



Qualitative Study on the Drivers and Barriers to Condom Use, HIV Testing, and Access to Social Hygiene Clinic Services among Males who have Sex with Males (MSM)



EPIDEMIOLOGY BUREAU | DEPARTMENT OF HEALTH

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FOREWORD

The Philippines is witnessing a dramatic increase of HIV infections in key affected populations. Majority of newly infected individuals are males having sex with males (MSM) who practice high rates of risky behaviors (2013 IHBSS). This **Qualitative Study on the Drivers and Barriers to Condom Use, HIV Testing, and Access to Social Hygiene Clinic Services among Males who have Sex with Males** was conducted to provide a more in-depth understanding of the factors behind high-risk behaviors and behaviors that protect against HIV infection that were reported in the 2013 IHBSS among males who have sex with males.

Results of the study indicate that factors such as access to information, perceptions of risk, availability of condoms and lubricants, and accessibility of HIV testing sites and Social Hygiene Clinics have a large impact on condom use and HIV testing. These findings are vital in providing guidance for improving our current programs and for planning other high-impact HIV prevention strategies.

As we gain further understanding of the factors influencing HIV spread in the Philippines, we increase the country's prospect of curtailing the epidemic.


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EXECUTIVE SUMMARY

In the recent years, a dramatic increase of HIV epidemic was seen in the Philippines particularly among key populations who are at greatest risk which include males who have sex with males (MSM), female sex workers (FSW), and injecting drug users (IDU). Responding to the need to target these key populations in the country's HIV prevention programs, the Epidemiology Bureau of the Department of Health (EpiBureau-DOH) conducts the Philippine Integrated HIV Behavioral and Serologic Surveillance or IHBSS every two years to monitor the magnitude and prevalence of HIV and STI, and to determine behavioral factors associated with HIV and STI transmission.

Supplementing the quantitative data derived from MSM respondents of the 2013 IHBSS, this study was commissioned by the EpiBureau-DOH to provide an in-depth qualitative data focusing on factors to condom use, HIV testing, and access to services among males who have sex with males (MSM). In summary, a total of 105 in-depth interviews were conducted with MSM participants from the 21 cities of the 2013 IHBSS. The interviews were audio-recorded and transcribed. Individual and collective analysis of the dataset produced thematic maps of the drivers and barriers behind condom use and HIV testing. Force field analysis was also used to compare the strengths of the drivers vis-à-vis barriers.

Drivers to condom use. The external factors that drive MSM to use condoms are: (1) access to condoms, (2) situational "it depends" factors, and, (3) the influence of others. Internal factors that drive MSM to use condoms are: (1) level of knowledge or awareness, (2) fear and perceived risk, (3) deliberate planning, (4) personal habit or routine, (5) personal motivations, e.g. "to be 'clean'" (*maging malinis*), and, (6) perception that one's sexual partner is "unsafe" or "unclean" (*hindi safe o hindi malinis*).

Barriers to condom use. External factors that bar MSM from using condoms are: (1) lack of access to condoms and lubricants, (2) lack of information about condoms and lubricants, (3) situational "it depends" factors, (4) the influence of others, and, (5) love or a romantic relationship. The internal factors that bar MSM from using condoms are: (1) lack of knowledge or awareness, (2) lack of perceived risk, (3) lack of deliberate planning, (4) the physical motivation for sexual pleasure, (5) the spontaneity of sex or the "heat of the moment", and (6) the perception that one's sexual partner is "clean" (*malinis*) or "safe".

Drivers to HIV testing. The external factors that drive MSM to get an HIV test are: (1) access to HIV testing, (2) HIV testing at venues, (3) work/school requirement, and, (4) the influence of others. The internal factors that drive MSM to get an HIV test are: (1) social awareness, (2) perceived risk, and, (3) validation of negative HIV-status.

Barriers to HIV testing. The external factors that bar MSM from getting tested for HIV are: (1) inaccessibility of HIV information and HIV services, (2) lack of information about HIV and HIV services, (3) stigma and lack of social support, and, (4) unethical behaviors at HIV testing centers. While internal factors that bar MSM from getting tested for HIV are: (1) lack of knowledge about HIV and HIV services, (2) lack of perceived risk, and (3) fears.

Findings of the study led to a development of models and recommended strategies. These may guide program implementors in providing more comprehensive and effective services for promoting condom use and HIV testing among males who have sex with males or MSM.

INTRODUCTION

The HIV epidemic in the Philippines has been rapidly changing and expanding in the past five years. Cases are mostly concentrated among males who have sex with males (MSM), female sex workers (FSW), and injecting drug users (IDU) in certain geographic areas.

