, the private sector. This strong multisectoral coordination, reflected by initiatives such as the Philippine National AIDS Council and the AIDS Prevention Act (Republic Act 8504), has been cited as one possible reason for the low and slow HIV epidemic.

These initiatives would not have been possible without active advocacy efforts from the different sectors. At times, the "pressure" has come from government and at other times, from civil society (especially from organizations of people living with HIV and AIDS).

The need for continuing advocacy remains. During the 7th International Conference on AIDS in Asia and the Pacific (ICAAP) in Kobe, the various acronyms for international HIV and AIDS programs were discussed, from UNGASS to GIPA (Greater Involvement of People with HIV and AIDS), often with impatience as gaps were described. Thus, while it was noted that in Asia the number of people receiving antiretroviral (ARV) therapy increased from 55,000 to 155,000 in the past year, this still represents a small fraction of the number of people who do need the drugs. More or less, only one out of every six persons living with HIV and AIDS in Asia is taking ARVs.

We see that advocacy relates as well in many vital ways to prevention and care and support. In the section on prevention, we noted Family Health International's observation that a supportive social and political climate is also needed for effective prevention. The drift to conservatism of the United States government, with insistence on "abstinence only" programs, has international repercussions as well, with dwindling support for programs that talk more candidly, and realistically, about sex. The United States government has also opposed programs that supply clean syringes and needles to injecting drug users (on grounds that this seems to promote or encourage drug use) and programs that reach out to sex workers (on grounds that this encourages prostitution). The impositions have reached the point where one country, Brazil, decided to turn down funds from the United States that had such conditionalities.

Advocacy efforts need to be more evidence-based, drawing on research findings. For example, the behavioral surveillance program shows a decline in consistent condom use among brothel-based sex workers in the Philippines, from 41 percent in 1997 to 30 percent in 2002 (cited in FHI, *AIDS in Asia*, p. 34). We need to ask: What are the reasons for this decline, and what will happen if this decline continues?

The social and behavioral research needed to guide advocacy and policy has to go beyond measurements of "sex acts" or even of condom use, and should probe more deeply into processes involved and outcomes from programs.

The use of scientific research, especially one that probes adequately into contexts, is important to show what works and what does not work among prevention programs. Much has been said, for example, about abstinence-only programs as the only way to prevent HIV transmission. Yet, a recent review of the evidence coming out of Uganda, where these abstinence-only programs were strong, showed that much of the decline in AIDS cases occurred more because of the number of people with AIDS who had died than abstinence and monogamy campaigns.

In another study, conducted in the United States, researchers found that teenagers who took a one-time pledge to keep their virginity until marriage actually caught sexually transmitted infections as often as those who did not pledge abstinence. The reason for this is that the virginity "pledgers" were less likely to use condoms. The study reminds us of similar moralistic denial in the Philippines, where young people will claim to believe in virginity and will then be caught unprepared when the occasion for premarital sex comes up, making them more vulnerable to pregnancies and sexually transmitted infections. Young people who are honest about their sexuality, on the other hand, will not necessarily engage in more sex—they will simply be better prepared.

Certainly, in the Philippine context, more attention needs to be given to the possible consequences of the conservative backlash. Already, non-government organizations in Manila are talking about closing shop because the conservative mayor, Lito Atienza, has warned them against promoting condoms. Atienza has already banned "artificial contraceptives" from health centers operated by the city government.

Advocacy among faith-based institutions will be vital to reverse the growing conservative backlash, one which contributes to the HIV and AIDS epidemic's spread. Within the Catholic Church itself, there are theologians and moral ethicists who argue that condom use is acceptable if one's sexual partner is infected with HIV. In such cases, it would be unjust to prohibit condom use, opening one partner to infection.

The conservative backlash has targeted reproductive health in particular, lashing out at family planning, sex education, and HIV and AIDS prevention, among others. The fact that conservatives recognize these linkages among different components of reproductive health should remind HIV and AIDS advocates that much needs to be done as well to integrate HIV and AIDS activities with the other reproductive health elements, if not health care in general. Providing sex education, for example, to such vulnerable groups as domestic helpers will help to prevent not just HIV and AIDS but also unwanted and early pregnancies.

Acronyms and Action

Through the years of the pandemic, we have seen the rise (and, often, the fall) of many acronyms and abbreviations relating to HIV and AIDS. Over the last three years or so, the most frequently cited have been those of UNGASS and the Three Ones, as well as the World Health Organization's "3 by 5".

Many of the international agencies' initiatives have been important. The "3 by 5" initiative, although limited in its scope, did push some governments into looking for ways to increase access to antiretrovirals. Although the Philippine government has been unable to provide subsidized antiretrovirals, health officials are looking for ways through which this might be done in the future, perhaps through PhilHealth.

On the other hand, the Three Ones—emphasizing the need for unified coordination, monitoring and evaluation—is certainly not new to the Philippines. We were one of the first countries to establish a multisectoral national body—the Philippine National AIDS Council (PNAC)—to help craft policies and programs. PNAC, with a secretariat based at the Department of Health, continues to play a lead role in the area of HIV and AIDS.

During the 7th ICAAP, much criticism was raised about "top-down" processes in HIV and AIDS programs, including the international initiatives and projects. At the conference, Periasamy Kousalya, coordinator of the Positive Women's Network of South India, described how the initiatives of community-based organizations eventually pressured local governments in India to roll out antiretroviral medicines and to institute mother-to-child transmission prevention programs. She said there was a need to "build a critical mass of community leaders" before moving on to national and international levels.

Kousalya's points were well made and we need to think of the processes involved in the Philippines. In documenting our good practices, we noted with some concern that many of these projects were initiated by foreign donors, with serious questions about sustainability after donors end their funding. Even where local initiatives were found, we also worried that these were really more "mayor-initiated", there because the mayor was supportive. A change in administration, or even new advisers whispering into the ear of the mayor, could turn the tide against HIV and AIDS programs.

Program effectiveness depends so much on processes, on how a sense of ownership is built by involving communities and different sectors of society. Without this sense of ownership among stakeholders, programs run into problems of sustainability. One of the good practices we looked at involved "100 percent condom use", which program implementers said was possible when they were still being supported by donors. Now, the condoms have run out, and they are a long way off from 100 percent. Their town is described in an internet website as a place where tourists can get sex workers who do not insist on using condoms.

In the Philippine context, the question as to why we were low and slow for such a long time continues to intrigue us. Clearly, there can be no single answer—biological, social or behavioral—to explain the epidemic's course in the Philippines, but the worst thing that can happen is to be lulled into complacency especially as the epidemic has now become "hidden and growing". UNAIDS director Peter Piot recently described the HIV and AIDS epidemic in the Philippines to be indeed hidden and creeping, only to become visible when it is too late.

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