

THE PHILIPPINES

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Current State and Future Projections of the Spread of HIV/AIDS

State of the Epidemic

Health experts have described the prevalence and growth of HIV/AIDS in the Philippines as low and slow (Tacio 2005; Mateo et al. 2005; HAIN 2003). Since 1984, when the first case of HIV/AIDS was documented with the death of a foreign national, there has been, as of March 2005, an incidence of only 0.01%, or 2,250 cases in a population of nearly 85 million. To the average layperson, the figure is not a source of concern, especially when compared with the figures of some neighboring Asian countries or when set side by side with the more daunting figures of two other communicable diseases, tuberculosis (TB) and malaria. According to the Department of Health (DOH), TB kills 75 Filipinos every day; while figures from the World Health Organization (WHO) showed that there were 43,644 malaria cases registered in the Philippines in 2003 alone (WHO 2005).

Local and international experts have been baffled by the low prevalence and slow growth of HIV/AIDS in the Philippines because the conditions that can make the situation explosive are present. In its 2002 report, the DOH's National HIV/AIDS Sentinel Surveillance System (NHSSS) attempted to offer some possible explanations: (a) the network of sex workers is not as extensive as those found in countries with high HIV prevalence; (b) the

rate of injecting drug use is low, although other types of drug use might be more prevalent; (c) the number of clients seen by sex workers per night is lower than in Thailand and Africa; (d) social hygiene clinics are available to regularly examine and treat infected establishment-based female sex workers; and (e) there have been early and accelerated multisectoral responses mounted against the threat of HIV/AIDS. The report says that the low rate of prevalence may also mean that the virus has not yet reached the critical level in the population to promote a rapid spread, and it is believed that the disease is concentrated in vulnerable groups (Mateo et al. 2005).

The low figures might also be the result of inadequate data capture, as reporting is done primarily through a passive surveillance system, the HIV/AIDS Registry, which logs chiefly Western blot-confirmed HIV cases reported by hospitals, blood banks, laboratories, and clinics. In addition, data input to the registry is limited because of the prohibition against mandatory HIV testing; thus it may not be sensitive to potential cases.

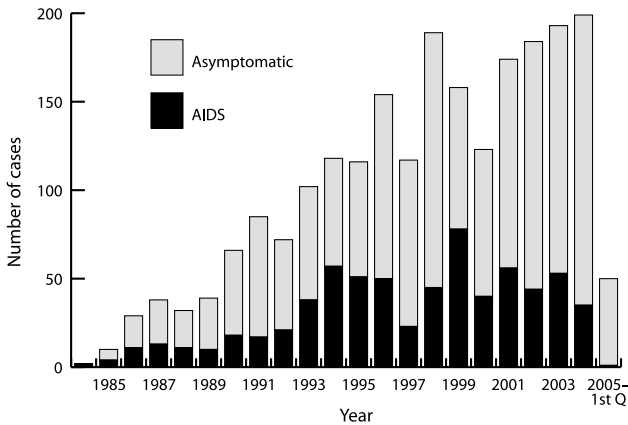
Two other possible reasons cited by the *HIV/AIDS Country Profile Philippines, 2002*, are the archipelagic nature of the country, which slows down the movement of people, and its detachment from mainland Asia, which may have helped shield it from the rapid cross-transfer of the epidemic (HAIN 2003).

Because of this low prevalence, the general public and the bureaucracy tend to view the problem as a low priority. Consequently, funds are not allocated for HIV/AIDS and go instead toward supposedly more urgent purposes like schools, infrastructure, and livelihood opportunities. But the low figures can give a false sense of security, for behind such impressive numbers, health experts agree, may lie a danger that is hidden and growing. They warn that such figures may not last long because the current epidemiological picture shows evidence of high-risk situations and practices that could lead to a growing epidemic. These include, according to the NHSSS, a high rate of sexually transmitted infections (STIs), consistently low condom use rates among sex workers (less than 30%), the increasing practice of anal sex, the trend for people to become more sexually active at a younger age, and the sharing of needles among injecting drug users (IDUs). Thus the impressive statistics may represent the calm before the storm. There may be a "tsunami" of AIDS heading this way. Indeed, the Philippine National AIDS Council (PNAC) is convinced that for every case documented, the

