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**A Report on  
AIDSCOM Activities  
in the Philippines  
1988 - 1990**

**The AIDSCOM Project  
The Academy for Educational Development  
Washington, D.C.  
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## **LIST OF ABBREVIATIONS**

- AIDSCOM** AIDS Technical Support Project: Public Health Communications Component. A project of the U.S. Agency for International Development (Contract No. DPR-5972-Z-00-7070-00) managed by the Academy for Educational Development in Washington, D.C.
- AIDSTECH** AIDS Technical Support Project: Technical Support Component. A project of the U.S. Agency for International Development managed by Family Health International in Durham, North Carolina.
- ARO** Asia Research Organization, Inc., the Philippine affiliate of the Gallup polling organization and an AIDSCOM contractor.
- DOH** Department of Health of the Republic of the Philippines. Generally used to refer to the Office of Public Health Services of the DOH.
- HIV** Human immunodeficiency virus, the causative agent of a range of diseases including AIDS.
- STD** Sexually transmitted disease.
- WHO**  
**WHO/GPA** World Health Organization and World Health Organization's Global Programme on AIDS, both headquartered in Geneva, Switzerland.

**I.****EXECUTIVE SUMMARY AND RECOMMENDATIONS**

The HIV pandemic is at an apparently early stage of development in the Philippines. In limited surveillance to date, only 141 HIV infections and 32 cases of diagnosed AIDS have been identified in a total population of more than 60 million. The majority of infected Filipinos are women who have been infected sexually in male/female contacts, primarily in large urban areas such as Metro Manila. Although HIV is clearly present and spreading in the country, the low incidence of infection and disease provides an opportunity — unprecedented in much of the rest of the developing world — to implement early prevention programs that have a real chance of preventing an AIDS crisis from developing in the Philippines. Aware of this advantage, the Philippine government has been working since early 1987 under the aegis of a special program within the DOH to plan and implement an ambitious range of prevention initiatives.

When AIDSCOM made its initial assessment visit to Manila in January 1988, the DOH was consequently prepared to implement AIDSCOM's immediate technical assistance in the specific areas of planning management systems, developing institutional capacity and skills, obtaining baseline research data, and designing and testing a pilot media information campaign. The DOH decided to limit these initial activities to Metro Manila. AIDSCOM began providing technical assistance to the DOH in February 1988. In August of that year, USAID Philippines concluded a delivery order with AIDSCOM in the amount of \$1 million to fund technical assistance activities through June 30, 1990, a period of time defined in this report as "Phase One" of AIDSCOM's technical assistance to the Philippines.

During Phase One, AIDSCOM concentrated on gathering and analyzing baseline research data in Metro Manila and on using that data to design, implement and evaluate a pilot media campaign, also in Manila. The data were obtained through extensive qualitative and quantitative surveys of 300 male and female young adults, 200 male and female commercial sex workers, 200 male and female expatriate Filipino workers and 200 men who have sex with men. A nationwide survey of a random sample of 1,500 Filipinos was also conducted. Collectively, these data showed that respondents were highly aware of AIDS but misinformed regarding its transmission and prevention. High percentages of those surveyed falsely believed, for example, that HIV could be transmitted through mosquito bites, coughs and sneezes or being near an infected person. Most of those surveyed also believed that AIDS was a "foreign" disease that Filipinos need not worry about. On the other hand, the respondents' reported sexual behaviors included several risk factors such as multiple partners and unprotected vaginal, oral and anal intercourse.

To correct false beliefs and misinformation, and at the same time to increase the public's ability to assess its possible risk of infection more accurately, AIDSCOM developed and implemented a pilot media campaign that focused on sexual transmission. The campaign included television, radio and newspaper ads that ran in Manila media during the period of February - May 1990. Immediately following the conclusion of the campaign, tracking surveys were conducted among random samples of 500 Metro Manila residents and 200 young adults.

The tracking results demonstrate that the campaign had significant reach: 100% of the tracking survey respondents saw or heard campaign ads. More than 50% said they would call the telephone hotline advertised by the campaign — a figure that proves campaign ads were effective because the hotline was not advertised elsewhere. (The hotline eventually received more than 5,000 calls, primarily from the young single males who were the campaign's implicit target audience.) The campaign also had measurable impact on the tracking sample's knowledge, attitudes and, potentially, behaviors. After the campaign, for example, AIDSCOM's surveys document decreases of up to 51% in the false beliefs that mosquitos, coughing and physical proximity can transmit HIV. Virtually all of the post-campaign respondents also said that AIDS is now a priority concern for them as well as all Filipinos, and nearly all said that Filipinos should know how to prevent AIDS. Other data indicate that many who had previously said they had no need to change their behaviors are now reassessing their behavior in light of what many described as the "new information" they learned in the campaign.

AIDSCOM's extensive research and pilot communications activities in Phase One thus prove the value of rigorous baseline data in the design and implementation of targeted information campaigns that reach their intended audiences with the correct messages. Other aspects of AIDSCOM's Phase One technical assistance — specifically planning management systems and building institutional capacity — were somewhat less effective although progress was made. Logistical constraints within the DOH and the pressure of other technical assistance activities deemed by the DOH to be higher priorities prevented AIDSCOM from fully achieving its management and training objectives. These crucial areas merit more focused attention in Phase Two technical assistance programs.

In order to enhance program effectiveness in Phase Two Philippine activities (approximately July 1990 through June 1992), AIDSCOM recommends that:

1. More emphasis needs to be given to building partnerships between the public and private sectors in HIV prevention by involving non-government and voluntary organizations more systematically in program planning, implementation and evaluation.
2. Research and communications activities (media campaigns, the hotline and materials development) that have proven effective in Phase One should be refined and extended not only in Manila but also in other urban areas, beginning with Cebu. New emphasis should be placed on the design, implementation and evaluation of operations research projects to educate special audiences such as young adults, men who have sex with men and sex workers.
3. Management and institutionalization issues should increasingly be analyzed and, if possible, resolved through more systematic collaboration with the private sector. Decentralization of responsibility for program implementation should be the ultimate goal.

## II.

### Introduction

In 1987, the United States Agency for International Development (USAID) initiated a new project called AIDSCOM to research and develop communications strategies for HIV prevention in the developing world. The Academy for Educational Development in Washington, D.C. received the contract to implement the new project under Contract Number DPR-5972-Z-00-7070-00, AIDS Technical Support: Public Health Communication Component. The Academy's partners in this endeavor are The Johns Hopkins University, Porter/Novelli, the University of Pennsylvania's Annenberg School of Communications and the PRISM/DAE Corporation.

AIDSCOM is an initiative of the Offices of Education, Health and Population of the Bureau for Science and Technology of USAID. The project relies on the shared resources of USAID's Bureau for Science and Technology, its regional bureaus and country USAID Missions to assist national AIDS committees in their HIV prevention efforts. AIDSCOM builds upon USAID's successful experience with social marketing and public health communication to create a model uniquely suited to HIV prevention needs in country-specific contexts. AIDSCOM works closely with AIDSTECH, USAID's program of general technical support, to complement the WHO's leadership in global HIV prevention and control activities.

The purpose of AIDSCOM is to research, develop and evaluate a range of effective public health communication strategies and methods for the prevention of HIV infection and AIDS in developing countries. AIDSCOM applies and further

develops the use of public health communication methodologies, prevention counselling approaches and condom marketing strategies to inform people about HIV infection and to understand, motivate and support the process of adopting specific risk-reduction behaviors to reduce the further spread of HIV.

Since 1987, AIDSCOM has conducted assessments of HIV prevention opportunities and programs in some 67 countries worldwide and implemented extensive technical assistance in 42 of those countries. AIDSCOM assists governments and a wide variety of non-government and private organizations throughout Africa, Asia, the Caribbean region, Latin America and the Near East.

One of the countries in which AIDSCOM has been most active is the Republic of the Philippines. AIDSCOM personnel first visited Manila in January 1988 and immediately that February began providing a wide range of technical assistance to the Philippine DOH, which manages the country's HIV prevention and control efforts. Since early 1988, AIDSCOM personnel and consultants have visited the Philippines more than 20 times, provided extensive assistance in the development of planning and management, research, training and a pilot communications campaign in Manila. These activities have involved the expenditure of some \$1.3 million in funds provided by the USAID Mission in Manila and the central AIDSCOM contract in Washington, D.C. Clearly, technical assistance to the Philippines is a priority for both AIDSCOM and USAID. The prospects for early prevention of HIV disease in this low-incidence country, and what is learned in the process of implementing prevention programs designed to do so, have important implications not only for USAID and AIDSCOM but also for the government of the Philippines and other governments in the region.

This report provides an internal, informal assessment of AIDSCOM's technical assistance programs in the Philippines during the period of January 1988 through June 1990, more than two years of intense activity that comprise Phase One of AIDSCOM's support to the Philippine program. As Phase Two (June 1990 through September 1992) is being planned, we believe it is useful to analyze which aspects of AIDSCOM's assistance programs have or have not worked so far, and why, so that future programs may be revised and improved. This report is not a formal evaluation. The analysis is AIDSCOM's alone and does not necessarily represent the views of USAID or the Philippine government.

### III.

#### **The Public Health Communications Process: Defining AIDSCOM Assistance to the Philippines**

AIDSCOM's technical assistance activities in the Philippines are determined by the government in response to the country's specific HIV prevention needs. To be effective, the prevention activities AIDSCOM supports in the Philippines must be firmly fixed in the Philippine context. It is also important to understand, on the other hand, that the methodologies AIDSCOM employs in the Philippines are defined by a specific, strategic public health communications process which transcends local circumstances although it necessarily takes those circumstances into account. In providing technical assistance that is responsive to the local environment and local needs, AIDSCOM therefore gains an important additional opportunity to test whether the public health communications process is

effective in terms of HIV prevention and why — or why not.

Put simply, the public health communications process is the dynamic interaction between communications methodologies and individuals whose behaviors place them at risk of HIV infection. The objective is to determine which methodologies most effectively address these individuals in ways that will implement and sustain behavior change and thus prevent the further spread of HIV. The communications methodologies AIDSCOM employs are derived primarily from theories of social marketing, which are in turn based on behavior change models developed over the past 20 years. The models include cognitive models (health belief, perceived self-efficacy), structural models (community and individual), and social and behaviorist models. In this way AIDSCOM's research and development programs build upon and extend the lessons learned in two decades of social science as it has been applied to USAID's health promotion programs worldwide.

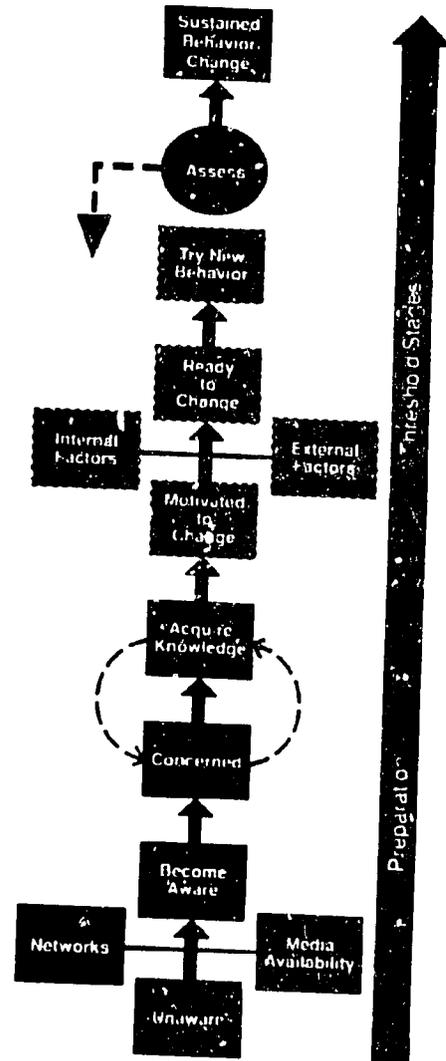
In social marketing terms, AIDSCOM's interventions focus on the "consumers" of prevention messages. The messages are designed to offer consumers benefits (social acceptance, protection of loved ones, longevity and self-efficacy among many others) for which they will pay a price (overcome barriers to behavior change) in order to achieve satisfaction (sustained avoidance of HIV infection). This process appears straightforward, but in fact HIV prevention presents significant new challenges to public health communicators. The behaviors that must be changed are particularly deep-rooted and complex, the barriers to change cross a number of psychological, social and cultural boundaries at once and the benefits of behavior change are often perceived as more theoretical than immediately concrete.

Because the consumer is uppermost, it is crucial to know as much as possible about that individual in order to determine which communications messages and channels may be most appropriate. We must understand the internal factors such as knowledge, attitudes, beliefs and behaviors as well as the external factors such as culture and society which directly affect the consumer's behaviors. And we must attempt to understand these things in a real world in which neither behaviors nor the factors shaping them are static. Behavior is a constantly changing continuum, not a fixed reality. The objective of changing behaviors therefore also involves a continuum of research, development and field support activities implemented with flexibility over time — in short, a process-oriented approach to HIV prevention that does not depend on any single intervention to be effective.

To make this process-oriented interaction between behavior change and public health communications clearer, AIDSCOM has developed the chart depicted in Table 1. It is important to make two points about the continuum. First, it is not an empirical model but rather a conceptual framework intended to facilitate discussion. Second, the linear grid is used for purposes of graphic convenience but should not connote that AIDSCOM believes actual behavior to be linear. On the contrary, the chart attempts to identify what are in reality frequently non-linear psychological and attitudinal stages along the continuum as well as other factors which support or impede the process of HIV prevention.

In practice, AIDSCOM tests various public health communications interventions in order to determine which of them are most effective in achieving any given stage or, more often, in moving individuals from one stage to another. In regard to HIV prevention specifically, many public health communicators believe that the nature of the

Table 1.  
THE HEALTH BEHAVIOR CHANGE CONTINUUM



communications intervention itself — how and by whom it is planned, implemented and evaluated — may help to define the actual prevention message in addition to being the medium by which it is conveyed. An example of this hypothesis would be the growing number of AIDS telephone hotlines being implemented throughout the world. Many of

these hotlines employ peer counselors (individuals who are themselves at risk of infection) to provide information, advice and counselling over the phone to persons who prefer to remain anonymous. The fact that the counselor may be much like the caller, can ensure confidentiality and deliver sensitive guidance from a perspective of shared understanding may itself convey to callers a greater incentive to change ("If he can do it, so can I!") than information alone would, no matter how targeted the information may be. In short, the hotline itself is as important as the prevention messages it provides.

