<table>
<thead>
<tr>
<th>Title</th>
<th>Strategies and approaches to AIDS communication in the Philippines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Hernandez, Enrique.</td>
</tr>
<tr>
<td>Date</td>
<td>1994</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/10220/1915">http://hdl.handle.net/10220/1915</a></td>
</tr>
<tr>
<td>Rights</td>
<td></td>
</tr>
</tbody>
</table>

This document is downloaded from DR-NTU, Nanyang Technological University Library, Singapore.
Strategies And Approaches To AIDS Communication In The Philippines

By

Enrique Hernandez
STRATEGIES AND APPROACHES TO AIDS COMMUNICATION
IN THE PHILIPPINES

INTRODUCTION

Testing for HIV in the Philippines began as early as 1985, initially among female sex workers in commercial establishments near the United States (US) military bases and in the redlight district of Manila. By 1986, the presence of HIV infection in the country was confirmed. With very little information available locally, the Government of the Philippines in 1987, working through the Department of Health (DOH), officially began to respond to the AIDS epidemic. Public information on HIV and AIDS was initiated through the issuance of press releases, and a technical committee tasked to draft a national medium-term plan for its prevention and control, was created. The DOH approved the Medium Term Plan for the Prevention and Control of AIDS (1988-1993) in April of 1988, and later that year, the National AIDS Prevention and Control Program was officially launched.

As of the early to mid-1980's, many Filipinos still believed that AIDS affected Americans and Europeans alone. Very little was known in the general community about the virus and little concern was given to it by most people. However, publicity about Filipinos becoming affected by HIV and/or AIDS helped lead the community to accept that the threat indeed exists.

The introduction of HIV in the Philippines was accompanied by facts and information, as well as by many myths and misconceptions about the disease. The continuously rising numbers of people with HIV reported both in the Philippines and the rest of the world resulted in a lot of publicity attendant to the epidemic. Mass media covered its spread with both factual and false information, not only providing thoughtful insights into the complex health and social problem, but also exploiting the population’s ignorance in furtherance of business interests.

In 1988, formal communication activities began. Early efforts were concentrated on gathering data about the general population and specific groups within that population. These included young adults, overseas contract workers, sex workers and men who have sex with men. In addition, mass media was utilized for two specific AIDS information campaigns. The first was generic, informing everyone about AIDS and attempting to correct misinformation within the community, particularly about HIV transmission. The second campaign, targeted young adults with two messages - to postpone sex, and to be careful and use protection when engaging in sex.

EARLY IEC STRATEGY
Telephone Hotline

Prompted by the need to provide access to further HIV/AIDS information and counselling, the DOH in February 1990, established a telephone hotline service in Manila. At that time, the operation of an AIDS Hotline was conceptualized to be an activity which would be central to other activities of the national AIDS program's over-all information, education and communication (IEC) strategy. It was intended to support the government's ongoing tri-media information campaign for the general population, and also complement other information drives conducted by non-governmental organizations, hospitals, clinics and testing centers. All data and feedback gathered from the callers were processed and analyzed, and disseminated to policy makers and program implementors. These were used to refine existing strategies, provide the needed direction, and improve the management of the national program.

In a country dominated by a conservative and extremely religious population, sex and AIDS were considered delicate and sensitive topics. AIDS-related messages in mass media campaigns remained limited and cautiously delivered. The telephone hotline aimed to provide a freer environment for more open conversations on sex and HIV, with the assurance of anonymity. Through these detailed discussions, callers were provided information and educated about HIV and AIDS, and were taught to assess their own personal risks of exposure to HIV. When deemed necessary by the counsellor, they were presented alternative sexual behaviors and practices which pose no- or low-risk, and/or were referred to specific persons or institutions to address particular concerns.

The AIDS information hotline service began operations simultaneously with the launching of the first phase of a tri-media information campaign which lasted for 13 weeks. The telephone hotline was manned by a team of seven trained counsellors from a non-governmental organization in Manila with previous experience in operating hotlines for adolescent counselling. As television, radio and print media flooded the public with "tickler" advertisements to try to correct common false beliefs and misconceptions about HIV, the frequency of calls to the hotline during the period, soared to an average of about 40 calls per day.