government is most likely missing three or four more cases. Jean-Marc Olivé, WHO representative to the Philippines, echoes that opinion and believes that the number of individuals in the Philippines already infected with HIV/AIDS is somewhere between 6,000 and 10,000 (Tacio 2005). Many victims are unwilling to be tested; hence, data from the country's approximately 500 testing centers (comprised mainly of blood banks and testing centers for overseas workers) and ten sentinel sites covered by the NHSSS are reflective only of the vulnerable groups that have been willing to be tested and do not reveal the velocity of transmission.

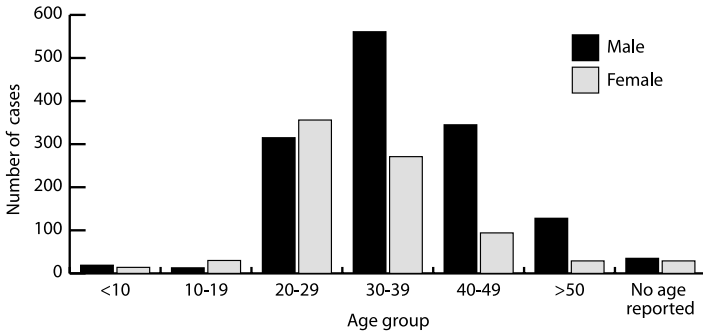
A 2005 report published by the National Epidemiology Center of the DOH (2005) summarizes the current state of the epidemic. From January 1984 to March 2005, there were 2,250 HIV Ab seropositive (i.e., HIV-positive) cases reported, of which 1,570 (70%) were asymptomatic and 680 (30%) were AIDS cases (see fig. 1). As shown in figure 2, roughly 69% (1,504) of those testing positive were between the ages of 20 and 39, while 63% (1,416) were male. Sexual intercourse (84%) remained the primary mode of transmission (see table 1). At the time of the report, a total of 266 individuals had already died due to AIDS-related complications. In the month of March 2005 alone, when the report was issued, there were 19 new HIV-positive cases reported (although no cases of AIDS), and those cases demonstrated similar patterns in terms of gender, age, and transmission modes, and a slight rise from the previous year's average monthly number of cases.

Figure 1. HIV-positive cases, January 1984–March 2005



Source: DOH (2005).

Figure 2. HIV-positive cases by gender and age group, January 1984–March 2005



Source: DOH (2005).

Note: There were 11 cases that had no reported age and/or gender and are therefore not included here.

Table 1. Reported modes of transmission, January 1984–March 2005

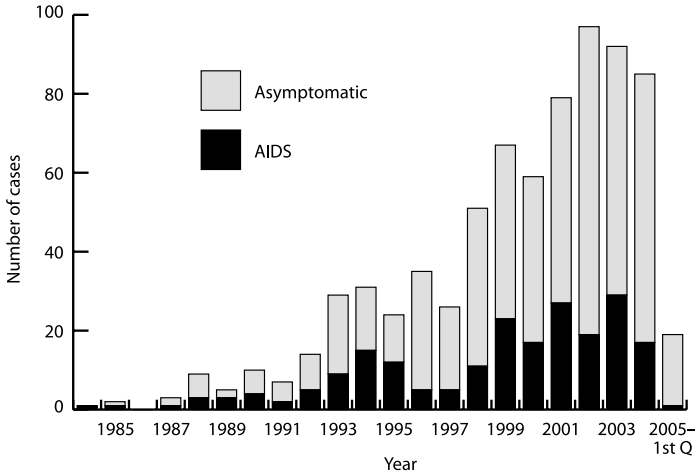
Reported mode of transmission	Cases
Sexual	
<i>Heterosexual contact</i>	1,388
<i>Homosexual contact</i>	389
<i>Bisexual contact</i>	118
Blood/blood product	19
Injecting drug use	6
Needle prick injury	3
Perinatal	33
Not reported	294
Total	2,250

Source: DOH (2005).