The public health communications process often begins by determining the elements that define each stage along the continuum. For example, how much and what types of information are likely to render a target audience "knowledgeable" enough to become concerned, or concerned enough to want to change? The predisposing, enabling and precipitating factors which will or will not move individuals from one stage to another are also important. One of the key questions to be answered is, for example, why individuals who are motivated and ready to change do not in fact do so. Some natural progression between stages would seem logical — i.e., concern about HIV and AIDS would seem naturally to encourage the desire for more information about them — but in reality such movements are often inconsistent and cannot be taken for granted. Moreover, many individuals move backward and forward along the continuum over time. It cannot be assumed, therefore, that interventions will necessarily achieve sustained results. Understanding why or why not is also an important issue in the communications process.

The continuum thus suggests the challenges facing AIDSCOM as well as other public health communicators. It is also useful as a kind of template which defines the ways

in which AIDSCOM's technical assistance programs are planned, implemented and evaluated in the field. In the Philippines, for example, we recognized early that we needed baseline information on HIV-related knowledge, attitudes and behaviors in order to determine the stages on the continuum at which we would need to address each of our given target audiences. Much of AIDSCOM's Phase One technical assistance was therefore devoted to gathering and analyzing crucial data. Since these data suggest that the Filipinos we surveyed are highly aware and concerned about AIDS but lack accurate knowledge about HIV transmission and prevention, we devised a pilot media information campaign to decrease false beliefs and misinformation while at the same time encouraging accurate assessment of personal risk and thus, hopefully, the motivation to change risk behaviors. During the period this report covers, in short, we have been concerned with investigating and defining the "preparation" stages of the behavior change continuum. In both the research and pilot media campaign, we studied the interaction between the continuum stages of concern, knowledge and motivation to change. Technical assistance in Phase Two will build on what we have learned by concentrating on a series of operations research projects and pilot interventions that explore the "threshold" stages of the continuum: how, why, under what circumstances and for whom can public health communications be employed to move individuals along the continuum from motivation and readiness to change to the trial of new behaviors and, hopefully, beyond.

AIDSCOM believes that public health communications play a pivotal role in disease prevention. To be sure, communications are not the only element in effective prevention programs nor can these programs achieve their objectives in isolation from basic service infrastructures, diagnostic and therapeutic

tools and the many other component parts of prevention programs. What public health communications programs do that other types of programs do not do, however, is to engage target audiences, invest them in the necessity of prevention through messages they find compelling, and promote the means and support they need to sustain prevention behaviors over time. Public health communications are the unifying force behind the different elements of prevention and, in the target audience's mind, the only force that gives prevention meaning and urgency.

#### IV.

### The Philippines: Country Background

#### HIV Infection and AIDS in the Philippines

The HIV pandemic is at an apparently early stage of development in the Philippines. To date, limited official surveillance programs have located 141 confirmed HIV seropositive individuals: 118 Filipinos and 23 foreign nationals. The majority of the Filipinos are women who have been infected sexually in male/female contacts. Transmission between men has also been identified, and is suspected although unconfirmed in several cases between mothers and infants. Of all infected individuals confirmed so far, 32 have been diagnosed with AIDS, or Class IV HIV disease. Five of the diagnosed AIDS cases have been confirmed as resulting from indigenous infection (the other cases were the result of infections contracted outside the Philippines). Clearly, HIV is present and spreading in the Philippines although perhaps less widely and at a slower pace than in some other Asian countries.

Table 2.  
INCIDENCE OF HIV INFECTION/AIDS  
Republic of the Philippines  
(As of June 30, 1990)

Risk Behavior Category	HIV+		AIDS		Total
	M	F	M	F	
<u>Sexual Vector</u>					
Male/Female/ Male	11	82	10	5	108
Male/Male	7		12		19
<u>Blood Vector</u>					
Transfusion		2	1	1	4
IV Drugs	1				1
<u>Unknown Vector</u>					
	21	17	3		41
<b>TOTALS</b>	<b>40</b>	<b>101</b>	<b>26</b>	<b>6</b>	<b>173</b>

Table 2 above helps to clarify what is known about HIV infection in the country. It is important to note that HIV surveillance in the Philippines has been limited to date, primarily to female sex workers who are required by law (under statutes pertaining to the health status of "hospitality workers") to submit regularly to testing for sexually transmitted diseases. These individuals have been the focus of surveillance not only because they are presumed to be most at risk of infection and are readily available for testing, but also because the donor agencies — primarily the U.S. Naval Medical Research Unit located in Manila — that support the bulk of the surveillance have been unwilling to attempt similarly widespread testing in other populations. Various small-scale attempts to

test persons other than sex workers have not been successful, either because the subjects in question were inaccessible or difficult to locate, or because the cost and labor factors in reaching them were considered too great.

Female sex workers are not, however, the only Filipinos at risk. Population and family planning studies conducted over the past few years and considerable anecdotal evidence suggest that unprotected sexual behaviors which increase the risk of HIV infection are occurring frequently throughout the country and among all sectors of the general population. AIDSCOM's own research strongly suggests that potentially risky behaviors begin early in the average Filipino's life and tend to continue within or outside the context of marriage. The same research also suggests that IV drug use, especially among young adults, may not be as rare as it is thought to be. Filipinos also travel more widely and frequently than perhaps any other Asians, often to parts of the world where HIV infection is widespread.

All of these factors argue for caution when assessing the reliability of the data presented in Table 1. Until surveillance programs become more systematic, and perhaps especially until they are made accessible to those who can be encouraged to volunteer for them, we are unlikely to understand the true nature and scope of HIV infection in the Philippines.

### **Rationale for the Project**

From a prevention perspective, the apparently low incidence of HIV infection in the Philippines presents significant opportunities for communications interventions. The Philippines is not facing, as

so many countries are, a crisis situation in which the virus is so widespread that prevention activities become little more than a triage approach to containing the problem. There is probably still time in the Philippines to instruct the general public and special audiences with accurate messages about risk behaviors and how to avoid them. There is still time in the Philippines, in short, to test the extent to which a low-incidence country, using public health communications and other innovative methods, can actually prevent an HIV disease crisis from happening.

The advantages of early, consistent and focused prevention measures would seem to be obvious in a country where poverty and many other endemic health problems already overwhelm the infrastructure's limited ability to respond to crisis. Given the Philippines' precarious economic circumstances and the severe limitations these impose on all public sector initiatives, a full-scale AIDS crisis at this time in the fragile democracy's history would be a disaster.

Since HIV infection in the Philippines seems to be limited so far to a relatively few individuals in the largest urban areas, an expensive national prevention campaign is probably not necessary if targeted regional efforts can be developed effectively. The Philippines' sophisticated media environment can also be used selectively to deliver maximum regional coverage at minimum cost. Target audiences, at least those to whom initial messages would be directed, are relatively accessible and indeed are already aware that AIDS is a potential problem in the Philippines.

The government is eager to exploit these advantages in an early prevention campaign, and is better equipped than some countries to do so. The DOH, which manages AIDS-related activities, has assigned some of its most talented managers, many of whom were trained in the U.S., to the AIDS program.

The DOH also has ready access to a resident world-class AIDS expert, a Filipina physician who has been working with AIDS since 1981 when she happened to be an associate of Dr. Michael Gottlieb, the physician who identified the world's first diagnosed cases of AIDS, at UCLA.

Since early 1987, when the National AIDS Prevention and Control Program was formally created within the DOH, these energetic individuals have sought to benefit from hard lessons learned elsewhere in the world. They have eschewed counterproductive activities such as quarantine and mandatory testing of citizens and foreign visitors, and concentrated instead on the development of policy, infrastructure and background data to provide a firm foundation for focused prevention programs.

## V.

### Technical Assistance Activities: 1988-1990

During Phase One of AIDSCOM's technical assistance to the Philippine National AIDS Prevention and Control Program — a period of time arbitrarily limited by funding resources to January 1988 through June 1990 — AIDSCOM and the DOH planned and implemented an ambitious series of public health communications initiatives. In this report, these programs are separately reviewed under the following general headings:

- Planning Management Systems and Programs
- Building Institutional Capacity and Skills
- Developing Baseline Research Data
- Designing and Testing A Communications Campaign

It is important to understand at the outset that AIDSCOM's terms of reference in the Philippines were (and are) influenced by significant constraints which, for better or worse, often affected program implementation. These constraints included the following:

1. **AIDS is *ipso facto* a political issue in the Philippines** because it is associated in the public's mind with a pivotal issue of national pride: the presence of U.S. military bases north of Manila — bases to which many Filipinos trace the introduction of HIV into the country. A poster published in 1989 by Gabriela, a women's coalition of organizations that advocates for the rights of female sex workers among others, succinctly sums up the extreme end of anti-U.S. sentiment in its headline, "No AIDS! No Nukes! No Bases!" Such associations mean that anything done about AIDS in the Philippines — and particularly anything done with U.S. support — will be more than normally scrutinized. The potential for negative political fallout exacts a toll in the form of a more than normal caution in HIV prevention planning and implementation.

2. **AIDSCOM and AIDSTECH, representing USAID, are to date the only foreign donor agencies supporting the national prevention program.** WHO/GPA has not yet convened a meeting of interested parties (donors meeting) in the Philippines, although one is planned for the fourth quarter of 1990. WHO's Western Pacific Regional Office, located in Manila, has a permanent regional AIDS Unit but reports that it is constrained from offering assistance locally until funds are made available through the international donors meeting. A few other countries have provided limited equipment and technical assistance. The upshot is that USAID provides the lion's share of support to the government's AIDS program, and as its agents, AIDSCOM and AIDSTECH have single-handedly had to attempt to cover a much wider range of

technical assistance responsibilities than would normally be feasible.

3. Time constraints imposed by arbitrary funding cycles have forced AIDSCOM programs to be implemented with an urgency that the government cannot always match. Major funding in the form of a USAID Philippines delivery order amounting to \$1 million did not become available to support AIDSCOM technical assistance activities until August 1988, and the funds had to be expended by June 30, 1990. This left less than two years in which to implement the bulk of the ambitious schedule of programming that is reviewed in this report. A team of AID/Washington evaluators said after their visit to Manila in the fall of 1989 that AIDSCOM was performing satisfactorily under the time pressure, but that is not really the point. In practice, the pressure to spend money quickly has frequently forced AIDSCOM to have to move out front of the government's normal implementation cycle. This necessity was accepted by all sides, caused no problems and, indeed, led to some interesting planning innovations that are discussed later in this report. But the urgency also eliminated flexibility and left little time to plan, develop and evaluate those innovative pilot projects which tend to be more labor- than capital-intensive.

## Planning Management Systems and Programs

### Highlights and Trends

In order to accomplish its Phase One objectives in planning management systems and programs, AIDSCOM provided the following technical assistance:

- Assistance in drafting and revising the Philippine Medium-Term Plan for the

### MANAGEMENT OBJECTIVES

The government has been aware from the beginning that prevention activities must be carried out in ways that cross internal lines of DOH authority as well as external boundaries between Departments of the government. Private, non-government and voluntary organizations, professional associations, advocacy groups, the Catholic Church and other interested parties must be consulted and involved in prevention programs on a routine basis. To help conceptualize and establish the means by which these objectives could be achieved, AIDSCOM was asked by the government to:

- (a) assist in the development of planning and management strategies;
- (b) provide background expertise on what has, or has not, worked in other countries;
- (c) help draft the Medium-Term AIDS Prevention and Control Plan;
- (d) provide a long-term Resident Advisor to the national AIDS program; and
- (e) participate as an honorary member of the National AIDS Advisory Committee in the ongoing management of the program.

Figure 1.

**Prevention and Control of AIDS.** In three visits to Manila between February - May 1988, AIDSCOM provided the then-national program manager, Dr. Manuel Dayrit, with advice and recommendations as he drafted and revised the DOH's version of the medium-term plan. A subsequent version of the plan, substantially rewritten by a WHO consultant, was approved by WHO/GPA in Geneva in the fall of 1988.

- **Consultation and support in the development of program plans and national, HIV-related program policies.** AIDSCOM funded and provided technical assistance to carry out two planning workshops. One three-day workshop, held in Puerto Azul in July 1988 for DOH staff managing various aspects of the AIDS program, included training in program management (setting goals and objectives), HIV prevention communications and hands-on exercises in the development of actual program plans. The other, four-day workshop, held in Villa Escudero in September 1988, concerned the development of national program policies to direct HIV prevention programming. The Villa Escudero workshop included 32 representatives of some 20 public and private agencies interested in working on HIV prevention.
- **Assistance in the development of national policies on HIV prevention.** By consensus, participants at the above Villa Escudero workshop produced a list of ten policy statements which were adopted as official policy by the DOH executive committee in January 1989. The policy statements are worth repeating below since they continue to drive government action on AIDS:
  - Prevention of HIV infection and AIDS shall be the priority of the national AIDS control program.
  - To prevent transmission of AIDS and other sexually transmitted diseases, protective measures such as condom usage shall be promoted for both sexes. These protective measures shall be made available and widely accessible.
  - AIDS education shall be integrated in existing school curricula at elementary, high school and college levels; implementation shall be the responsibility of the Department of Education, Culture and Sports.
  - No mandatory testing shall be required except for those already regulated by law. Persons who engage in high-risk behavior shall be encouraged to undergo voluntary testing. Pre- and post-test counselling shall be made available.
  - Infected or sick individuals shall be referred for appropriate counselling and care. As a matter of public policy, no person shall be subjected to quarantine and isolation.
  - Tourists shall not be required to undergo testing for HIV infection.
  - Health and social support shall be provided to infected and sick individuals by government and non-government organizations.
  - Information on the testing, counselling and care of individuals shall remain confidential.
  - HIV screening of blood donors and blood for transfusion shall be required. Voluntary blood donation shall be encouraged.
  - Communication campaigns on HIV and AIDS shall be part of an information delivery system integrated into other closely related programs.
- **Provision of a resident advisor to advise the national program.** Two resident advisors were in fact hired over the Phase One period. One, Ms. Jenny Catindig, served AIDSCOM and the DOH from April through September 1988. The other, Nora Quebral, Ph.D., served AIDSCOM and the DOH from April 1989 through June 1990. Both individuals were brought to Washington by AIDSCOM for extensive orientation and training during the course of their duties.
- **Development of collaborative working relationships with AIDSTECH and the WHO Western Regional Office in Manila.** From the first assessment visit to Manila in January

1988, when AIDSCOM and AIDSTECH personnel formed a joint team, through the equal division between them of a Mission buy-in and on through more than two years of program activities, AIDSCOM and AIDSTECH have forged a close working relationship. Throughout Phase One, individuals representing both projects usually travelled to Manila at the same time. In the U.S., constant contact by phone and frequent exchanges of staff between Washington and Durham have provided support and consultation at all levels for the Philippine program. AIDSCOM and AIDSTECH have also collaborated as a joint team in their ongoing relationship with WHO's Western Regional Office in Manila, with whose permanent regional AIDS staff the projects are frequently in touch -- most recently in April 1990 when WHO, DOH and the projects met in Manila to develop an operational plan for implementing the Philippines' medium-term prevention plan.