Efforts have been made to track the magnitude of the epidemic and to provide strategic information for effective prevention interventions as well as linkage to care and treatment. Responding to the need to target these key affected populations in the country's HIV prevention and treatment programs, the Epidemiology Bureau of the Department of Health (EpiBureau-DOH) initiated an active HIV surveillance system in 1993 to monitor the HIV situation in the Philippines. In 2005, serologic and behavioral surveillance were integrated to develop the Philippine Integrated HIV Behavioral and Serologic Surveillance (IHBSS). It was conducted every two years since then with the objectives of determining (a) the prevalence of HIV and STIs among key affected populations, (b) the behavioral factors that are associated with HIV and STI transmission, and (c) the outcome of HIV and STI intervention programs. Overall, the IHBSS provides strategic information to guide HIV and STI policies, programs, and services at the national and local level. The fifth round of the IHBSS was conducted in 2013.

While the IHBSS is able to provide national and city-level quantitative data on HIV prevalence, the behavioral factors associated with HIV transmission, and the outcome of HIV intervention programs for key affected populations, it cannot fully explain the reasons behind risk behaviors and protective behaviors against HIV. Thus, this study was commissioned by the EpiBureau-DOH to provide qualitative data that can explain the reasons for engaging in behaviors that can put one at risk of HIV and behaviors that can protect one from HIV. Such in-depth information derived from qualitative data can supplement the quantitative data of the IHBSS and provide valuable direction for HIV programs at the national and local scale.

This study focused on factors to condom use, HIV testing, and access to services among males who have sex with males (MSM) as a key affected population. To supplement the quantitative data derived from MSM respondents of the 2013 IHBSS, this study analyzed qualitative data derived from in-depth interviews with 105 MSM participants from the 21 cities of the 2013 IHBSS. The present study looked at condom use as the primary HIV prevention strategy among MSM and HIV testing as the primary link to HIV care and treatment among MSM. The objective of the present study was to understand the drivers and barriers to condom use among MSM and the drivers and barriers to HIV testing among MSM.

The 2013 IHBSS for MSM

To contextualize the qualitative data on condom use, HIV testing, and access to services among MSM derived from the present study, the quantitative results from the 2013 IHBSS for MSM are first presented.

The 2013 IHBSS defines males who have sex with males or MSM as born male, 15 years or older, and reported having oral or anal sex with a male in the past 12 months. The 2013 IHBSS was conducted in venues where MSM find sexual partners such as cruising sites, hotspots, and establishments in the 21 cities included in the survey. Using Time Location Sampling, a total of 6,281 MSM respondents were surveyed from venues on the day and time when the venue is most frequented by MSM. At least 300 MSM respondents were surveyed per city.

The 2013 IHBS for MSM was conducted in 21 cities: 6 cities in Metro Manila (Caloocan, Manila, Marikina, Makati, Pasay, Quezon City); 2 cities in Cebu Province (Cebu, Mandaue); 6 cities in Luzon (Angeles Pampanga, Bacoor Cavite, Baguio, Batangas, Puerto Princesa Palawan, San Juan del Monte Bulacan); 2 cities in Visayas (Bacolod, Iloilo); and 5 cities in Mindanao (Butuan, Cagayan de Oro, Davao, General Santos, Zamboanga). The cities were selected based on their vulnerability to the HIV epidemic; the size of the surveillance population in the city; the presence of an HIV and STI laboratory; the geographic representativeness of the site; and the willingness of the site to conduct the IHBS.

Venues where MSM find sexual partners were mapped for each city. MSM respondents were sampled from these identified venues per city. A 30-minute face-to-face survey was administered with each MSM respondent after screening for eligibility and acquiring informed consent. Responses were recorded on the survey questionnaire by the interviewer. The 150-200 item questionnaire included questions on the following themes:

- a) Demographic and other background characteristics;
- b) Gender identity, lifetime and recent sexual behaviors and partnerships
- c) Commercial, non-commercial, same-sex and opposite-sex relationships;
- d) Condom and lubricant use;
- e) Alcohol and drug use and their relationship to sexual relationships and condom use;
- f) Use of social networking media sites to meet sex partners;
- g) STI and HIV knowledge and attitudes; and,
- h) Access and utilization of STI and HIV services and programs.

A total of 6,281 males who have sex with males from 21 cities participated in the 2013 IHBS. Their ages ranged from 15 to 75 years old; 15% were aged 15 to 17, around half or 49% were aged 18 to 24, and 36% were aged 25 years and older.

In terms of education, 50% reached high school followed by 31% who reached college, graduate, or vocational level and 18% who reached elementary. 2% did not complete any grade level. In terms of gender identity, 49% identified as male and 31% identified as transgender or female. In terms of sexual preference, 57% preferred males, 29% preferred females, and 14% preferred both.

In terms of sexual behavior, 71% of the MSM respondents reported having anal sex (with 66% within the past year or the last 12 months) whereas 29% reported never having anal sex. In terms of sexual position, 33% reported engaging in oral sex only, 27% were bottom (or anal receivers), 20% were top (or anal inserters), and 20% were versatile (both anal receivers and anal inserters).