Of the 2,250 HIV-positive cases, approximately one-third (745) were overseas Filipino workers or OFWs (fig. 3), including seafarers (36%), domestic helpers (17%), health workers (9%), and entertainers (7%). As with the overall cases, those infected were predominantly male (75%), and as shown in table 2, sexual intercourse was the leading mode of transmission for both sexes (92%).

Among the general population in the Philippines, the awareness of the disease is high at 90%, as revealed by most surveys. This is attributed to media publicity and the availability of information, education, and communication (IEC) activities and materials. But this high level of awareness has

Figure 3. HIV-positive cases among OFWs, January 1984–March 2005



Source: DOH (2005).

Table 2. Reported modes of transmission among infected OFWs, January 1984–March 2005

Reported mode of transmission	Cases
Sexual	
<i>Heterosexual contact</i>	533
<i>Homosexual contact</i>	110
<i>Bisexual contact</i>	40
Blood/blood product	10
Injecting drug use	1
Needle prick injury	3
Not reported	48
Total	745

Source: DOH (2005).

not necessarily translated to behavioral change or the adoption of effective preventive measures, and it has not changed prevailing attitudes, beliefs, and practices. Many people, even among vulnerable groups, continue to have misconceptions about the disease, believing it can be treated by a concoction of drinks, or can be prevented through the use of detergents as a douche, the use of antibiotics as prophylactics, coitus interruptus, washing of the penis, etc. Not a few insist they are invincible, convinced as they are that “the disease can happen to others but not to me.” About 60% of the

youth surveyed in the Young Adult Fertility Survey (YAFS) believed there is now a cure for HIV/AIDS and have therefore become lax and complacent (Esguerra 2005; HAIN 2003). And while a majority of registered and freelance sex workers sought medical help from social hygiene clinics, and men who have sex with men (MSM) have relied on advice from friends, other vulnerable population groups have not been known to engage in positive health-seeking behavior. Young people, out of embarrassment, often do not report reproductive health (RH) problems. According to one survey, "Of the 2,424 young males who had any serious RH problem, only 22 percent (533) sought medical attention. Many teenagers are ashamed to admit having RH-related problems, making them unlikely to seek advice from medical personnel" (HAIN 2003).

Table 3. Health-seeking behavior of sentinel groups

Source of information or treatment	Registered female sex workers (%)	Freelance sex workers (%)	MSM (%)	IDUs (%)*
Social hygiene clinic	65	39	19	—
Private doctor	19	15	32	40
Hospital	7	7	17	7
Friend or relative	18	23	40	60
Co-worker	14	9	22	13
Pharmacy	11	14	15	40
Self-medication	13	26	25	—

Source: HAIN (2003).

* In Cebu only.

Thus the big challenge in HIV/AIDS prevention is moving from simple awareness to effecting behavioral change. This involves overcoming misconceptions and promoting such safe-sex practices as fidelity and responsible behavior, including the use of condoms (HAIN 2003).

Populations Most Vulnerable to the Disease

In an interview for this study, Dr. Roderick Poblete, director of the PNAC, pointed to five groups that are most vulnerable to HIV infection—women, young adults, MSM, sex workers, and OFWs. The characteristics of each group were described in the *HIV/AIDS Country Profile Philippines, 2002*, and this section paraphrases that description (HAIN 2003).

Women—Women tend to be vulnerable to HIV/AIDS as a result of various physiological, socioeconomic, and cultural circumstances. Women are less capable of protecting themselves or negotiating for safe sex—a factor that applies to female sex workers negotiating with clients as well as to women in general who may be put at risk by their partners' risky behavior. A 2001 study conducted in three major cities in the Philippines found that about 40% of women respondents lacked the confidence to ask their regular partners to use condoms even if they had adequate knowledge of HIV/AIDS and other STIs. About 43% of them admitted to having been forced into sex at times, and 15% believed it was their "obligation" to have sex with their partners.