### Discussion

The planning of management systems and programs probably demanded more of AIDSCOM's time and technical assistance effort during Phase One than any other single element of the program. During calendar year 1988 alone, AIDSCOM provided some five person-months of intensive technical assistance in planning and management. This level of intensity was not sustained throughout Phase One, but it did contribute to the high cost of managing AIDSCOM's technical assistance to the Philippines during this period.

The concentration on planning and management is not surprising in a program that was, throughout much of Phase One, new not only for AIDSCOM but also for the DOH. Both were starting essentially from scratch on the subject of HIV prevention in the Philippines and, in a short time, had to generate the basic logistical and administrative

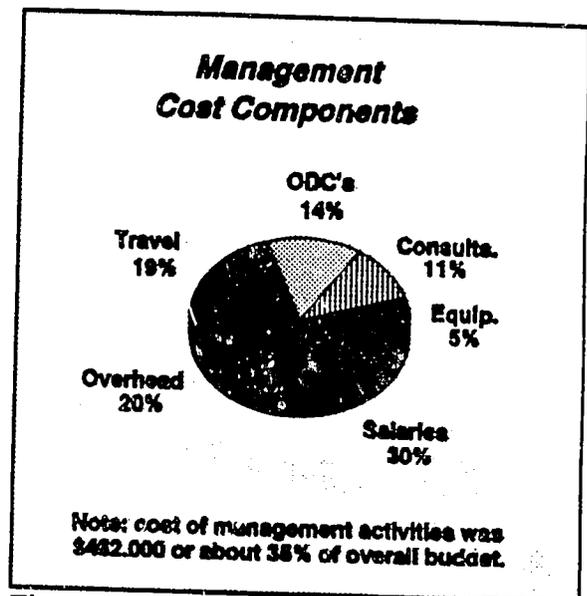


Figure 2.

infrastructure, determine what to do and then implement programs -- all with no precedents to follow and thus no real idea of what would or would not work. This situation had its clear pluses: authority was limited to a few people and decisions could be made quickly, there was (and still is) an openness to new ideas and approaches and an extraordinary degree of trust was developed almost immediately that continues to allow the various players involved to resolve problems amicably when they arise. But there was a down-side as well, and in the years since 1988 it has become clear that this down-side is systemic.

The government concedes that the basic structure of the national AIDS program is an impediment. The national program was set up as a "floating" entity without bureaucratic identity within the DOH. The program and its only full-time employee, the national AIDS program manager, are responsible to the National AIDS Advisory Committee, for which the program office functions as implementing agency and secretariat. The idea was that

members of the advisory committee, who are all managers of established DOH divisions, would back up and support their operational decisions regarding HIV-related matters by lending their own divisions' staff, administrative infrastructure and even funding to the AIDS program. For whatever reasons, it has not worked out that way. The advisory committee has not been able to meet more than three or four times since 1988. The national program manager's position has changed hands three times since March 1988. Temporary, part-time staff from other divisions have come and gone frequently in the AIDS program, which renders continuity difficult at best -- particularly when, as has often been the case, the temporary staff are the only ones available to be trained in key aspects of HIV prevention programming. Until recently the AIDS program lacked basic necessities such as computer equipment, a photocopier and space to house a growing operation, and it still lacks a telephone. More importantly, the national program has been unable to access its DOH-allocated budget due to an administrative snafu. Efforts are being made as this is written to locate the national program in an established DOH division, provide it with more permanent staff, space and equipment and free up funds, but these initiatives are likely to take time.

There are larger and more fundamental issues contributing to the national program's malaise, however, that may not be as relatively easy to resolve as the administrative problems. These larger issues are perhaps best described as constraining points of view, first, regarding the priority HIV prevention enjoys within the DOH and, second, regarding the nature of the role that the DOH plays in prevention programs overall. On the first issue, it makes sense in a country with many endemic health problems that AIDS, which is not yet a problem, is perceived within the DOH to be a lower priority than other, more immediately serious health issues. It is always hard to make

a case for committing time and resources to the prevention of diseases such as HIV disease which are initially invisible for long periods of time. Nevertheless it is troubling that, even after the HIV risk to Filipinos at large has been well-documented, DOH officials continue in the press and in public statements to accord a low priority to the development of a strong indigenous HIV prevention capability. AIDSCOM and AIDSTECH, USAID and no doubt many other donors will continue to support the national program, and that is as it should be. But outside support cannot be guaranteed and, in any case, outsiders will have difficulty contributing to the institutionalization of an indigenous prevention capability if the government itself is not convinced that such a capability is important.

**Partnerships between the government and non-government, voluntary and private-sector organizations are lacking in HIV prevention programs.**

In regard to the second constraining point of view, the DOH has from the beginning tended to insist that all HIV prevention initiatives in the Philippines originate in and be managed or overseen by the DOH. In this the DOH is following the path that most governments take, believing that its own expertise and resources are better suited than others to tackle the problem. This approach is probably appropriate in a country whose centralized bureaucracy controls much of the existing health-care infrastructure, but bureaucracies do not always take advantage of the additional (and in HIV prevention, often pivotal) resources offered by the non-government, voluntary and private sectors.

Although the DOH is willing to work with these organizations -- and indeed has renewed its overtures to such groups in recent months -- the fact remains that in 1990, only one or two non-government organizations of any kind are working on HIV prevention. To be fair, the responsibility for this situation can be laid only partly at the DOH's doorstep; despite prodding, very few non-government organizations have expressed interest in AIDS and those that do require constant attention to ensure their participation. Still, as early as October 1988 (in the AIDSCOM-sponsored consultative workshop described on page 14) the DOH obtained written commitments of specific support for HIV-related programs from at least 20 different public and private agencies. None of these commitments was followed up in a systematic way (the then-national AIDS program manager wanted to do so but lacked the time and resources to undertake this full-time job adequately). As already noted, no non-DOH agencies sit on the national advisory committee and none has even been invited to attend committee meetings.

Given all of these factors, the national AIDS program finds itself still isolated and somewhat alone, both within and outside the DOH, even after two years of intense and often highly visible activity. This state of affairs has caused some staff frustration, particularly in regard to many programs that are undertaken only to have to be shelved, delayed or discontinued later on. The situation has also affected AIDSCOM, perhaps most tellingly in the case of its resident advisor in Manila.

The idea of having an AIDSCOM resident advisor in Manila has never sat well with the DOH. Eventually the idea was accepted on condition that the individual would be a Philippine national who would work out of the DOH's AIDS program office. In theory the resident advisor was to advise and assist the national program manager on

substantive issues pertaining to AIDSCOM's ongoing technical assistance as well as public health communication issues in general. In practice, the resident advisor was perceived to be in effect an employee of the DOH charged with providing logistical support to the program as a member of the "AIDS secretariat." This significant difference in perceived definition of responsibilities caused continuing although not insurmountable problems. The first resident advisor AIDSCOM hired took her theoretical autonomy perhaps too seriously in the actual context of the job, made unfortunate waves and with general consent was soon asked to resign. Following her departure the advisor's job description was substantially rewritten (one of a total of four such revisions since 1988) and, after a long hiatus, a new advisor hired. This individual, perhaps the Philippines' foremost authority on development communications and a universally respected professional woman, happened to take up her duties at the DOH during a transition between national program managers. For several months she was the only ranking individual in the AIDS program office, a position that was awkward at best and, eventually, one that led to the only friction between AIDSCOM and the DOH that has occurred in the course of their working relationship. This happened when the newly hired national AIDS program manager misunderstood the resident advisor's position, believing that the resident advisor was a member of the DOH staff and must be loyal to the DOH alone. The confusion on which this belief was implicitly based led to yet another revision of the advisor's job description -- this time making the incumbent directly responsible to a DOH manager outside of the AIDS program altogether. Unfortunately, when delivery order funding for AIDSCOM's Phase One technical assistance ran out in June 1990, the second resident advisor also resigned, citing a desire to return to semi-retirement.

In the end, AIDSCOM's experience with the position of resident advisor offers instructive lessons. First, as long as the position is filled by a Philippine national who works out of the DOH, institutional responsibilities and loyalties will be difficult to make clear. If the position is to be refilled, therefore, it would probably be advisable for the new resident advisor to maintain an office and work outside of the DOH. Second, it is not clear that the DOH needs (or can properly absorb) local, day-to-day technical assistance of the substantive kind that the resident advisor was originally envisioned to provide. If such assistance is required, AIDSCOM personnel or local consultants and contract agencies are able to provide it. What the DOH really needs is its own administrative and logistical staff who can keep track of details as well as design and manage programs, and AIDSCOM cannot provide these permanent employees. Third, and perhaps most importantly, two years of program implementation experience strongly suggest that AIDSCOM itself does not need a local resident advisor as originally envisioned. Like the DOH, AIDSCOM needs an administrator capable of tracking program implementation, monitoring AIDSCOM-funded contractors and consultants and making sure that the several different elements of AIDSCOM's technical assistance programs interact properly.

### **Building Institutional Capacity and Skills**

#### **Highlights and Trends**

In order to accomplish its Phase One objectives in building institutional capacity and skills, AIDSCOM provided the following technical assistance:

- **Training and assistance in communications methodology, research and materials**

#### **TRAINING OBJECTIVES**

Because the DOH has decided to set up a special new "floating" AIDS prevention and control program that is responsible directly to the Undersecretary for Public Health Services, the AIDS program needs significant technical assistance from outside agencies such as AIDSCOM to build capacity and improve staff skills. Accordingly, AIDSCOM was asked by the government to:

- (a) provide the AIDSCOM Resident Advisor with staff, equipment and logistical support which could bolster national program capacity;
- (b) develop and implement in-service training programs for AIDS staff in the areas of policy, planning, communications methodology, research and materials development;
- (c) develop and implement in-service training programs for non-AIDS personnel within or outside the DOH in the areas of counselling, telephone hotlines and educational interventions; and
- (d) provide opportunities for AIDS staff to visit the U.S. or other locations for the purpose of in-service training and AIDS-related conference attendance.

Figure 3.

development. (Training and assistance in policy and planning issues are discussed on pages 14-15 above.) In addition to overseeing AIDSCOM's technical assistance in the areas of communications methodology, research and materials development, DOH AIDS staff were also included and trained in the actual

implementation of programs. They participated in the selection of local contractors to carry out different components of the technical assistance, helped to plan and implement specific projects and assisted in the analysis and evaluation of the final outputs. Although specific, individual trainings were sponsored by AIDSCOM (at Puerto Azul, Villa Escudero and in Manila on several occasions) to institutionalize new capacity and skills, the bulk of the training was of a "hands-on" nature. As a result of this approach, the DOH gained knowledge and expertise in its own right in developing communications programs, designing educational materials and analyzing research data. In addition, AIDSCOM provided training in computer hardware and software skills to members of various DOH divisions in June 1990.

● **Training and assistance in the development of counselling, telephone hotline and educational intervention programs.** AIDSCOM sponsored a number of specific trainings in these areas. AIDSCOM consultants trained 40 counselors and 40 health-care personnel, all of whom are DOH staff working in the four major DOH health regions of the country, in two back-to-back trainings in prevention counselling theory and techniques in Los Banos early in 1989. AIDSCOM also trained 30 representatives of the DOH, non-government and private agencies in the theory and techniques of operating a telephone hotline service in Manila in January 1990. In the same training and in the implementation of the media information campaign (discussed below), AIDSCOM provided training in the theory and techniques of educational interventions to the DOH, AIDSCOM's communications contractor in the Philippines, Campaigns, Inc., and Kabalikat, a non-government health promotion agency. In addition, AIDSCOM provided ongoing technical assistance to the DOH's Manpower Training Division in developing an HIV-specific training curriculum that was field-

tested in mid-1989 and will be used to train 6,000 DOH health personnel nationwide.

● **Support to DOH AIDS staff in attending in-service trainings and orientations in the U.S.** AIDSCOM provided funding during Phase One for several DOH AIDS staff to attend AIDS conferences abroad and in-service trainings and orientations in the U.S. These activities included: support for national program manager Dr. Enrique Hernandez and AIDS information officer Peter Resurreccion to attend the first international WHO conference on information and education interventions in Ixtapa, Mexico, followed by a visit to Washington and New York for orientation (October 1988); support for Dr. Enrique Hernandez to attend the sixth international conference on AIDS in San Francisco (June 1990); and support for DOH Region 7 (Cebu) health education officer Lita Lumibaw to attend a month-long training in HIV information, education and communications at the University of California in June and July 1990.

● **Provision of logistical staff support, transportation and equipment to the resident advisor for use in the DOH.** AIDSCOM provided the resident advisor and DOH with the following staff, equipment and services during Phase One: a full-time administrative assistant and secretary; two computers, a laser printer and various computer software programs including two designed for desktop publishing; a rental typewriter; a rental car and full-time driver; office and computer supplies; and, at one point for several months, rented office space and telephones in the Philippine Convention Center.

### Discussion

Institutionalizing expertise is never an easy process at a national organizational or bureaucratic level. The process requires ample resources and patience but above all time — a

commodity that was in short supply during this reporting period. While a good beginning was made toward building program capacity and skills, much more needs to be done.

At the micro level within the DOH, AIDSCOM's technical assistance demonstrably contributed to refinements in knowledge and techniques that were quite accomplished to begin with. In a series of trainings and "hands-on" implementation exercises, DOH staff gained expertise in HIV-related communications, prevention and such specific skills as counselling. But AIDSCOM's contributions required a labor-intensity and number of visits to Manila that realistically cannot be sustained over time. Because so much time and effort were required in Manila, moreover, very little time and few resources were left over for macro-level institutionalization activities throughout the rest of the country. It must be emphasized, however, that by the end of 1988 the DOH had decided to limit all of its HIV prevention activities in Phase One to the Metro Manila region. From that time until the summer of 1990, the DOH stopped planning the implementation of programs outside Manila and, as a consequence, so did AIDSCOM.

The difficulties encountered with institutionalization in Phase One stemmed mainly from the lack of a concrete national training plan, which in turn led to an over-dependence on ad hoc training arrangements. As one of the only two donor agencies supporting the national program in Phase One, AIDSCOM was frequently expected to provide training inputs that, in a larger field of supportive donors, would logically have been implemented by other agencies. To be fair, AIDSCOM probably also "bit off more than it could chew" in believing that it could in fact deliver the majority of training inputs that would be required in Phase One. In addition, AIDSCOM realized over the course of these two years that other objectives, such as

research and the media campaign, were of a more immediate priority than the relatively more long-term objective of institutionalization.

Clearly, a more systematic approach to institutionalization is required. AIDSCOM's role in institutionalization needs to be more clearly defined, and this task cannot be accomplished in a vacuum. Many more players — particularly non-government, voluntary and private-sector players — must be engaged in the institutionalization process.