After a year's absence, the DOH in April 1991, decided to re-run the television and radio advertisements as part of a maintenance campaign. The AIDS Hotline was again activated, this time based in a center established to provide information and documentation, which was also located in Manila. This resulted in a significant number of calls made to the hotline.

From May 1991 onwards, the broadcast media ads were withheld. The number of calls decreased progressively and callers were mostly spill-overs of the previous tri-media information campaign. An attempt to sustain AIDS public information was made through the issuance of press releases and distribution of leaflets and brochures.

In September 1991, updates on AIDS appearing in newspapers, and press conferences held at the Information Center during and after its official opening to the public, influenced the number of calls which increased temporarily, gradually decreasing in the succeeding months.

Towards the end of November 1991, about a week prior to the observance of World AIDS Day,
brochures and condom packets with the hotline's number were distributed. Again, the number of callers was noted to increase.

At this time, the DOH made announcements and sent-out letters to organizations and schools inviting individuals to attend a training course on HIV/AIDS telephone hotline counselling. Applicants came from different professions (medical, business, education, government employees and students) with ages ranging from 21-45 years old. All of them were screened, and trained in HIV/AIDS education and counselling. From over 60 applicants, 20 were chosen and invited to become volunteer hotline counsellors. Thereafter, volunteers were continuously provided advanced training, follow-up meetings and regular updates. Under supervision, the volunteers manned the hotline in preparation for the second phase of the mass media information campaign.

Based on the HIV/AIDS-related knowledge, attitudes, practices and behavior studies that were conducted, the DOH moved its information campaign from among the general population to the next phase, this time specifically addressing one of the identified target audiences - male and female young adults. This consisted of messages which revolved around the theme of "being extra careful in sexual relationships". As a result, calls made to the hotline during the months of February - May 1992, were observed to have risen to as many as 60-80 calls per day, mostly from young male adults.

Results

There were two types of callers the hotline received. The profile of the callers during the media campaign shall be described through a fellow named Joey. Joey was watching television at home and saw the AIDS advertisements. Intrigued by the message, he was prompted to call the hotline. He is around 16-20 years old, single and a college student. He has many friends from both sexes and hangs-out with his male "barkada" (close peer group). Joey joins his male buddies for occasional drinking sprees in bars and night clubs. Once or twice a month, after these drinking sprees, he goes to massage parlors and has sex with sex workers. Joey has both vaginal and oral sex, and being sexually-excited and under the influence of alcohol, doesn't care about using a condom. Besides, he doesn't carry one around.

In the absence of a media campaign, the profile of the callers appears to be quite different, as shall be described through another fellow named Fidel. One day, during Fidel's morning break at the office, he picked up a newspaper and chanced upon an article on AIDS. Warned about the modes of transmission, he called the AIDS hotline and inquired about the disease. Fidel is around 21-25 years old, single and a young professional working in an office. He has a girlfriend with whom he has sex with occasionally. Like Joey he maintains a peer group composed of male professionals whom he joins for night-outs. Sometimes, he engages in unprotected sex with sex workers. He also practices risky sexual activities. Unlike Joey who is just curious about AIDS and its transmission, Fidel worries about his sexual behavior and believes he may have contracted HIV due to his promiscuity.

Calls made to the hotline had typical peak hours which were noted during breaktimes and after work, and which coincided with the airing of the AIDS ads on primetime television.
The inquiries made by the callers can also be divided into two categories. Non-AIDS related questions usually dealt with a) sexually-transmitted diseases (STDs) like gonorrhea and syphilis, and b) sexuality (human anatomy and reproduction, homosexuality, masturbation and its effects). Others were c) prank or dirty calls (looking for phone pals, sex-over-the-phone, making curses, caller masturbating, children playing with the phone) or d) inquiries regarding the address or activities of the Center.

AIDS-related inquiries included queries about a) general HIV/AIDS information, b) modes of transmission (sex, blood, kissing, mosquito bites, toilet seats, swimming pools), c) AIDS symptoms, d) HIV anti-body tests (window period, testing centers), e) prevention and care (government activities, medicines/vaccine for AIDS), f) statistics (worldwide and local numbers of people with HIV and AIDS), and g) safer sex practices (condom-use, monogamous relationships).