Young Adults—The 3rd YAFS study, conducted in 2002 by the University of the Philippines Population Institute, showed that young adults have liberal attitudes on sexuality and sexual practices. At the same time, unfortunately, they still seem to have poor knowledge about STIs and AIDS. One-third thought AIDS can be cured, and a large proportion thought that they were not vulnerable to the disease. This was confirmed by another study, conducted in 2000 among third- and fourth-year students (18–22 years old) in Manila universities to identify their level of knowledge, attitudes, and perceptions about HIV/AIDS and other STIs. That study found that, despite better knowledge about transmission and prevention, misconceptions and risky behavior were still present. Premarital sex and inconsistent condom use were common. Condoms were used only during intercourse with sex workers (and even then, not consistently). The combination of immature sexual attitudes and lack of information places young adults at a risk of contracting HIV/AIDS, and efforts by conservative lobbies to stifle sex education in schools does not help in reducing the risk.

Men Who Have Sex with Men—More than 20% of all reported HIV cases in the Philippines involve male-to-male transmission. The actual rate, however, could be much higher since the stigma attached to homosexuality prevents many men from admitting that they have engaged in homosexual activity or from coming out to their families and work colleagues. Discrimination, harassment, and outright physical violence against homosexuals still occur in the Philippines. Moreover, religious attitudes labeling homosexual

acts as “sinful” perpetuate the stigma. As a result of these conditions, many MSM live in the shadows, maintaining their anonymity by keeping sexual relationships casual and discreet. This very secretiveness, however, hinders access to HIV/AIDS information, education, and treatment, leaving MSM at a high risk of contracting HIV/AIDS.

Sex Workers—The illegal status of sex workers hinders their access to information on RH and STIs, health services, and education programs, increasing their vulnerability to infection. Moreover, this makes them unable to negotiate for safe sex and impose safe sexual practices on their clients. A 2000 Health Action Information Network (HAIN) study titled “A Matter of Time” revealed different risk levels among various types of sex workers. Women and child sex workers were more susceptible to infection than males because of a lesser ability to negotiate for safe sex. On the other hand, freelance sex workers and male sex workers were getting little information on HIV/AIDS because there were few information programs that targeted them.

The practice of issuing certificates to entertainment establishments that ensure clients of “wholesome” and “sanitary” services was questioned since sex workers and establishment owners may conceal risky behavior and infections to get their certification. Clients who perceive these places as being free of HIV/AIDS or STIs may be lulled into a false sense of security by these certificates and thus unwittingly engage in risky behavior.

Overseas Filipino Workers—Current statistics indicate that about 30% of Filipinos infected with HIV are OFWs. The vulnerability of migrant workers is determined and influenced by several factors, including limited knowledge about HIV/AIDS, low condom use, poor health-seeking behavior, and an attitude of invincibility toward HIV/AIDS. A gap between knowledge and behavior has also been reported. The everyday reality of their lives, such as emotional loneliness caused by being away from home, cultural adaptations, and difficult working conditions, also contributes to their vulnerability.

The lack of knowledge about HIV/AIDS among seafarers, combined with their high-risk sexual practices, put them at a particularly high risk of contracting HIV. About 20% of the 1.2 million seafarers worldwide are

Filipino. In 1996, there were 307 shipping companies deploying 200,000 Filipino seamen. Macho values—including a belief that it is natural for them to “taste” women at every port—put seafarers at risk. Commercial sex workers (CSWs) are present in almost every port and are sometimes brought on board. But according to a study by the Department of Labor and Employment’s Occupational Safety and Health Center, only 49% of seafarers practice safe sex.

With the increasing number of OFWs who are HIV-positive, serious attention should be given to protecting them and reducing their vulnerability. Social welfare institutions must be equipped to respond to the needs of those infected and to prevent infection among those who are about to leave.

Social and Economic Impact

The interaction between HIV/AIDS and the Philippine economy, development, and social life may be described as a two-way process, albeit uneven. The lack of development increases vulnerability and susceptibility to the disease, while the disease itself negatively impacts development.

The impact on the macro level seems to be minimal, owing to the low prevalence rate. As far as employment and productivity are concerned, for example, there is a large pool of untapped labor so that any loss of manpower because of the disease is scarcely felt—for every individual who is unable to join or is forced to leave the labor force owing to the epidemic, several replacements are readily available. In the case of OFWs, for example, 745 cases of HIV/AIDS out of 8 million workers can hardly be seen as alarming.