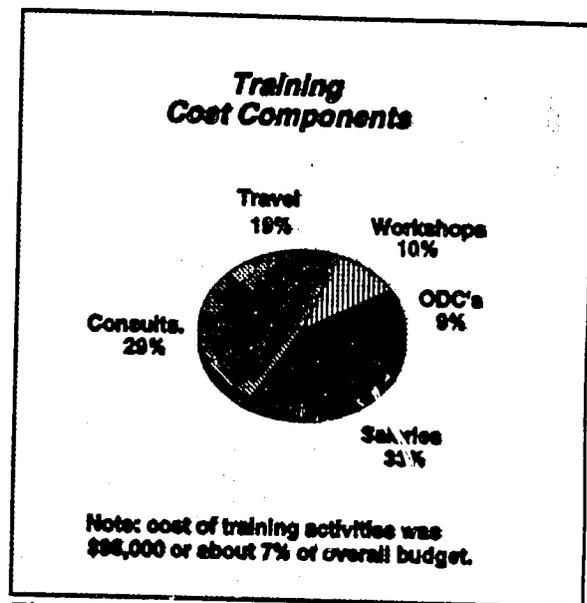


Figure 4.

WHO and other bilateral donors need to play a much more active role. Once a national training plan is developed and more players become involved (which realistically may not happen until early to mid-1991), AIDSCOM can implement those specific institutionalization programs in which it has the necessary expertise or which require the types of training inputs that AIDSCOM is able to offer. Although ad hoc opportunities for training will undoubtedly occur, care should be

taken to avoid the expectation, which was unavoidable in Phase One, that AIDSCOM, AIDSTECH or USAID for that matter are all-purpose training resources.

## Developing Baseline Research Data

### RESEARCH OBJECTIVES

Lacking the ability to date to conduct widespread surveillance, the government has had to assume the probability that certain "sentinel" populations — male and female sex workers, men who have sex with men, young adults and Filipinos who work overseas — are more likely than others to contract HIV infection. In order to understand these groups more fully and develop prevention programs specifically aimed at their needs, the government has asked AIDSCOM to:

- (a) design and implement knowledge-attitude-practices (KAP) surveys among the five "sentinel" populations using samples drawn from the Metro Manila area;
- (b) design and implement a survey of the knowledge and attitudes of the general population regarding AIDS; and
- (c) summarize and present the results of these studies in ways that facilitate and provide direction for the development of communications programs about HIV infection and AIDS.

Figure 5.

### Highlights and Trends

In order to accomplish its Phase One objectives in developing baseline research data, AIDSCOM provided the following technical assistance:

- **Funding assistance to hire two local research suppliers.** AIDSCOM provided significant funds and technical assistance to conclude contracts with the Asia Research Organization (ARO), to implement the nationwide survey on AIDS, and Total Research Needs (Trends), to implement the KAP surveys within Metro Manila. Both groups were chosen on the basis of their numerical scores in a competitive bidding process by a selection committee that included DOH and AIDSCOM representatives.
- **Extensive technical assistance in the design, pre-testing, revision and fielding of eight research projects in Metro Manila and throughout the country.** AIDSCOM and one of its subcontractors, Porter/Novelli, provided some six person-months of intensive technical assistance to the DOH, ARO and Trends during Phase One. Activities included:
  - **Development of a research plan,** the first of its kind ever developed in the Philippines on the subject of AIDS, including both qualitative (focus group discussion) and quantitative phases. A discussion guide was designed for the qualitative phase as were coding and tabulation guides and guidelines for the training of interviewers in the quantitative phase.
  - **Implementation of eighteen separate focus group discussions** among the seven target populations in Metro Manila (male and female young adults, male and female commercial sex workers, male and female expatriate Filipino workers and men who have sex with men) to assess the nature and depth of their AIDS-related knowledge and attitudes, and to

determine the language and lifestyle variables that might affect research among each population.

- **Design and implementation of seven separate but related KAP surveys.** On the basis of the qualitative findings, separate questionnaires comprising as many as 150 open-ended and close-ended questions were developed for each of the seven target populations. To ensure comparability of data, all questionnaires contained identical core questions on the demographic and psychographic characteristics of each target population, as well as similar or identical questions regarding knowledge, attitudes and behaviors associated with AIDS, condom usage and such variables as media habits. Each questionnaire was pre-tested among its target population, and some questionnaires (sex workers and men who have sex with men in particular) had to be revised as many as eight times before they were approved for fieldwork. The seven quantitative surveys were fielded in Metro Manila in a total overall sample of 900 Filipinos between January - April 1989.
- **Design of a nationwide survey of Filipino knowledge and attitudes associated with AIDS.** In 1987, the Gallup research organization conducted a worldwide survey of knowledge and attitudes associated with AIDS under its own auspices. The 1987 survey was also fielded in the Philippines by ARO, Gallup's Philippine affiliate. AIDSCOM arranged with ARO to rerun the original survey intact with some new and updated questions added. The national survey of a representative sample of 1,500 Filipinos was completed in November 1988.
- **Documentation, analysis and dissemination of all qualitative and quantitative data.** AIDSCOM completed full final reports on the results of the national survey, 18 focus group discussions and 7 KAP surveys by the summer of 1989. In the case of the KAP surveys of male and female young adults, AIDSCOM (through the New York office of Porter/Novelli) tabulated all data in-house owing to the urgency of presenting the results quickly to DOH managers. The data obtained in the national survey and sex worker and young adult KAP's were formally presented to representatives of the DOH and several non-government organizations in dissemination seminars held in Manila in April and July 1989. Extensive analysis of the data is ongoing as this report is written. In an effort to include non-government and voluntary organizations more effectively in the research effort, AIDSCOM in April 1990 arranged for consultants from the Health Action Information Network (HAIN) and the University of the Philippines in Manila to conduct an in-depth analysis of the overall research findings.
- **Presentation of data in special formats at international conferences.** On the basis of data obtained in the KAP survey of female sex workers, AIDSCOM developed and delivered special presentations at two successive, WHO-sponsored international conferences on AIDS information, education and communications (IEC). One presentation, informally dubbed "Maria I" and presented at the First International Conference on IEC in Ixtapa, Mexico in October 1988, concerned the knowledge and attitudes of a representative female sex worker studied in AIDSCOM's survey. The other presentation, informally dubbed "Maria II" and presented at the Second International Conference on IEC in Yaounde, Cameroon in October 1989, concerned the importance of psychographics in determining whether or not a representative female sex worker studied in AIDSCOM's survey would or would not use condoms, and why.

### Summary of Research Findings

#### 1. Awareness of AIDS and Perception of Personal Risk

● "Top of mind" awareness of AIDS is highest among sex workers (32%) and men who have sex with men (47%), lowest among young adults and overseas workers (15% among males and 7% among females).

● Perceived personal risk of HIV infection tends to correspond with "top of mind" awareness of AIDS. About 32% of respondents felt they were at high personal risk of infection, with the highest percentages among female sex workers (64%), male sex workers (48%) and men who have sex with men (32%). Among the young adults and overseas workers, more males (25%) than females (19%) perceived themselves to be at personal risk.

#### 2. Correct and Incorrect Knowledge About AIDS

● A majority (66%) of the respondents said they had little or no knowledge about AIDS while 76% believe that "little is known about how AIDS spreads." Being aware of AIDS does not therefore denote accurate knowledge about the disease. The data show that, while substantial numbers understand HIV is transmitted sexually by infected individuals (90%), perinatally (65%), through blood transfusions (60%) and shared needles (46%), there remain widespread and significant misconceptions about HIV transmission.

● Significant numbers believe HIV can be transmitted through the air, through water and as the result of casual social contact with infected individuals. Common false beliefs include transmission through living with an infected individual (27%), sharing utensils (26%), public toilets (21%), mosquito bites (21%), sneezing and coughing (18%),

swimming pools (17%) and breathing infected air (15%).

● Nearly half (45%) of those surveyed believe AIDS is a Western disease that Filipinos should not worry about. This perception may be related to data showing that most respondents do not personally know anyone who has AIDS (only 35% said they had even heard of Filipinos with AIDS and only 7% actually knew someone with the disease). It may also be related to widespread media publicity about HIV-positive cases found mainly among female sex workers near the U.S. military bases. The data do in fact show that 80% of respondents believe the presence of the bases increases the possibility of spreading AIDS in the Philippines.

● Vulnerability to infection is perceived to be the result of identity rather than behavior. Groups perceived to be most vulnerable to getting AIDS are: female prostitutes (24%), homosexuals (17%), promiscuous females (15%), male prostitutes (12%), bisexuals (8%), promiscuous males (8%) and Americans (7%). These perceptions may again be related to media publicity about AIDS that stereotypes those already known to be infected (in much the same manner that the media reinforces stereotypes of sexually-transmitted diseases as being associated with women (sakit sa babae).

● Donating blood is perceived by more than half (55%) to be a transmission vector, which may be a confusion of the correct perception that HIV can be transmitted through blood transfusions.

● Many (44%) believe that HIV infection is readily apparent to the naked eye, although most (55%) are aware that a person can be infected with HIV and still look healthy. Those most aware of the "hidden" nature of HIV infection were homosexual/bisexual males (75%); those least aware were male sex workers (29%). Disturbingly, male sex workers (59%)

and female sex workers (65%) were most likely to believe that they could "sense" if a partner was HIV-infected, for reasons ranging from smell to physical manifestations such as skin lesions.

### 3. Awareness of Diagnostics

● Most respondents (83%) are aware that an individual can be tested for HIV infection, and most (66%) also said this involved a "blood test." However, knowledge about diagnostics beyond this point is not necessarily accurate. About half of the sex workers who said they had taken the test reported that the blood sample was taken by pricking the finger. All kinds of tests were cited by respondents as tests for AIDS: urine tests (14%), X-rays (6%), inspection of genitals (3%) and Pap smears (3%). Other respondents cited tests involving the saliva, semen, stool and the eyes. About 9% of respondents said they knew of a test for AIDS but did not know what the name of the test was. These data have implications for information campaigns that encourage testing, as well as policy discussions regarding the regulation of testing in physician's offices and particularly in private clinics, where bogus or inaccurate testing is said to be occurring more frequently.

### 4. Sources of Information About AIDS

● Most respondents said they got information about AIDS mainly from the media (92%) followed by friends and colleagues (39%) and clinics and hospitals (14%). Their trusted sources of information are ironically almost the reverse of actual sources, however: medical personnel (41%), the media (an average of 35% with a low of 15% for sex workers) and books (9%). Nearly 40% of respondents said a doctor's office or clinic would be the most convenient place to get information about AIDS, followed by health centers/hospitals (24%) and newspapers and magazine stands (10%). On the type of information sought

about AIDS, more respondents were interested in treatment (48%) than in prevention (28%), transmission (22%), symptoms (20%) or origins of the disease (18%). Most respondents (69%) said they had made an effort to get more information on AIDS.

### 5. Psychographic Characteristics

Each survey contained a battery of 50 questions on "psychographic" variables designed to determine how respondents viewed themselves and their lives. Psychographics attempts to measure individual "locus of control" (whether a person feels in control of people and events, or controlled by them); assertiveness; group orientation; moralism; rationality and individualism. These traits could provide insights into the prospects for behavioral change leading to risk reduction. It is, however, difficult to draw general conclusions using group averages. Summary reports on each of the survey populations will include deeper analysis of psychographic characteristics. Overall, the following trends are worth noting:

● Women tend to feel less in control of themselves and their environment (lower locus of control) than men do, regardless of survey population. Women also have lower scores for assertiveness. However, women have higher scores for moralism, including female sex workers.

● Male overseas workers score highest for locus of control, assertiveness and group orientation.

● Sex workers, particularly the women, generally scored lower than the other groups for most of the psychographic traits. Their scores for group orientation were low compared to the other groups. A form of fatalism, expressed by agreement with the statement that "We all die anyway so why worry about AIDS," was expressed by 30% of

male sex workers and 45% of female sex workers."

● Filipinos probably view control of themselves and their environment differently than Westerners, which may necessitate new approaches to information dissemination and appeals to change risk behaviors. Preliminary analysis using group means suggests that two forms of locus of control may be operational among the survey populations:

○ A collective type of locus of control built around assertiveness and group orientation, suggesting that assertiveness for many may actually be developed only within groups; and

○ An individualistic type of locus of control built around rationality, moralism and individualism.

#### 6. Sexual Behaviors and Attitudes

● The median age for first sexual intercourse is around 17 for males and 20 for females (except for female sex workers who reported a median age of 16 for first sexual experiences with customers). These figures should be interpreted with caution considering that a significant percentage of respondents reported they had never had sex (89% of young adult females; 37% of young adult males; 32% of female overseas workers, 17% of male overseas workers and 6% of gays/bisexuals).

● Most (62%) of the female sex workers' customers are married Filipinos (it should be noted that female sex worker sample was drawn from individuals working outside the tourist belt).

● Male sex workers have more varied sex partners than their female counterparts, and many of the male sex workers' customers are married women. In the past four weeks before the survey, 57% of male sex workers had had sex with homosexuals; 47% with married

women/matrons; 25% with female prostitutes; 22% with unmarried women/widows and 9% with bisexual/married men.

● There is considerable "crossing of gender boundaries" among all male respondents. For example, the "gay/bisexual" sample reported that they have sex most often with men who they perceive to be non-homosexual, with 49% reporting that almost all of their sex partners are non-homosexual Filipino males. One-third of the gay/bisexual sample have had sex with women. Some young adult males (27%) and male overseas workers (17%) report having had sex with other men including non-homosexuals, homosexuals, bisexuals and male sex workers. Reports of same-sex intercourse were low among women (5% for the overseas workers, 2% for young adults and 0 for sex workers). In order to describe more accurately what appears to be the sexual reality among the Filipino men surveyed, therefore, we have chosen the term "men who have sex with men" to refer to this population.

● Respondents are sexually active with sex workers, although it is difficult to generalize about multiple partner activities. Among male respondents, 38% have had sex with sex workers (male and female). Of these, nearly half (42%) reported having had sex with sex workers within the past year.

● Respondents in general, but particularly sex workers, do not use protection in vaginal intercourse. Majorities of both female sex workers (54%) and male sex workers (63%) report having unprotected vaginal intercourse "most or half of the time."

● Anal intercourse, perhaps the sexual behavior most likely to transmit HIV, is not widely practiced even among men who have sex with men. Only 18% of men who have sex with men regularly engage in anal sex (giving or receiving). A third of male sex workers and 17% of female sex workers engage in

unprotected anal intercourse with transfer of semen "most/half of the time". Among other survey populations, only 1% of young adult males, 6% of overseas workers and none of the women from either of these two populations admit to having tried anal intercourse.