The concerns of callers who required counselling ranged from a) simple curiosity about AIDS, b) fear due to promiscuity, c) seeking medical advice, d) anxiety concerning the health of families and friends, e) interest in safer sex practices, and f) worries due to misconceptions about transmission, to actually g) coping with HIV infection.

For callers interested in having themselves tested, pre-test counselling was done to assess their personal risks and prepare them for the possible implications of the test results. They were then referred either to government laboratories or to other private DOH-accredited laboratories and clinics.

The duration of the calls varied. Hotline counsellors allowed a maximum of 15 minutes for basic information and 30 minutes or more for pre-test and post-test counselling. When necessary, callers were invited to visit the Center for face-to-face counselling.

Conclusion

It was deemed that there existed a need for this kind of support service and that people actually use it. AIDS information hotlines and centers should continue as a regular public service and duplicated in key cities and urban areas throughout the country. Aside from the usual telephone counselling, face-to-face counselling should also be made available. Selected volunteers could be tapped to conduct peer counselling, and services of these centers expanded to become future alternative sites for HIV-testing.

PRESENT IEC STRATEGY

Heavy emphasis is now placed on community-based communication interventions, with much local input into their development and implementation. It is recognized that behavior change is not easily accomplished especially when dealing with habits and practices that have existed over a long period of time. Sustained, continued and massive communication interventions are needed to effect and maintain modifications in behavior, especially sexual behavior.
The over-all strategy adheres to the concept of incorporating activities and messages into as many parts of an individual’s environment as possible. A multi-channel approach fosters the belief that an idea is more acceptable to individuals when they are exposed to it from different sources and in different forms, the key factor being that the basic message is the same. Moreover, communication campaigns and interventions should be able to stand alone, or be incorporated into existing channels, and be interpersonal.

It is also important that message dissemination not only be widespread but also be sequenced properly. The messages must be disseminated in such a manner that one flight of messages builds upon the previous flight and expands from it. Each of the messages should give just one primary piece of information with a maximum of two secondary points, in order for people to remember. The sequence should lead towards a specific communication objective outlined for a particular audience segment.

And in order for communication efforts to be productive, it is important to recognize that the target audiences not only be exposed to, and comprehend the messages disseminated, but also be able to internalize the need to take a specific action to reduce their risk of acquiring the disease. The heterogeneity of Philippine society, and the varied lifestyles of individuals the communication interventions target, necessitate an approach that recognizes the communication needs at various stages of the decision-making process. This is important because people have different preferences and needs depending upon their lifestyles and where they are in the life cycle.

Communication objectives include not only encouraging target audiences not to engage in activities that place them at risk of acquiring or transmitting HIV, but also changing the existing behavior patterns of target audiences to minimize HIV transmission.

Any AIDS communication activity must take into account the various social and cultural variables which influence and restrict behaviors and practices. As is often the case, the mores and values of society are often less open than the mores and values of individuals. Today’s Filipino is much more worldly than any previous generation. Changes in the more conservative and traditional ways of doing things can be attributed in part to mass media, the substantial international movements of Filipinos and the electrification of rural communities, making available many forms of entertainment including television. The approach should attempt to address these changing social conditions in the development of AIDS communication interventions that achieve the objectives without compromising traditional norms and values.

Audience Segments

Priority segments of the general population have been identified and fall into three general categories: 1) the “influentials”, or groups which have general influence over national and local policies and the decision-making process, such as policy makers, politicians, health care workers and religious leaders; 2) the “gatekeepers”, or groups which control access to a channel of communication and/or to the decision-making process, such as media practitioners, entertainers and teachers, and 3) the “groups-at-risk”, or groups that engage in certain activities that put them at risk of exposure to HIV, such as overseas contract workers, sex workers and their clients,
injecting drug users, men who have sex with men, etc.

Influentials

The influentials are a population segment important to recognize. This group as a whole, has as much misinformation about the disease as does the average Filipino. A constituency needs to be built within this group to actively support HIV prevention and care. A plan for capturing the hearts and minds of this segment is the key to any successful future activity directed at other groups. Additional support must be given by them so that the program takes on a higher priority for both internal and external resources. This segment then must have its knowledge base increased through factual and scientifically-sound information. Many have only heard of rumors and falsehoods about the disease. Core groups must be convinced to become AIDS advocates so they can convince their peers to support HIV prevention and care.