In fact, as mentioned earlier, it is believed that TB and malaria, if unattended, can have a more negative impact on the economy and development than HIV/AIDS. Reports from the DOH show that TB kills 75 Filipinos a day. It is the sixth leading cause of mortality and morbidity in the country. While there have been favorable figures in detection and cure (61% detection and 77% cure rates versus targets of 70% and 87%, respectively), the Philippines still has the ninth highest rate of TB in the world and the third highest in the Western Pacific region. Malaria, on the other hand, is the eighth leading cause of morbidity in the Philippines. Data from the WHO’s Rollback Malaria Monitoring and Evaluation program show that over a 10-year period, 90% of cases on average are found in 25 of the 65 endemic

provinces. In 2003 alone, there were 43,644 cases of malaria reported in 15 provinces. The disease affects the poorest in the country and there is a high incidence among indigenous people (WHO 2005).

As a result, programs targeting TB and malaria have been receiving funding priority. Several TB initiatives are highly visible and seem to be receiving a much more positive reception than HIV/AIDS from employers, chambers of commerce, and employer and employee federations. There is currently a major anti-TB program underway, assisted by the United States Agency for International Development (USAID), that targets the workplace and the workforce. Preventive and curative measures are also being undertaken for malaria, such as dissemination of mosquito nets, training of health personnel, and monitoring of drug efficacy.

It is at the micro level where the impact of HIV/AIDS is most felt. This consists chiefly of loss of job, income, and family cohesion; deprivation of savings; increased health expenses; and funeral costs should the victim eventually die. Most affected, of course, are the poor families of sex workers and OFWs. The costs of managing the disease are way above the average Filipino's means: approximately US\$12,000 per person annually at the current price of antiretroviral therapy; for AIDS cases, approximately US\$300 per person per day if confined in a government hospital.

The irony is that it is difficult to intervene at the micro level because of the highly individualized and unique character of each case. In the case of groups at risk, such as CSWs, MSM, and IDUs, their activities and practices are in the shadows and therefore beyond the reach of government to have an impact. This is where actual cases that people living with HIV/AIDS (PLWHA) can relate to at a deeply personal level would be helpful; unfortunately, case studies suitable as behavioral-change tools are rare. Health officials agree that it is much easier to do interventions at the programmatic or policy level, such as developing IEC materials and supporting the efforts of institutions such as schools, offices, and businesses to conduct programs on HIV/AIDS.

Future Projections

For a country that registers a low incidence of HIV/AIDS, it is rather difficult, if not moot, to make projections five years hence, particularly if the purpose of the exercise is to change behavior, influence policy, or generate

more resources. A current modeling exercise being done by the PNAC focuses on aggressively targeting IDUs on the assumption that this sector is most uncontrolled in terms of transmission and its velocity. The country has an estimated 3 million drug users. Around 15,000 of them are believed to use injectible substances and about 80% of those users share needles (Esguerra 2005). But the model shows that even runaway growth in this group would raise the prevalence rate to only 0.9%, still way below the Southeast Asia threshold and still not enough to ring the alarm bells.

It is projected, however, that the danger of an epidemic remains since the ingredients are already present—e.g., increased sexual activity of the youth, an already large sex industry, the high rate of STIs both among the vulnerable groups and the general population, inadequate knowledge about the disease, poor health-seeking behavior, and a suspected increase in the number of IDUs. Added to this is the dwindling of resources given to combating the disease (because the “low and slow” spread of the disease tends to lessen the priority given to it in the authorities’ and other people’s minds). For that reason, the 4th AIDS Medium-Term Plan (AMTP IV; 2005–2010) was drafted on the basis of this future potential for an epidemic. In order to maintain the low incidence of the disease, the plan seeks to do the following (PNAC 2005 3):