- Respondents displayed several positive attitudes toward sexual behavior which may prove useful in formulating HIV prevention programs. More than three-quarters (86%) of respondents agree that sex partners should discuss previous sexual experiences.

A similar percentage (85%) believe sex should be limited to one partner and 73% say sex should be limited to married partners. However, 48% of young adults and overseas workers believe it is "natural for men to pursue sex at every opportunity."

#### 7. Substance Use and Abuse Behaviors

- Males generally report higher rates of substance use and abuse than females (with the exception of sex workers, who were unfortunately not asked questions about substance abuse). Of the 700 respondents from the non-sex worker populations, 45 or only 6% admitted having used drugs intravenously and 16 had shared needles. The highest percentage of intravenous drug use was reported among young adults (22 males and 3 females for a total of 25). Other forms of substance use and abuse, while not directly related to HIV infection, should be considered because of the possibility of impaired judgement prior to sexual encounters. About 36% of respondents have used marijuana and 77% have used alcohol. About 12% of the respondents admit frequent use of alcohol beverages during the past six months. (These figures should be interpreted with caution. A large number of respondents admitting the use of intravenous drugs, marijuana and even alcohol could not recall when they last used these substances.)

#### 8. Condom Usage Behaviors and Attitudes

- About one-third (32%) of the males have used condoms but those reporting that they "always use condoms" are limited to a range of 1% of young adult males to 4% of male sex workers. (Not all respondents are sexually active, however.)

- Condom usage is mainly perceived as a preventive measure against sexually transmitted diseases (83%) but many (58%) also believe that condoms protect them against HIV infection.

- Receptivity to condom usage is high. Among males not involved in sex work, 67% said they would agree to use a condom if their partner requested it. The use of condoms as a way of showing "concern for partners" was cited by 74% of respondents. Most sex workers expressed the desire that condom usage would become "more fashionable." Among sex workers who have tried to use condoms, however, 67% of the males and 46% of the females have experienced customer refusal to do so.

- Religious beliefs may pose barriers to use of condoms. Among males, 19% believe condom use is a sin. (Significantly, 28% of female sex workers share this belief.)

- Knowledge about correct condom usage varies. Among males, 31% expressed uncertainty about correct usage, while 14% thought that condoms can be washed and reused.

- Negative attitudes toward condom usage are widespread. Among these barriers are feelings that condoms reduce sexual sensitivity (77%), interfere during intercourse (67%), offend regular partners (77%), create feelings of distrust (65%) or insult (63%) and may be unreliable (68%). Most (68%) respondents felt the use of condoms might give the impression that "I am unclean" and 53% said they would forget to use condoms when

sexually excited. Access to condoms and buying them may also be constraints: 40% of respondents said condoms are embarrassing to buy and 22% said they are too expensive.

#### 9. Reported Preventive Behavior Change

● Fear of AIDS has provoked many to change their behavior but reported behavior changes are not necessarily protective. Although 76% of respondents said they were aware that they could take personal steps to prevent AIDS, only 25% of respondents said they have taken steps toward "a lot of behavior change" while 42% said they had moved toward "a little behavior change." The data suggest that there is a gap between known effective preventive measures and the actual behavior changes respondents are making. For example, many accurately said they could prevent AIDS by having a regular partner (54%) and using condoms (36%). But the tendency to associate AIDS with groups ("them") rather than behaviors ("us") is also evident: 69% said they would avoid sex with sex workers and 65% that they would avoid sex with homosexuals. Most disturbingly, significant percentages believe that such non-protective measures as taking vitamins (36%) or antibiotics (33%), washing after sex (31%), withdrawal (19%) and regular medical check-ups (68%) would prevent them from getting infected.

#### Discussion

Without question, the development, implementation and analysis of these research projects are among AIDSCOM's most notable achievements in Phase One technical assistance to the Philippines. The surveys yielded rich data sets that will be useful for years to come as a baseline against which to measure changes in knowledge, attitudes and behaviors. The data are also invaluable in terms of designing programs and evaluating program effectiveness. The next section of this report

**The research projects are important achievements, yielding rich baseline data for program design and evaluation and models for future efforts.**

will show, for example, that the data were pivotal in both the development of the pilot media information campaign and the evaluation of its impact on basic knowledge and attitudes. In addition, the methodology employed in these surveys is an important benchmark for future research projects in the Philippines and elsewhere. The survey instruments developed by AIDSCOM for these projects have already been used as models for similar projects being designed by researchers from AIDSTECH, the University of California at Los Angeles and the University of Texas. Finally, the data have made it possible to break new theoretical ground, specifically in the analysis of psychographics as a crucial determinant of risk behaviors. (For examples, see the section on "Psychographic Characteristics" on pages 26 and 27.)

These benefits would seem to justify the significant cost of the research, on which about 38% of available Phase One resources were expended. This magnitude of cost was not anticipated when AIDSCOM's technical assistance budget was first projected in early 1988, largely because it was then difficult to estimate the amount of time and effort that would eventually be needed to accomplish the task. Nothing like these surveys had ever been undertaken on the subject of AIDS or on the same scale in the Philippines, and several of the target populations had not been studied previously. That meant much more time than initially planned in gaining access to and

interviewing subjects, revising instruments and particularly in analyzing data and developing presentations based on that data. In a real sense, AIDSCOM and its research partners were explorers in uncharted territory. The eventual cost increases in that exploration were borne because the benefits were perceived to be (and are) crucial to the success of the entire technical assistance effort.

It must also be pointed out that high development costs in Phase One will yield substantial savings in Phase Two: future research projects will not need to go over the same ground and will therefore be much less labor- and capital-intensive. Because care was taken in Phase One to enhance local research skills in AIDS-specific areas, most Phase Two projects can now be designed, implemented and to a great extent analyzed by local experts. In that regard, AIDSCOM was indeed lucky to have located both ARO and Trends, its competitively selected partners in these research projects. These firms did a consistently excellent job, turning in rigorously accurate data reports on time or in advance of deadlines and frequently under-budget.

Finally, it is important to point out that while the research projects were excellent overall, we did make some mistakes that will need to be rectified in future projects. Among the points that will require attention:

- The questionnaires we used were probably too long (an average interview took two hours) and yielded more data than we actually needed. Now that we know this, future projects will not need to be nearly as comprehensive. They should focus instead on data regarding knowledge, psychographics and behavior, which turned out to be the subject areas most useful to the DOH and AIDSCOM in Phase One.
- Despite our best efforts, some of our own assumptions, particularly assumptions about

behavior, may have crept into some of the studies. For example, we failed to ask a uniform set of questions about specific sexual behaviors of all of our survey samples, perhaps on the assumption that sex workers and men who have sex with men, who were asked the most wide-ranging behavioral questions, are the only ones whose sexual activities merit comprehensive study. There are gaps even within the comprehensive data sets. For example, we failed to ask specific questions about anal intercourse of more than the male sex worker and men who have sex with men samples, perhaps on the assumption that only these individuals practice anal sex (but also because the questions were deemed too explicit for such samples as young female adults). While these quibbles may seem minor, they do remind us that more care must be taken in future studies to root out investigator bias.

Some subject areas were also left out, for reasons of time or space or simply because they did not occur to us at the time, that we later wished had been included. Some of these subjects areas now turn out to be crucial,

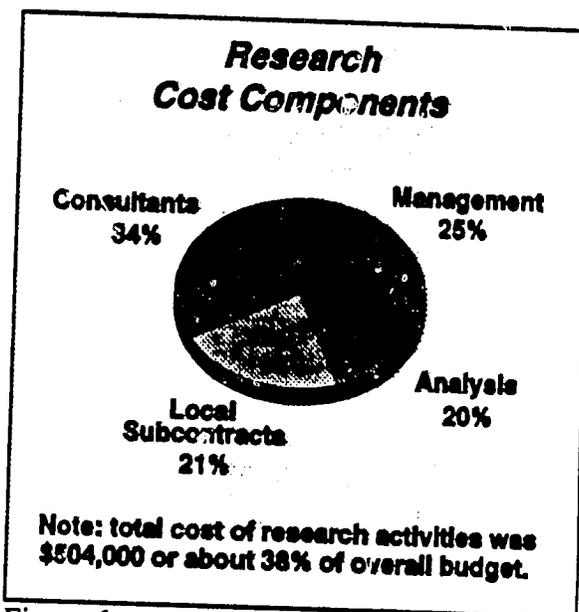


Figure 6.

according to the existing data: definitions and perceptions of what constitutes a "relationship," feelings regarding cross-gender behaviors and analysis of social networks, among several others. Omissions of one kind or another are common to all research, and did not uniformly characterize these studies. But the missing data do present opportunities for significant future work.

## Designing and Testing A Communications Campaign

### CAMPAIGN OBJECTIVES

Once extensive background research and planning are completed, the AIDS program would like to launch a pilot campaign limited to the Metro Manila region, where most HIV infections have so far been found. Accordingly, the government has asked AIDSCOM to:

- (a) develop creative strategies for communicating about AIDS to the general public and special audiences, based on careful analysis of background research;
- (b) design and implement targeted information and prevention campaigns using appropriate media and specially developed educational materials; and
- (c) develop and implement a systematic media relations function within the DOH to make effective use of print media in particular in correcting inaccurate information, promoting prevention and informing the public about the government's AIDS program activities.

Figure 7.

### Highlights and Trends

In order to accomplish its Phase One objectives in designing and testing a communications campaign, AIDSCOM provided the following technical assistance:

- **Funding and technical assistance to hire a local communications supplier.** AIDSCOM provided significant funds and technical assistance to conclude a contract with Campaigns, Inc., of Makati, Metro Manila, to assist in the design and implementation of a multi-media communications campaign in the Metro Manila region only. The firm was chosen in a competitive bidding process by a selection committee that included DOH and AIDSCOM representatives.
- **Extensive technical assistance in the design, pre-testing, implementation and evaluation of a multi-media communications campaign in Metro Manila.** AIDSCOM and one of its subcontractors, Porter/Novelli, provided more than three person-months of intensive technical assistance to the DOH and Campaigns during Phase One. Activities included:
  - **Development of "creative briefs" based on the research data** to identify key trends in the knowledge, attitudes and behaviors of survey populations and, on the basis of those trends, suggest the tone, approach, potential reach and other elements of the media campaign. Three such briefs were developed: for the general public and young adults, as the basis for the media campaign, and for sex workers, as the basis for a specifically targeted intervention.
  - **Design and pre-testing of two complete campaign treatments**, one based on a "celebrity" appeal and one based on a non-celebrity appeal. Both treatments were similar in substance but pre-testing was necessary to determine whether a campaign based on popular Filipino celebrities would be better recalled and thus more effective than a

campaign based on non-celebrities. As it turned out, the non-celebrity approach fared better in pre-testing and was thus chosen as the basis for the campaign.

- **Design and pre-testing of the final, non-celebrity campaign treatment.** Once the non-celebrity approach was selected it had to be developed into a full-fledged campaign, including three different 30-second television spots, three different 30-second radio spots and a "tickler" ad for newspapers. Realizing the potential complexity of designing and approving so many products in a short (three month) timeframe, AIDSCOM worked out an innovative approval process with the DOH. This entailed an agreement signed by the Undersecretary for Public Health Services which laid out a process and deadlines for DOH approval of all campaign products, and specified for Campaigns a detailed listing of over 200 steps (most of which required specific approvals from both DOH and AIDSCOM) toward completion of campaign preparations. The preparation and approvals process was eventually completed on time without difficulty or delay.
- **Implementation of the media campaign in Metro Manila.** The media campaign was launched on television and radio and in newspapers in Manila on February 7 and ran through May 15, 1990. Television and radio spots ran continuously throughout each day of the campaign on three TV channels and ten radio stations; newspaper ads ran daily in seven different newspapers, including the tabloid press. TV Channel 2, the most frequently watched station, was chosen as the leader in television advertising; Channels 4 and 9 were also used for spot advertising in special sponsorships of the Philippine Basketball Association's 1990 play-offs and in the first airing in Manila of the AIDS film, "An Early Frost."

- **Development of educational materials to support the media campaign.** Prior to the campaign launch, AIDSCOM provided significant funding and technical assistance in the design, pre-testing and production of several educational materials to support the campaign and the overall AIDS program. These materials included:

- a 12-page brochure containing general information about HIV infection, AIDS and their prevention, published in 200,000 copies in English and Tagalog.
- an 8-panel, 2-sided, fold-over brochure containing specific information about HIV prevention, published in 125,000 copies in English and Tagalog.
- two 4-color posters repeating messages and graphics used in the television spots, published in 10,000 copies in Tagalog.

- **Development and distribution of a special information packet on AIDS for Filipino physicians.** AIDSCOM provided significant funding and technical assistance in the design, production and distribution of a special information packet on AIDS. The packet comprised a specially printed folder containing copies of the above brochures as well as a letter signed by Secretary of Health Bengzon and several individual pages of information on AIDS — including infection control, transmission vectors, prevention, sterilization, HIV blood testing, blood transfusions, the overall Philippine AIDS program and the media campaign and telephone hotline — which was believed to be specifically useful to physicians. The packet was mailed to every one of the 10,000 physicians throughout the country who had registered with the Philippine Medical Association.

- **Development and implementation of a multi-phased media relations program.** AIDSCOM provided ongoing assistance to the

DOH in implementing a series of briefings, media events and press placements in Manila media, all of which were designed to educate the media about AIDS and increase the frequency and accuracy of AIDS-related media coverage. These activities included:

- ten informal briefings of approximately five journalists in each briefing.
- a "media event" held in a Manila hotel in February 1989 which was attended by 60 journalists from TV, radio and newspapers. At this event, and for the first time ever in the Philippines, several HIV-infected female sex workers and a gay man spoke to the press about their experiences and feelings from behind a curtain. The event produced a surge in media coverage of AIDS that lasted several weeks.
- another media event held in a Manila hotel in March 1990 which was attended by 70 journalists from TV, radio and newspapers. Again, HIV-infected sex workers spoke from behind a curtain. The event resulted in increased coverage of AIDS that lasted for several weeks and was followed by considerable coverage of the media campaign and telephone hotline, which were then underway.

### **Planning and Implementing the Campaign**

The media campaign was dependent upon the baseline research for its substance and character. Had the data not been as extensive or as lucid as it is, the campaign would have been quite different or, more probably, not feasible at all. As it was, the data contained clear indications of the direction in which the campaign had to go.

**Because false beliefs prevent accurate assessment of risk, the campaign focused on decreasing misinformation.**

The roughly 2,400 Filipinos we surveyed were highly aware of AIDS and concerned about it, but their knowledge about the disease and its prevention was miniscule. What most said they knew was based to a disturbing degree on false beliefs and plain misinformation. The data made clear that false beliefs about HIV transmission in particular were probably fueling an abnormally high level of fear and at the same time making it difficult for people to assess their own potential risk of infection accurately. On the other hand, many of those we surveyed — particularly young males and sex workers generally — were responding to their fear of AIDS with preventive behaviors such as frequent check-ups, antibiotics and washing after sex that are not in fact protective. In addition, the data indicated a strong tendency among all populations we surveyed to believe that AIDS was a "foreign" problem, a problem of "others" such as homosexuals and, as a result, not something that Filipinos needed to worry about.