Factual information about the occupational risks and modes of transmission are given to health care workers to increase their knowledge about HIV and AIDS. They are also provided with details of the skills required to protect themselves in the workplace. The clergy should also be provided facts about the disease and information on the ways by which different religions in other countries have responded. Both segments must be convinced of the seriousness of the problem, and encouraged to take a more pro-active stand in working with the government and other non-governmental organizations (NGOs) in combating the disease. Attitudes and prejudices shall have to be modified to facilitate their full cooperation and involvement. Each group must overcome its reticence and actively advocate for HIV prevention and care in a more accelerated pace.

Most of the work for these audience segments will have to be carried-out through interpersonal communication. One-on-one meetings are most effective but small-group meetings are also important. As the core group of advocates is formed, seminars and larger meetings may be held. Some mass media support to persuade influentials to become supporters of HIV/AIDS-related programs may also be useful, and tri-media campaigns could be effective in reinforcing the advocates’ work.

Health care workers can be educated through the use of small group meetings/discussions and conferences supported by appropriate teaching materials, and by integrating HIV/AIDS education into student health care worker curricula in all training facilities. The private business sector’s involvement with the churches can be utilized to support these activities and to strengthen the response.

Gatekeepers

"Gatekeepers" is the term coined to identify those groups of persons who because of their vocations and lifestyles, can provide publicity and influence regarding certain current events. The networks through which the gatekeepers operate could be a useful resource in the promotion and publication of HIV prevention messages. At the same time, the public’s opinion related to HIV and AIDS could be assessed.
This segment must assume a more active role in HIV/AIDS education activities. The industry must undergo an attitudinal change from passive acknowledgement of its existence to active confrontation towards halting the spread of the disease. Since the entertainment community is looked upon as role models, they should be in the forefront as positive role models for others to follow. Those that exemplify positive behavior may be publicly rewarded for setting a good example.

Most of the work with this audience segment will need to be through interpersonal channels. Individuals who understand the problem should be used as vehicles for disseminating information to their peers. One-on-one and small group meetings should be the principal mechanism for reaching this particular segment. Special audiovisual materials can be prepared to facilitate delivery of information. Mass media can play a role in convincing this particular segment to actively participate in HIV prevention. Examples of the Enter-Educate concept can be highlighted and praised by both official and non-official sectors so that the entertainment industry will become aware of the inherent advantages of participating in HIV prevention.

The development of teaching modules on AIDS communication for teachers and counsellors should emphasize Filipino values and respect for basic culture and practices. The school-based AIDS education program must consider that students, especially adolescents, need to be encouraged to discuss sex and HIV with their superiors, parents and peers in a relaxed atmosphere.

Talking about HIV and AIDS has successfully increased awareness and the level of knowledge among audiences. The gatekeepers, especially because of their access to the general population and other special target groups, should be fed with factual information regarding modes of transmission and prevention to increase their understanding of the disease and their confidence to talk about it. Gatekeepers should also be informed regarding certain issues related to the disease to provide them with topics for discussion that would hopefully raise public opinion which can be a major factor in the formulation and implementation of national policies and programs. Both interpersonal and mass media communications are conveniently available to these segments. Peer education is very important and will need to be emphasized.

Groups-at-risk

Within a community, all individuals involved in activities that place them at risk of exposure to HIV, can acquire the disease. Furthermore, groups within a community may be more at risk due to a higher prevalence of HIV within that particular group or within the groups they engage with in risky activities, or because of the risky activities practiced by the group itself.

The provision of accurate and relevant information to groups identified to be at risk of exposure to HIV is paramount to stemming the spread of HIV within the community. Education must be culture-sensitive and acknowledge the mores and values of the particular group, and must be supported by materials which encourage risk-reduction and the maintenance of such behavior.

Equally important is that message concepts and all materials be pre-tested on their respective audiences before they are produced in final form. Interventions should also be directed at
continuing to further increase awareness and knowledge among the general population through mass media. And ultimately, the provision of information and education on HIV and AIDS must also be supported by legislation designed to encourage risk reduction and its support.

References:

- AIDS Hotline Reports, 1990-1992

DR ENRIQUE HERNANDEZ
PRESIDENT
PHILAIDS, PHILIPPINES