- intensify prevention interventions among highly vulnerable groups identified in AMTP III—CSWs, MSM, IDUs, and clients of CSWs—and scale up prevention efforts toward other vulnerable groups (e.g., OFWs, youth, and children)
- expand coverage and integrate HIV/AIDS in the development priorities at the local level, giving priority to identified risk zones
- improve the coverage and quality of care and support for PLWHA
- strengthen management support systems for the national response

A notable difference is that the current plan is more explicit than its predecessor with regard to attention to infected and affected children. Its policy directions also include mechanisms to ensure a protected level of funding support, the setting up of systems to measure the quality of every intervention, and the alignment of directions and goals with the Philippines Medium-Term Development Plan, the Millennium Development Goals, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment on HIV/AIDS, and

the Association of Southeast Asian Nations (ASEAN) Joint Ministerial Statement and other international commitments. Specifically, the objectives of the new plan are fourfold: (1) to increase the proportion of the population with risk-free practices; (2) to increase the access of people infected and affected by HIV/AIDS to quality information, treatment, care, and support services; (3) to improve accepting attitudes toward people infected and affected by HIV/AIDS; and (4) to improve the efficiency and quality of management systems in support of HIV/AIDS programs and services (PNAC 2005, 17–18). The third objective is particularly significant as there is now a more explicit statement about the need for an accepting attitude toward those infected and affected. As Dr. Poblete of the PNAC has repeatedly emphasized, acceptance and compassion are a necessary component of the HIV/AIDS program.

Responses to HIV/AIDS

Government

The official response of the country to the spread of HIV/AIDS is embodied in Republic Act 8504, or the AIDS Prevention and Control Act of 1998. This lays down the basis for the various strategies and mechanisms to be adopted by the government and other sectors in containing the disease. From that legislation has sprung executive orders and policies mandating local governments, schools, and employers to institute HIV prevention and management programs. These include policy guidelines on HIV/AIDS prevention and control, policies and strategies for sexually transmitted disease (STD)/HIV/AIDS in the workplace, integration of HIV/AIDS education in schools, guidelines on the entry of people with HIV/AIDS into the country, and policy guidelines on testing among children. Soon after the legislation was enacted, the PNAC, which is the highest policymaking, coordinating, and directing body on HIV/AIDS, developed the AMTP.

Although the AIDS Prevention and Control Act has been hailed by the United Nations for its many innovative features, because of prevailing conditions this law has not been fully implemented. The PNAC, consisting of members from the government, public, civil society, and private sectors,

is striving to make the country free from the epidemic, but its budget is constrained. To begin with, the country's budget for health and other social services is severely limited. There is currently a budget of US\$20 million available for five years, ending in 2009, which consists mainly of grants from the United Nations; the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); USAID; and the Japanese government. This is not sufficient to meet a projected need of US\$8.5 million annually to implement the necessary programs on prevention, care, and support for PLWHA.

Local government units, meanwhile, are mandated by the AIDS Prevention and Control Act to start their own prevention programs. Local HIV/AIDS councils have been formed through executive orders and are multisectoral in composition. Some local government initiatives and efforts to support local HIV/AIDS councils include the following: (a) local ordinances to improve the quality and expand the operation of social hygiene clinics; (b) assumption of the operating costs of surveillance activities; (c) community outreach and preventive education activities of several nongovernmental organizations (NGOs); and (d) adoption of local ordinances mandating 100% condom use policies in registered entertainment establishments. According to Mateo et al. (2005), 18 out of 48 cities in the country had active HIV/AIDS councils. Budgetary constraints, though, remain a problem.

To support the national AIDS program set forth in the AMTP, assistance from the Global Fund could be secured, but unless it can be demonstrated and verified that there is indeed a need for additional funds, this may not be forthcoming. The challenge, therefore, is to show that there is a hidden disease that must be addressed immediately and urgently.

Aside from the PNAC, the DOH has its own National AIDS and STI Prevention and Control Program, and the monitoring done by the NHSSS in ten sentinel sites is an important component of the overall program. A multi-ministerial approach is also employed through which institutional and other support is provided by various government agencies, including the Departments of the Interior and Local Government, Tourism, Social Welfare and Development, Labor and Employment, Foreign Affairs, Justice, and Education; the National Economic and Development Authority; the Commission on Higher Education; and the Technical Education and Skills Development Authority.