On the basis of these findings, the DOH, AIDSCOM, Trends and Campaigns came to consensus agreement that the media campaign would focus on the following basic messages:

- Anyone can get AIDS, even Filipinos.
- AIDS is transmitted sexually through intercourse with an infected person.
- You can't tell if someone is infected just by looking at them.

- AIDS is not transmitted through the air or water via mosquito bites, public toilets or coughs.
- Vitamins, antibiotics and taking baths will not prevent AIDS.
- You can prevent AIDS through knowledge. Learn more. Call the hotline.

The objective of these messages was to decrease false beliefs and misinformation and at the same time increase the ability of individuals to assess their own risk behaviors more accurately. The messages were also meant to instill the idea that AIDS is preventable, that individuals can protect themselves through information and that help was available to them through a telephone hotline. Finally, we wanted to target the discriminatory blaming of homosexuals and foreigners which obscured the fact that HIV was a threat to non-homosexuals and non-foreigners as well.

**Cultural factors make explicit discussion of condoms and safer sex difficult except in private educational settings.**

Obviously, the selection of these messages left out others such as the promotion of condom usage or safer sexual practices. The inclusion of such messages was debated but ultimately rejected by the DOH, which wanted to avoid shocking the public and avert a confrontation over condoms with the Catholic Church (which had signaled that it would not interfere with AIDS prevention programs if discretion were used in promoting condoms for purposes of disease prevention). Explicit messages about sex and condoms had never appeared on Philippine media. The DOH was

understandably leery of creating a sensation with its fledgling AIDS program that could very well shut the program down, just as the Philippine family planning program had been shut down some years earlier. Instead, the DOH preferred to limit explicit discussions about sex and condoms to private hotline conversations and to small-scale counselling and educational programs.

Once these decisions were made, designing the campaign was relatively easy. The target audience would be the general public with emphasis on young male adults. Because the psychographic data showed correspondence between the attitudes and beliefs of sexually active young male adults, male sex workers and men who have sex with men — in short, that young male Filipinos tended to feel the same way about themselves and their behavior regardless of personal characteristics — we decided that a media campaign targeted at young males would also reach less accessible male sex workers and men who have sex with men. We also took care to build in messages that would reach female sex workers, i.e., advising that measures such as taking antibiotics and washing (behaviors that sex workers had adopted in their previous experience with other STD's) were not protective.

AIDSCOM's communications contractor, Campaigns, Inc., believed on the basis of previous experience that the campaign would be more effective if it contained celebrity appeals. The research had suggested a number of entertainers who were popular with survey populations. Because neither the DOH nor AIDSCOM was convinced that a celebrity approach would work, it was decided to develop prototypes of both a celebrity and non-celebrity approach to the campaign and let the pre-test results decide the issue. For the celebrity prototype, a woman singer, basketball star and male comedian were initially selected, but the DOH decided instead to use a famous

television talk-show hostess in place of all three. The non-celebrity prototype was nearly identical to the campaign that eventually aired. Extensive pre-testing of both prototypes was conducted by Trends, the research contractor, as part of its original contract with AIDSCOM. The pre-tests yielded data that showed both prototypes were effective, with a slight edge in recall and other important variables going to the non-celebrity approach. Meanwhile, the talk-show hostess announced that she was cutting back on her television work to devote more time to an evangelical religious group she had joined! This demonstrated the risk in using celebrities in ad campaigns: for better or worse, their personal lives can become associated with the campaign's message in unexpected ways.

The non-celebrity approach was thus chosen by acclamation. It consisted of three separate but related ad treatments. In each, a recognizable Filipino character appears on-screen first (or is heard first in the radio ads), speaking about the typical false beliefs and misinformation that the research had identified. At this point the screen appears to shatter with a loud sound of breaking glass (also heard in the radio ads). Then an authority figure appears sitting behind a desk to respond to the preceding misinformation with strong promotion of the accurate messages. (The type of authority figure we used was ultimately a middle-aged man in a business suit who looked much like a news anchorman. The other option discussed was a physician in a white coat, but this was rejected because we did not want to encourage the common view that physicians are the best source of accurate information about AIDS when most Filipino physicians still know very little about AIDS.) The final frame, held for several seconds with a male voice-over, advises the audience to call the information hotline number which is displayed and repeated orally. The boxes contain the scripts for the ads that eventually aired in Manila, and show the ways

**AD #1:  
"Misinformed"**

**Woman Character:** I've heard you can get AIDS from mosquito bites or public toilets. And if someone sneezes on you, you're dead!

**SHATTER NOISE**

**Authority Figure:** Wrong! You can't get AIDS from mosquito bites or public toilets or coughs. AIDS is transmitted through sexual intercourse with a person who has the AIDS virus. And you won't know who has it. Anyone can get infected, even we Filipinos.

**Voice-Over:** Stop AIDS! To know how, call the AIDS Hotline at this number.

Figure 8.

in which the selected basic messages were "translated" into advertising copy.

In the section below entitled "Measuring the Campaign's Impact," we assess the extent to which the campaign treatment and messages we chose were effective. Here, however, it is necessary to discuss a problem we encountered with Ad #2, "Prejudiced."

Although extensive pre-testing was conducted on each of the ad treatments, and although those pre-tests garnered high marks for message recall and understanding, the pre-testing was limited to representative members of the general public only. This was logical given the fact that the overall campaign was targeted at the general public. We did not realize at the time, however, that an ad designed to debunk the idea that only certain

**AD #2:  
"Prejudiced"**

**Male Character:** Why should I bother about AIDS? Only whites get it. And homo's. It's because they do all sorts of things, so they get punished with AIDS.

**SHATTER NOISE**

**Authority Figure:** Wrong! The truth is, anyone can get AIDS: white or Filipino, male or female, gay or non-gay. AIDS is contracted through intercourse with a person who has the AIDS virus. And you won't know who has it!

**Voice-Over:** Stop AIDS! To know how, call the AIDS Hotline at this number.

Figure 9.

groups are susceptible to AIDS could in fact offend one of those groups. Unfortunately, that is precisely what happened.

Within two weeks of the launching of the campaign in February, several individuals describing themselves as gay and some representatives of gay organizations located as far away as southern Luzon began calling the telephone hotline to complain about Ad #2. Some of these callers cited specific incidents of discrimination against them which they attributed directly to the ad. One caller, a nurse assistant in a Manila hospital, said he had been told he could no longer serve patients because he was gay. Another caller said customers in the Manila beauty shop where he worked had asked to be manicured by someone else who was not gay. The head of a gay organization in a barangay (village) south of

**AD #3:  
"Strike Anywhere"**

**Male Character:** AIDS? I won't get it. I always take vitamins, and I take a bath after. . .well, you know what. Besides, I take antibiotics.

**SHATTER NOISE**

**Authority Figure:** Wrong! Neither vitamins, taking baths nor antibiotics can prevent AIDS. It is transmitted through sexual intercourse with a person who has the AIDS virus. And you won't know who has it. Anyone can get infected, even we Filipinos.

**Voice-Over:** Stop AIDS! To know how, call the AIDS Hotline at this number.

Figure 10.

Manila called to say that his barangay captain had asked him and his friends to leave town because they were gay.

Several of these individuals said they understood the intent of the ad but were afraid that the average Filipino would not. Their personal experience seemed to verify that point. In order to preserve the good working relationship that has been developed with members of the local gay community in Manila, and with DOH approval, the ad was taken off the air in early April. In discussions with influential gay leaders in Manila following the cancellation of the ad, DOH and AIDSCOM representatives gained insight into their concerns. It became clear that any reference to homosexuality in public campaigns on the subject of AIDS would probably provoke a negative reaction. Like their counterparts in other countries, the gay

community in the Philippines has suffered at the hands of the media. When they are mentioned at all in the media, the reference is usually negative. By presenting an explicit caricature of such references in order to dispel them, the campaign ad nevertheless struck a raw nerve. It was, in short, the wrong treatment of the right issue.

In the end, the damage that might have been done by this unfortunate event was contained. As the next sections will show, the campaign ultimately decreased blaming attitudes toward gay men despite the fact that the ad designed to achieve this objective did not appear for most of the campaign. What we should have done — and in future will do — is involve the populations being discussed in information campaigns in the actual design of those campaigns. We will certainly pre-test ads among more representative audiences, particularly if those audiences are referenced in the ads. These are old lessons learned early in developing countries. We have had to relearn them once again in the Philippines.

### The Telephone Hotline

Based as it was on a promotion of the importance of accurate information about AIDS, the media campaign could not have been effective without the telephone hotline service to which viewers or listeners were referred in the advertisements. Although the pivotal role of the hotline was understood from the beginning by both the DOH and AIDSCOM, a series of administrative delays (caused mainly by the lack of adequate telephone capability at the DOH) prevented the hotline from being set up until just prior to the launching of the campaign. Ideally, the hotline would have been implemented at the DOH; eventually that will happen. For the duration of this campaign, however, we had no choice but to contract the function to PCF, a non-

government agency with considerable experience in family planning, teenage sexuality and telephone hotlines.

PCF did an admirable job of implementing the telephone hotline on very short notice. The agency was chosen to do so, in fact, because it was just completing work on a highly successful telephone hotline called "Dial A Friend," a project funded by The Johns Hopkins University, which was designed to offer guidance and counselling to teenagers regarding their sexuality and relationships. A team of seven PCF counselors had been answering the "Dial A Friend" phones for more than two years and had received extensive training in the methodology of counselling on issues of sexuality. The same counselors were available to staff an AIDS hotline for the DOH. In January 1990 they received additional training on AIDS-specific issues.

While PCF's experience in managing "Dial A Friend" seemed at the time to be an ideal background for the AIDS hotline, the DOH and AIDSCOM were soon disabused of any such assumption. In early meetings to set up hotline operations, it immediately became apparent that PCF had objections in principle to performing important parts of the hotline task. Apparently as a matter of corporate policy, for example, PCF refused to permit its counselors to discuss subjects such as masturbation and anal and oral intercourse unless callers asked specific questions about these behaviors. Moreover, PCF refused to discuss sexual behavior in general except in the context of abstinence and monogamy. These non-negotiable positions were understandable: in earlier years, PCF had been burned by the religious opposition to contraception which ultimately closed down family planning programs in the Philippines. However, PCF's objections did raise serious concerns about its ability to implement the AIDS hotline effectively at a moment when there was no

longer time to locate another contractor to do so.

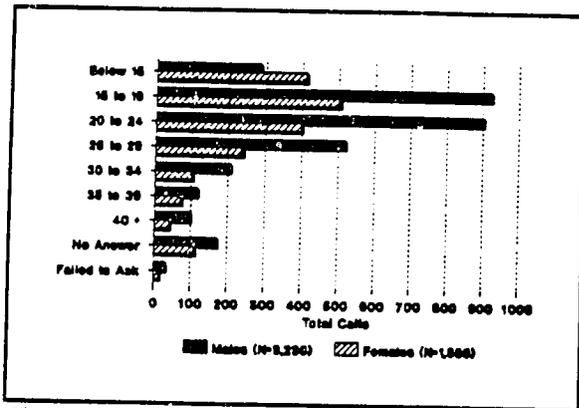


Figure 11. AGE OF HOTLINE CALLERS (February - June 1990)

Ultimately the DOH negotiated a compromise with PCF which permitted the work to continue on schedule. The compromise included agreement that PCF would not offer information on sensitive sexual issues. In response to callers' direct questions about specific sexual issues, PCF further agreed to provide only the Catholic Church's position on the matter (e.g., masturbation is a sin), or to point out that the behavior in question would not transmit HIV or, finally, to refer the caller to another agency for more information. Under these circumstances, it is not surprising that the hotline counselors referred 79% of the calls they eventually received to other agencies.

PCF's uneasiness with its role highlighted the current lack of official or even unofficial consensus in the Philippines regarding what to say to the public about AIDS and, more importantly, how to say it. Caught off-guard by PCF's positions, the DOH quickly had to reconsider its own views of these issues. In the end, few conclusions were reached beyond the necessity of a working accommodation with PCF in order to launch a media campaign that was crucially dependent

upon a telephone hotline service. It will be important to discuss and resolve these issues before proceeding with the planned continuation of the hotline in Phase Two.

Despite the problems in its implementation, however, the hotline appears to have been quite effective. It received a total of 5,124 calls during five months of operation, primarily from young single males — the intended target audience of the media campaign. Most callers wanted basic information about HIV infection and AIDS or clarification of true versus false transmission vectors. Of the young males who needed additional guidance, many expressed concern about their past sexual encounters with female sex workers. The young females who requested additional guidance were often worried about the sexual behavior of their male relatives or partners.

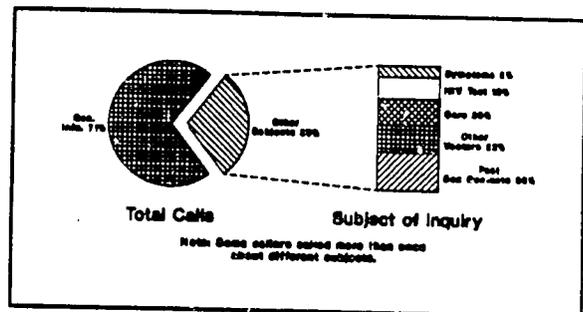


Figure 12. TYPES OF HOTLINE INQUIRIES (February - June 1990)

Other concerns presented by callers who requested additional guidance included anxieties about HIV blood testing (specifically getting the test and learning the results), fears about working next to an infected person, speculation about possible disease symptoms and treatment modalities. Several of these callers also had difficulty accepting the fact that their beliefs (a favorite was that mosquitos transmit HIV) were in fact false.

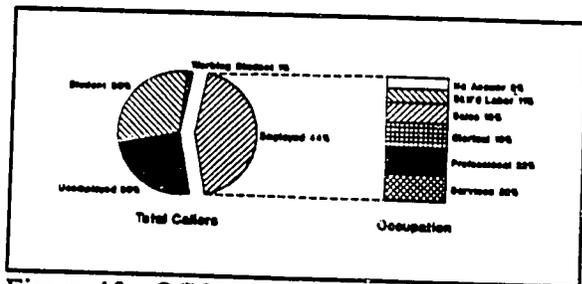


Figure 13. OCCUPATION OF HOTLINE CALLERS (February - June 1990)

Nearly 80% of the callers said they were calling from their own or a friend's home. That fact, the fact that almost half of the callers were employed and their generally high level of education all suggest a potential point of concern, however. In a country where telephone ownership is still limited to the middle and upper classes and then only to relatively few people, socioeconomic factors may have outweighed personal interest in determining who did or did not call the hotline in Manila. There is nothing wrong with reaching the young people who actually called the hotline. On the other hand, it may be unrealistic to expect a telephone hotline to reach individuals who are not relatively affluent. If that is the case, then future media campaigns might need to direct those who are interested or concerned to more accessible types of information resources than just a hotline.