These efforts are focused on each agency's respective sector. For example, the Department of Education has developed curricular and teaching materials for high school students, while the Commission on Higher Education has developed similar materials for college students. The Department of Labor and Employment has formulated the National Policy on Sexually Transmitted Diseases and HIV/AIDS. The Department of Tourism has conducted an information campaign about the disease for those employed in the tourism industry, especially hotel workers. The Department of Social Welfare and Development has worked with NGOs in the care of PLWHA. The National Economic and Development Authority has made impact studies on the socioeconomic costs of HIV/AIDS. Even the Department of Justice has been actively involved in the national AIDS program by conducting orientation programs on the HIV/AIDS law for justices and prosecutors. Of course, the Philippine Information Agency is at the forefront of developing the communication plan for the PNAC.

Nongovernmental Organizations

NGOs have been equally active in the fight against HIV/AIDS in the Philippines, and the government has duly recognized their contributions. Nine NGOs are members of the PNAC, and several government programs and projects are conducted in collaboration with them, focusing on surveillance, care, education, advocacy, and IEC. The *HIV/AIDS Country Profile Philippines, 2002*, lists 70 NGOs working in this field. Their services include information dissemination, research centers/libraries, training and education, biomedical research/surveillance, social behavior research, clinical services, advocacy, and care and support for PLWHA. Some of them have tapped into various official development assistance sources and most, if not all of them, have mainstreamed their HIV/AIDS programs into their respective clinical, social welfare, or development programs.

Some of the more prominent indigenous NGOs that focus on the disease are the AIDS Society of the Philippines (research, care, and support), the Reachout Foundation International (information, training, research, advocacy, care, and support), the Remedios AIDS Foundation (information, resource center, training and education, clinical services, and advocacy), and the Library Foundation (training, research, and advocacy). One NGO, the Pinoy Plus Association, is the national organization of PLWHA, providing

advocacy, care, and support. It has worked with the PNAC in developing a "Home Care Manual for HIV/AIDS Caregivers." Others have integrated HIV/AIDS into their core work in development, such as Caritas Manila and the Institute for Social Studies and Action. Philippine Business for Social Progress developed a manual for AIDS in the workplace (supported by the United Nations) and a manual for morticians. Many others operate at the regional level (HAIN 2003, 18–19).

One international NGO that has consistently assisted the Philippines HIV/AIDS program is Family Health International, which for more than a decade has provided technical assistance to the DOH, local government units, and other partners through improved national case management guidelines and other activities. In particular, it established the national STD surveillance system.

One notable international source of funding in this field has been the Levi Strauss Donor Advised Fund, which provides small grants to NGOs in the Philippines. While the Donor Advised Fund was seen as a developmental fund in general, it showed strong concern for education and support programs for PLWHA, including training, institutional support, and financing to help promote entrepreneurship among them. The Levi Strauss Foundation also supported the Positive Lives Program, an awareness and education program initially launched by Network Photographers and the Terrence Higgins Trust. The program centers on Positive Lives caravans—photo displays installed in schools, malls, and business offices—that aim to elicit compassion for those affected and thus to eliminate discrimination and stigmatization.

It is acknowledged that the government-NGO relationship is highly favorable in the Philippines. In fact, the government wishes to tap NGO services for populations at risk that it cannot reach for either legal or logistical reasons. Voluntary counseling and testing (VCT), for example, is deemed by the government to be more effective in the hands of NGOs.

Business Sector

Again because of the current low prevalence and the stigmatization of HIV/AIDS, the business response has been characterized as modest and lukewarm. In fact, as mentioned above, professionals involved in TB prevention believe there is a stronger and more favorable response to including TB

in the workplace programs. Small and medium-sized enterprises are more vulnerable, but budgetary constraints and the aforementioned reasons have prevented them from more aggressively implementing HIV/AIDS programs. Philippine Business for Social Progress, a foundation established and supported by the Philippine business community, has developed programs and materials for HIV/AIDS in the workplace programs with the Department of Labor and Employment, but there has been limited response to date.