**Materials Development**

Of the three basic types of materials AIDSCOM assisted the DOH in developing during Phase One — brochures, posters and a special information packet for physicians — only one of the brochures presented any problems. This was the 8-panel, 2-sided, fold-over brochure containing specific information about HIV prevention. The intent of this brochure (entitled "What Can I Do To Protect Myself From AIDS?") was to treat in

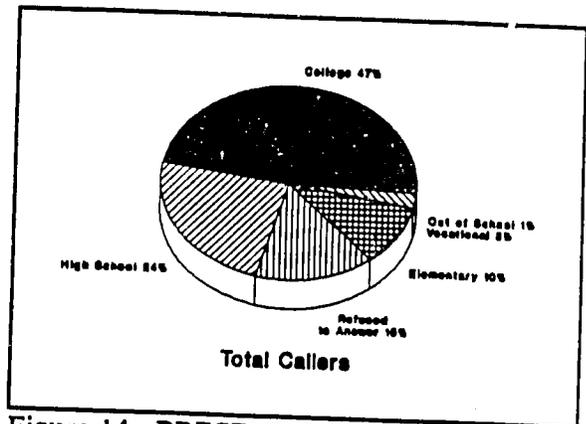


Figure 14. PRESENT OR HIGHEST EDUCATION LEVEL OF HOTLINE CALLERS (February - June 1990)

more detail than the general information brochure the specific concepts and methods underlying sexual HIV prevention. It was designed to be small enough to be inserted inside the general information brochure only for those persons who requested the types of information it contains. Like its general information counterpart, the "prevention insert" brochure is written in the simplest possible English and Tagalog words. The text first asks readers to assess their own risk based on what only they know about their actual behavior. It then goes on to emphasize that the safest sex is abstinence or monogamy. If the reader does not or cannot practice the latter, however, the brochure also provides more detailed information about specific sexual behaviors or situations which will or will not increase the likelihood of HIV transmission. The basic approach is to encourage readers to think about their behaviors, avoid behaviors that are risky or cause unhappiness and be creative.

The DOH approved the original brochure and it was printed as originally written in some 30,000 English and Tagalog

copies. At that point, however, the various issues related to the telephone hotline came up (see the previous section) and, in the ensuing review of programs and materials, the DOH changed its mind regarding the prevention insert.

The ways in which the DOH rewrote or revised the original brochure text indicate what it may or may not be possible to say publicly in the Philippines regarding HIV prevention. For example, the original brochure contained the following text: 'Try having fun with behaviors that don't pass body fluids between your partner and you. Use the body's real sex organ: your brain! Fantasy is very safe sex. So are masturbation and mutual masturbation, massage, rubbing, stroking and hugging. Be creative. You don't have to "go all the way."' In the revised brochure, this section simply reads: 'Try sexual behaviors that will not expose you to HIV infection. Rubbing, stroking and hugging are all very safe sex. You don't have to "go all the way."' The revised cover text also added a new caution that the contents are intended for 'mature men and women who are sexually active.'

The revised brochure was sent back to the printer for a run of 20,000 English and Tagalog copies. (The cost of reprinting was minimal since the original layout boards had already been produced.) Fortunately, the original brochures were not discarded. The complete print run of packaged originals was retained in storage for future use in private educational programs for such audiences as sex workers and men who have sex with men. The upshot was that the DOH eventually got two, differently targeted brochures instead of one, all-purpose brochure.

This episode is instructive for purposes of future planning. It highlights the importance for governments of deciding in advance what they want to say to their

populations on the subject of AIDS. The sensitive nature of messages about sex in most societies will undoubtedly lead to the ongoing revision of sex-based messages that we encountered in the Philippines. While occasionally frustrating, this process of fine-tuning communications materials can also lead to new approaches that were not initially obvious — as it did in Manila by producing two brochures that will, in the DOH's judgment, each be more widely useful among its target audiences than only one brochure would have been.

#### Measuring the Campaign's Impact

Since research was the driving force behind the campaign, it made sense from the beginning to plan for tracking surveys that would follow the conclusion of the pilot media campaign in order to measure its impact. Two such tracking surveys were carried out in June 1990 by the same local research contractors who had completed the original baseline research.

ARO conducted a quantitative survey using a stratified, multi-stage probability (or random) sample of 500 male and female adults aged 18 through 55+ in Metro Manila. The results of this survey were compared to ARO's baseline survey of a random sample of 246 male and female adults in Metro Manila in November 1988. With the exception of questions in the 1990 survey specifically related to the media campaign, all questions asked of the 1990 sample were identical to questions asked of the 1988 sample.

Trends also conducted a multi-stage probability (or random) sample of 200 male and female young adults aged 18 through 24 in Metro Manila in June 1990. The results of this survey were compared to Trends' baseline survey of 300 Metro Manila young adults in

mid-1989. As with the ARO tracking survey, all questions in Trends' 1990 survey were identical to 1989 survey questions, except for 1990 survey questions related specifically to the media campaign.

For purposes of clarity, we have used only the general population tracking data as a basis for this discussion and for Figures 15-19. Data from the young adult tracking surveys are also cited in the text as a point of comparison or to provide contrast to the general population data.

As Figure 15 makes clear, the media campaign appears to have been very effective in reaching all of the general population sample (96% of the young adult sample also said they saw or heard campaign ads). It is also striking that 52% of the general population sample recalled that campaign ads promoted a telephone hotline they could call for more information. This figure by itself validates other clear evidence in the survey that our sample actually saw and benefitted from the campaign, since only the campaign ads promoted the AIDS hotline. Our sample could not have learned about the hotline through any other source of information except the media campaign.

Nearly all (90%) of the general population sample said that television had been their primary source of awareness of the campaign. Radio (18%) and newspapers (10%) followed television as primary sources. Television was also cited by large majorities of

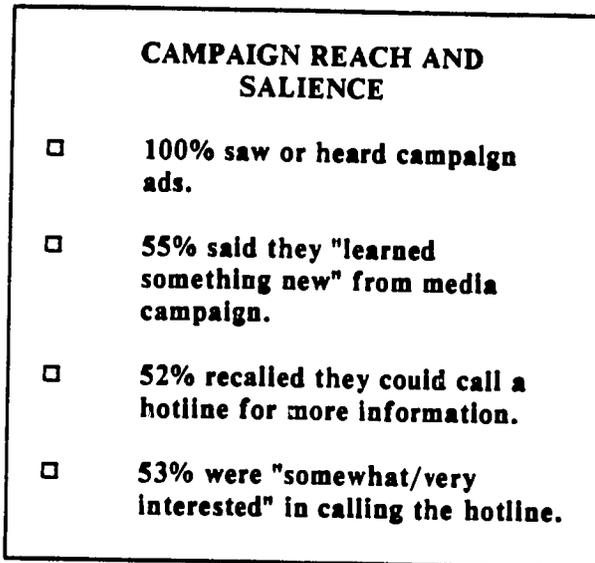


Figure 15.

hotline callers as their primary source of information about the hotline.

In data not shown in the Figures, AIDS was clearly demonstrated to be a salient subject among the general population sample: 59% recalled AIDS as the subject of health advertising in the past five months versus the next highest recall of 17% for advertising about drug abuse, 11% for measles and so on. The data

from the tracking survey of young adults corroborate the salience of AIDS: 46% of the young adults surveyed recalled AIDS as the subject of health advertising, with ads on drug abuse and measles also recalled to a much lesser degree.

In order to discuss the campaign's significant impact on knowledge and attitudes associated with AIDS, it is important at this point to repeat the basic campaign messages we promoted:

- Anyone can get AIDS, even Filipinos.
- AIDS is transmitted sexually through intercourse with an infected person.
- You can't tell if someone is infected just by looking at them.
- AIDS is not transmitted through the air or water via mosquito bites, public toilets or coughs.
- Vitamins, antibiotics and taking baths will not prevent AIDS.
- You can prevent AIDS through knowledge. Learn more. Call the hotline.

<b>PERCEIVED TRANSMISSION VECTORS</b>			
<u>Perceived Vector</u>	<u>1988</u>	<u>1990</u>	<u>CHANGE</u>
Insect bites.	66%	14%	- 51%
Kiss on the cheek.	31%	6%	- 25%
Coughs or sneezes.	52%	11%	- 41%
Shared drinking glasses.	55%	15%	- 40%
Working near someone with AIDS.	39%	17%	- 22%
<b>False Belief Index</b>	<b>49</b>	<b>13</b>	<b>- 36</b>

Figure 16.

False beliefs regarding transmission vectors were interpreted in the 1988 baseline studies to mean that many Filipinos might be fearful of AIDS for the wrong reasons. On the basis of this hypothesis, we reasoned that decreasing false beliefs might concurrently increase people's ability to assess their true risk of sexual infection. This hypothesis appears to be corroborated by the data shown in Figures 17 and 18.

The first and perhaps most obvious place to assess the campaign's impact is in the data on basic knowledge about HIV transmission. As Figure 16 makes plain, this measure yielded striking evidence of campaign effectiveness. In only four months of operation, the campaign appears to have persuaded large numbers of Metro Manila residents to change their beliefs about the ways HIV is transmitted. (Similarly, significant changes in beliefs about insect, air and water transmission vectors occurred in the young adult sample.) These changes are important not only because of the large decreases in false beliefs but also because persistent numbers of people of all ages appear to cling to false beliefs no matter what they see or hear.

<b>WHAT MESSAGES REACHED AUDIENCE, AND DID THEY AGREE WITH MESSAGES?</b>		
<u>Message</u>	<u>% Who Said Message Was "Stated/Implied"</u>	<u>% Who Agreed</u>
1. Anyone can get AIDS, even Filipinos.	98	98
2. Filipinos can get AIDS through sex.	98	99
3. Anyone can protect themselves from AIDS.	97	98
4. AIDS can be cured.	12	13
5. AIDS is transmitted through the air.	9	21
6. AIDS is not transmitted by: Mosquito bites	72	77
Touching someone	76	82
Public toilets	80	82
7. You can get more information about AIDS by calling hotline.	98	99

Figure 17.

CHANGES IN ATTITUDES ABOUT AIDS AND THE HIV-INFECTED			
Attitude	1988	1990	Change
AIDS is likely to become epidemic among these groups of people:			
General Population	56%	71%	+ 15
People needing transfusions	75%	88%	+ 13
Married who have affairs	88%	94%	+ 6
Men	76%	85%	+ 9
Women	61%	77%	+ 16
I would refuse to work beside someone who has AIDS.	59%	43%	- 16
AIDS sufferers should be treated with compassion.	74%	67%	- 7
It is people's own fault if they get AIDS.	65%	81%	+ 16

Figure 18.

In Figure 17, for example, the now widely accepted beliefs that "anyone can get AIDS, even Filipinos" and "Filipinos can get AIDS through sex" appear, in Figure 18, to have changed in people's minds the mental description of who precisely is at risk of infection. In the 1988 baseline studies, virtually all of our samples were convinced that homosexuals, sex workers and foreigners — in short, persons other than themselves — were the individuals most likely to be at risk of HIV infection. Following the media campaign, however, as Figure 18 makes clear, the general population sample we surveyed are much more likely to see themselves and people like themselves (men, women and married persons who have affairs) as

potentially vulnerable to HIV infection. Particularly striking is the large increase in the belief that women are at risk of infection.

These data suggest that the campaign may have caused many Filipinos in Metro Manila to become more thoughtful about their behavior and potential HIV risk. In related data, 24% of the general population sample said the message they perceived most clearly in the campaign was to be "extra careful in sexual contacts" and 22% said this was "new information." (The young adult sample got that message much more

strongly: 90% agreed that "careful sexual practices" would prevent infection, more than double the number of young adults who said the same thing in the 1989 baseline.) Perhaps as a result of these insights, fully half of the general population sample said they had changed or were seriously thinking of changing

ATTITUDES TOWARD BEHAVIOR CHANGE			
Attitude	1988	1990	Change
I have changed my behavior.	15%	22%	+ 7
I'm seriously thinking of changing my behavior.	22%	28%	+ 6
I haven't thought of changing my behavior.	7%	12%	+ 5
I have no need to change my behavior.	56%	36%	- 20

Figure 19.

their behavior — an increase of 13% over those who felt the same way in 1988. Most importantly, the general population sample were far less likely after seeing the campaign to believe that they had no need to change their behavior. (This is an interesting contrast to the young adult sample, who were more convinced after the campaign that they did not need to change their behavior: 68% said it was "not at all likely" that they would get AIDS, up from 49% in the 1989 baseline survey. This may indicate that the campaign helped our young adult respondents to reassess their behavior in light of new information and conclude that they are not, in fact, at risk.)

The tracking survey of the general population also yielded both heartening and dismaying data on measures of what might be described as discriminatory attitudes. Hearteningly, the data in Figure 18 suggest that decreasing false beliefs about casual transmission might make people more willing to work alongside someone who has AIDS. But there may be an ironic twist to this new attitude. Empowering survey subjects to understand their own risk better and thus believe more strongly that they can do something to prevent risk also seems to have increased their attitude that "it is people's own fault if they get AIDS." The blame implicit in such an attitude may have led to the decrease evident in Figure 18 in the sample's willingness to be compassionate toward HIV-infected persons. If our assessment of these specific data is correct, then these unanticipated and quite unintended results of the process of changing overall attitudes represent an urgent challenge for future communications activities.

Other changes in discriminatory attitudes were not, however, so surprising. Although the one ad designed to counter discriminatory attitudes (see pages 35ff.) had to be pulled off the air early in the campaign, its objectives seem nevertheless to have been achieved by the overall thrust of campaign

messages. Take, for example, general public attitudes toward homosexuals as being the population most likely to get AIDS. Following the campaign, virtually all of both the general population (98%) and young adult (96%) samples agreed that "homosexuals are not the only ones who can get AIDS." In the general population sample, half as many individuals (12%) said they were avoiding homosexuals to avoid AIDS in 1990 as said so in 1988 (32%). On the other hand, the number of young adults who said that avoiding homosexuals (and others such as sex workers and strangers) would prevent AIDS doubled from 35% in 1989 to 79% in 1990. The marked increase among young adults may not, however, reflect discriminatory attitudes so much as it reflects this sample's evident new resolve to avoid unsafe sexual situations and behaviors.

### Discussion

The data demonstrate that the pilot media campaign achieved its basic objectives very effectively. In a short period of time, the campaign had a significant positive impact on the Metro Manila population's knowledge and attitudes associated with AIDS. By effectively debunking false beliefs and misinformation, the campaign increased accurate knowledge about HIV transmission at the same time that it bolstered the belief of many Filipinos that they are not only capable of preventing AIDS but also must make it a priority to do so. This constructive sense of personal empowerment makes AIDS a highly salient issue indeed in the minds of many of those who must now reevaluate their behavior in light of the campaign's new information. Many of these individuals are likely to be more careful in their behaviors now than they were prior to the campaign.

As a result of the campaign, AIDS is firmly "on the map" in the minds of Metro

Manilans. Also more visible are the efforts of the DOH to prevent AIDS — a byproduct of the campaign that is important for a program that has had trouble getting attention in the past. In addition to running paid campaign advertisements, for example, Manila media also provided increased news coverage about AIDS generally and the DOH prevention program specifically. There are indications in this report is written that the campaign may have provoked a greater sense of urgency among government policy-makers to take AIDS seriously. That cannot help but have a positive effect on many of the bureaucratic and administrative frustrations the AIDS program has long suffered within the DOH.

In terms of the public health communications process which guides AIDSCOM's technical assistance activities, it is now quite clear that, in Metro Manila anyway, media is an effective channel with which to move people along the behavior change continuum. The campaign demonstrated particular effectiveness at the stages of knowledge and concern, and corroborated the hypothesis that accurate knowledge does in fact enhance concern which in turn encourages a willingness to consider behavior change. These are key findings that will be important in the planning and implementation of prevention programs well beyond the Philippines.

Having acknowledged the effectiveness of the media campaign in changing knowledge and attitudes, however, it is also necessary to ask whether a media campaign is in and of itself the most effective use of limited resources to promote HIV prevention messages. The cost of the campaign was not exorbitant in terms of overall Phase One expenditures (the research that made the campaign possible was twice as expensive), but neither was it cheap. The majority of funds spent on the campaign were spent in the space of four months on media air time. To contemplate spending

resources at this level of intensity over an extended period of time would require very substantial resources indeed. Is it worth it? To answer this question, we must be clear about what media campaigns can reasonably be expected to accomplish.

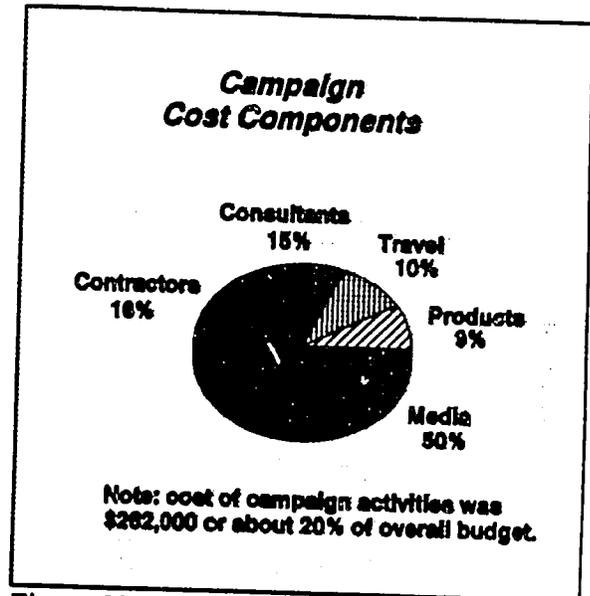


Figure 20.

By itself, a media campaign such as the one AIDSCOM supported in Manila cannot be — nor was it intended to be — the only means of promoting HIV prevention. What media does best — and did very effectively in Manila — is to create a positive social environment in which the necessity of prevention and the methods by which prevention is achieved are better understood. By itself, a media campaign will not, however, bring about sustained behavior change. Achieving that more complex objective requires the existence of a broad range of non-media prevention programs which, ideally, a media campaign supports and enhances. Lacking this broad range of additional prevention programs, any media campaign, no matter how effective, runs the risk of "whistling in the wind."

Fortunately, the DOH is developing such a broad range of non-media prevention programs and, in the hotline and other types of ongoing local education activities, residents of Manila who were so clearly affected by campaign messages also had resources to turn to for additional information and support. But the fact remains that there are not yet nearly enough information, education and support services available to Filipinos, either within or outside Manila. Until such services are well-established in at least the major Philippine urban areas, it will probably be advisable to use media sparingly and with caution.

The DOH and AIDSCOM would not be well-advised, for example, to extend the Manila campaign to the entire country based on the success of the Manila experience alone. There is no evidence that such a campaign is even necessary on a nationwide basis, since infections have so far been identified primarily in large urban areas. Moreover, there are unlikely to be sufficient funds available in the near term to undertake an ambitious national campaign. On the other hand, the same approach and even the ads used in the Manila campaign would almost certainly be useful in Cebu with appropriate regional modifications. Cebu's well-established commercial sex industry and large number of sexual tourists render it the next most logical venue for the type of campaign conducted in Manila.

In Manila itself, the Phase One campaign should be followed up early in Phase Two with a less intensive campaign (fewer spots running less frequently for longer periods of time) that would perhaps be targeted specifically at young adults. While young adults appear to have gained much from the Phase One campaign, they also display the typical tendency of their age group to feel a certain immortality in the face of deadly disease. Since young adult Filipinos are clearly sexually active, they, like their peers in other countries, are the logical next stop for a virus

that spreads by respecting no age or sex. Because young adults tend to be avid consumers and trendsetters, media campaigns directed at them can also easily include a myriad of tie-in events or products, such as contests, tee shirts and comic books, which would catch the eye and ear of not so young Filipinos.

## VI.

### Conclusions and Recommendations

Overall, we believe it is fair to say that AIDSCOM achieved its Phase One technical assistance objectives on behalf of the DOH and the Philippine AIDS program. A sound baseline of information and experience has been established to enable managers on both sides of the Pacific to plan and implement more effective prevention programs. Much has been learned about what does or does not work in HIV prevention in the Philippines; we are now a long way past the point of starting from scratch. And along the learning curve, several milestones have been achieved.

The rich research data sets and successful pilot media campaign are notable highlights and provide a strong foundation for future technical assistance. Management systems and particularly the process of institutionalization need more attention in Phase Two programming. Not all of the problems in these areas will be easily resolved, but persistence and attention to basics may make some of the them more manageable.

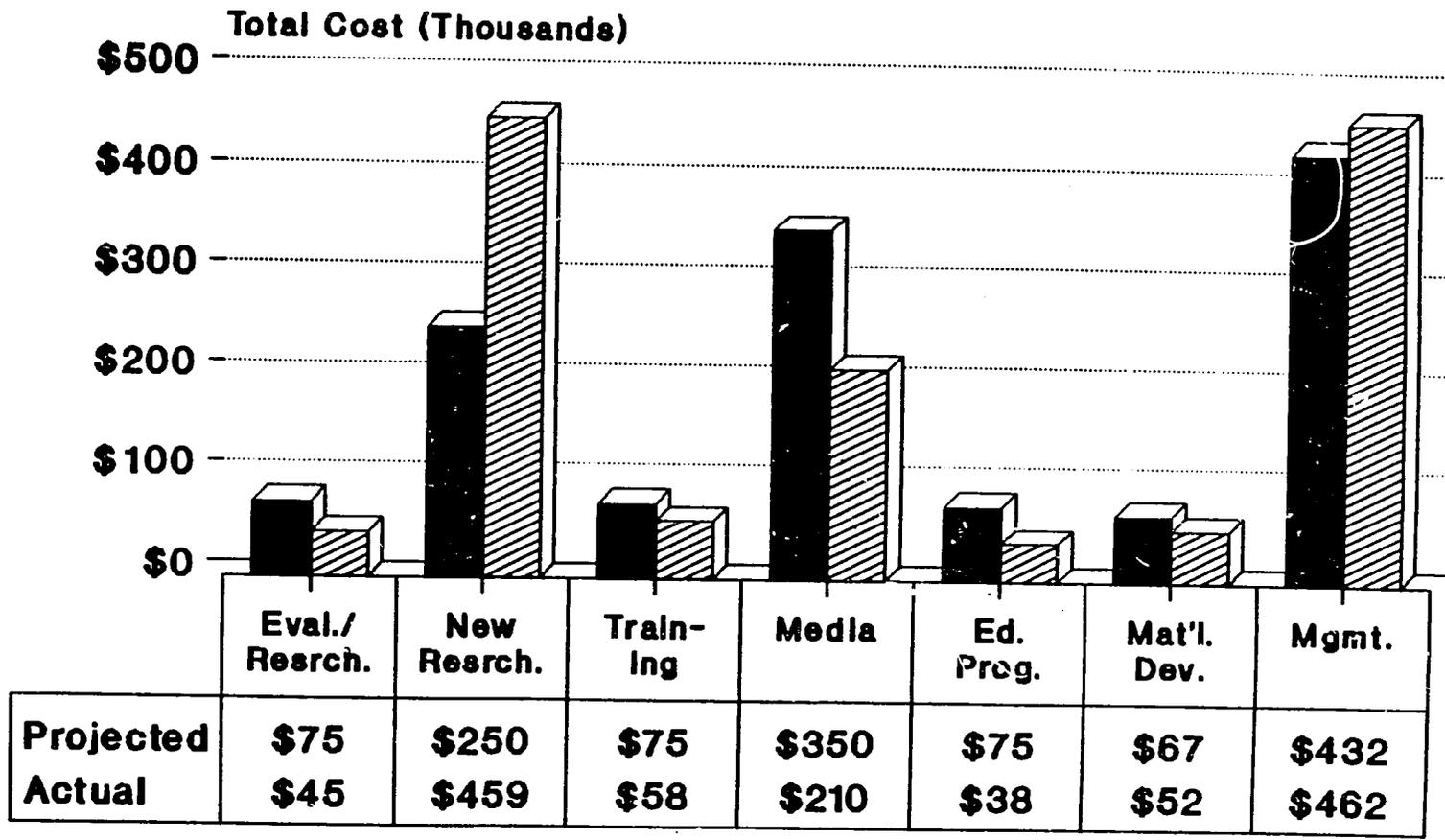
It is now apparent that much more work needs to be done in collaboration with non-government and voluntary organizations. AIDSCOM will make this a priority in Phase Two. The first step will probably be the opening of a special "AIDS Information

Center\* in downtown Manila in late 1990 which will be managed by a private group and serve as a venue for information and education programs developed by such groups.

The following are specific conclusions and recommendations that AIDSCOM has drawn from its experience during Phase One programming:

1. AIDSCOM should continue to provide technical assistance to the DOH in planning management systems and programs but with more emphasis on building national partnerships between the public and private sectors and on implementing programs outside Manila. AIDSCOM should attempt wherever possible and appropriate to involve non-government, voluntary and private-sector organizations in its technical assistance activities.
  2. Greater emphasis should be placed on designing, implementing and evaluating a series of small-scale operations research projects that test a range of communications methodologies in seeking to educate special audiences such as young adults, women, sex workers and men who have sex with men.
  3. AIDSCOM should rethink the necessity and priority of the resident advisor's position within the DOH, recommend major revisions in the advisor's scope of work or replace the current position description with one that emphasizes administrative duties only.
  4. Within the context of a national training plan which is broadly supported by other donors, AIDSCOM should define — and stick to — a specific subject area or areas in which its technical assistance would contribute to measurable enhancements of institutional capacity and skills.
  5. AIDSCOM should balance its technical assistance in institutionalization
- activities between the public and private sectors, with increasing emphasis on the latter.
6. AIDSCOM should continue to refine and expand its research activities in the Philippines. The Manila studies should be replicated in revised form in other cities, beginning with Cebu, and in rural areas to increase the data baseline and enhance its comparability. Emphasis should be placed on knowledge, psychographic and behavioral variables.
  7. AIDSCOM should augment KAP-type research with other types of studies, including ethnographic and networking studies. Whenever possible, these projects should be designed, implemented and/or analyzed by local experts.
  8. AIDSCOM should follow-up the pilot media campaign in Manila with a campaign perhaps targeted specifically at young adults. The ads used in the Phase One Manila campaign should also be pre-tested in Cebu and, with appropriate regional modifications, launched in a new Cebu campaign as soon as possible in Phase Two.
  9. The telephone hotline should be reinstated in Manila during the fourth quarter of 1990. If possible, it should be housed in a new downtown facility that will function not only as a hotline office but also as a venue for small-scale information and education interventions with special target audiences.
  10. More attention will need to be paid to developing a range of educational materials in Phase Two. Materials are specifically needed for young adults, sex workers and men who have sex with men. Basic prototypes can be developed and pre-tested for content and language modifications appropriate to particular regions of the Philippines.

# Projected vs. Actual Costs: 1988-1990

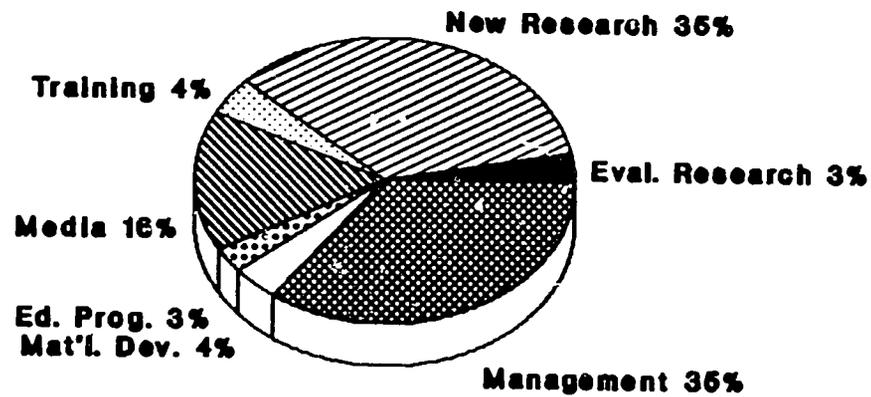


Projected
  Actual

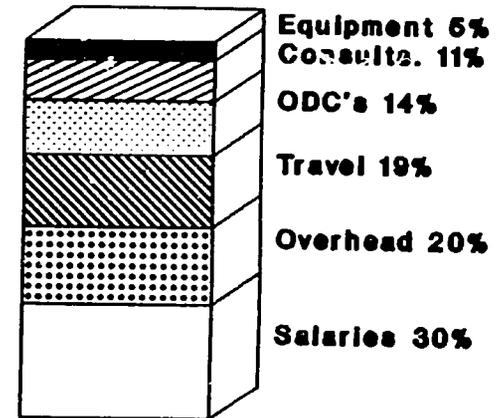
Mission Buy-In: \$1,000,000  
 Central Funds: \$ 324,000

59

# Program Expenditures: 1988-1990



**Expenditures**



**Management Costs**