Media

The *HIV/AIDS Country Profile Philippines, 2002*, reported that a 1999 survey found media to be the main source of information on HIV/AIDS in the ten sentinel sites monitored by the DOH. However, as admitted by Dr. Michael Tan of HAIN and Dr. Poblete of the PNAC, this has not necessarily meant quality information. Media representations are still largely sensationalistic, carrying commonly held prejudices, focusing on horror stories, and creating more aversion rather than providing a dispassionate treatment of the disease and offering sympathy for the sufferers. Reports emphasize the social stigma even in news coverage. Reporters carry their prejudices and project them, says Tan, and sometimes complicate AIDS education because prejudices are reinforced (HAIN 2003, 12). The few columnists and broadcasters who have treated the disease with more sobriety are those who have done so because of their passion for the cause. There is clearly a need for better education among media practitioners on the disease.

To help in this area, several initiatives have been introduced that seek to promote excellence in media reporting. For example, the AIDS Society of the Philippines holds an annual program for the media, the National Media Workshop on HIV/AIDS Reporting, and presents AIDS Media Awards. Another award, the FVR Excellence Award on HIV/AIDS for Media, was recently launched under the auspices of former President Fidel V. Ramos. Perhaps reflecting these efforts, there has been a noticeable shift toward greater sobriety in news treatment of the issue, especially in the print media.

Regional and International Cooperation

Dr. Poblete assesses official regional and international cooperation as being beneficial to the Philippines in a variety of ways—providing mutual support;

learning from the experiences of other countries; establishing protocols for cross-border travel and labor migration; and enabling research, training, and other capacity-building activities. Program donors include the United Nations—especially the Joint UN Programme on HIV/AIDS (UNAIDS), the UN Educational, Scientific and Cultural Organization (UNESCO), the UN Children’s Fund (UNICEF), the UN Development Programme (UNDP), and the UN Fund for Population Activities (UNFPA)—the World Bank, the WHO, German Technical Cooperation (GTZ), the Japan International Cooperation Agency (JICA), and the International Labor Organization (ILO).

Country actions are guided by regional and international principles and declarations. Because of fund limitations, though, regional cooperation has been limited, especially in action-oriented programs at the field level. There is a need for improved monitoring and evaluation systems to guide countries in their commitments, sharing of best practices, and a wider opening of the gates of information (Mateo et al. 2005).

There is definitely a need for cross-border surveillance and preventive mechanisms because of increased migration brought about by increased economic and social interactions. Sharing of experiences and best practices among NGOs should also be encouraged.

Conclusion

The Philippines is fortunate—at least for the moment—to be a low-prevalence country. The prevalence and growth of the disease are described as low and slow, and its occurrence remains concentrated in five vulnerable groups. However, it is generally recognized—and feared—that there is a lurking danger, that the low-prevalence figures are just the tip of the iceberg, and that there might in fact be a “tsunami” of HIV/AIDS headed toward this country. Thus, the current favorable situation should not be a reason for complacency and laxity. Rather, both the general population and other stakeholders should continue to be vigilant and presume that for every case reported there might be more unreported. Only through vigilance can the country be assured that it can prevent and manage this epidemic, which greatly affects those who are among the most impoverished. More solid

data should be generated. A strong and committed leadership to combat the disease even at this "low and slow" stage must be built and sustained. VCT programs should be strengthened and expanded. Monitoring and reporting systems should be improved so that a more accurate scenario can be drawn.

Importantly, prevailing prejudices and stigmas must be overcome. Compassion for PLWHA should be the norm so that those in the shadows can be encouraged to come out. Toward this end, the role of a sober and sympathetic media cannot be overemphasized. The AMTP IV, which focuses on preventing the further spread of the disease and reducing its impact on individuals, families, and communities must not only be championed but, more importantly, must be seen as a final line of defense to save the country from the scourge of HIV/AIDS. To achieve this, the work of NGOs and the private sector must not only be supported but optimized. Finally, for the Philippines to increase its preparedness, it should lobby for more regional and international cooperation, particularly in action-oriented programs at the field level.



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