Condom use during last anal sex increased only by 2% from 2011 to 2013. Among the MSM respondents, 37% reported using a condom the last time they had anal sex, 32% reported not using a condom, and 31% reported never using a condom during anal sex. The top three reasons for not using condom given by the respondents were: (1) condom not available – 34%; (2) does not like condom – 26%; and, (3) not necessary – 22%. The other reasons identified were: partner objected – 7%; forgot to put on condom – 3%; does not know how to use condom – 2%; and, condoms are expensive –

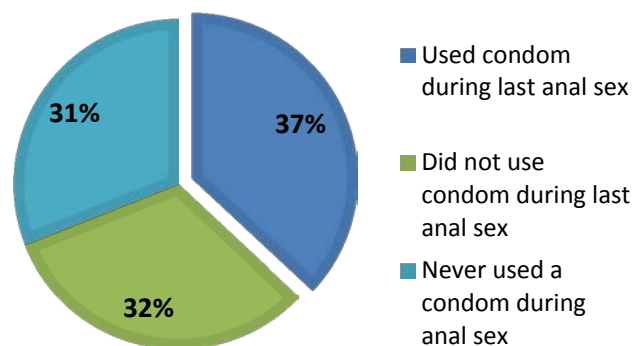


Figure 1. Percentage of MSM who used a condom during last anal sex, 2013 IHBS

1%. 6% of the respondents gave others reasons for not using a condom.

In terms of HIV testing as the primary link to care and treatment, an overwhelming majority of 85% of the MSM respondents in the 2013 IHBSS reported never being tested for HIV. Only 15% of the MSM respondents have tested for HIV with 8% getting a test in the past 12 months and getting the results.

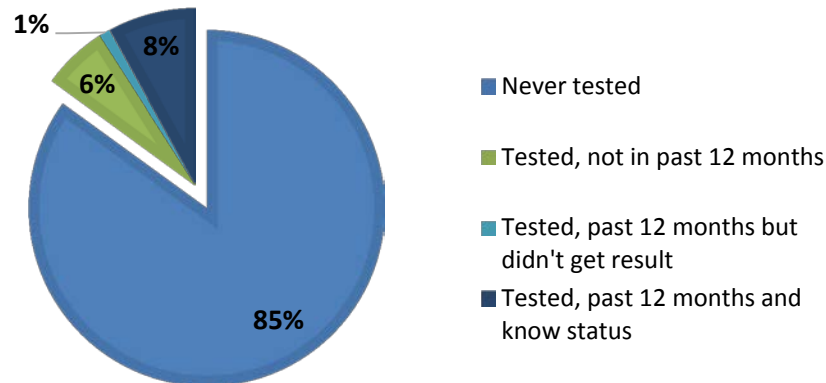


Figure 2. Percentage of MSM who got tested for HIV, 2013 IHBSS

A total of 185 MSM respondents or 2.93% disclosed that they were HIV-positive. The top three reasons for not getting tested for HIV given by the respondents were: (1) feels no need to get tested – 34%; (2) afraid to get tested – 30%; and, (3) does not know where to get tested – 23%. The other reasons identified were: no money for testing – 5%; and, testing facility too far – 1%. 5% of the respondents gave others reasons for not getting tested.

In terms of HIV knowledge, 5 knowledge questions were asked. Only 35% of the MSM respondents correctly answered all 5 knowledge questions. In terms of attitude, 57% felt at risk of HIV; 41% knew where to get tested for HIV; and 53% felt comfortable going to a social hygiene clinic for HIV testing.

From the 2013 IHBSS, only 37% of MSM respondents used a condom the last time they had anal sex and only 8% have had an HIV test and knew their status. The top reasons for not using a condom among MSM were that condoms were not available, they don't like using condoms, and believing that condoms are not necessary. The top reasons for not getting tested for HIV among MSM were feeling that there is no need to get tested, being afraid to get tested, and not knowing where to get tested.

Research Objectives

The present study supplements the 2013 IHBSS for males who have sex with males with the goal of understanding factors behind high-risk behaviors and behaviors that protect against HIV at specific venues in the 21 cities of the 2013 IHBSS.

Specifically, this aims to identify the drivers and barriers to condom use, and to identify the drivers and barriers to HIV testing. Behaviors are seen as a duality with condom use as a protective behavior against HIV and non-condom use as a behavior that puts one at risk of HIV.

The specific objectives of the present study are:

1. To understand the factors behind condom use and non-condom use
 - a. To identify drivers to condom use
 - b. To identify barriers to condom use

2. To understand the factors behind testing for HIV and not testing for HIV
 - a. To identify the drivers to HIV testing
 - b. To identify the barriers to HIV testing
3. To develop models that would provide recommendations to address existing program challenges and issues

METHOD

The study utilized a qualitative research design with semi-structured interviews as the data collection method, and thematic analysis and force field analysis as data analysis strategy. A total of 105 males who have sex with males or MSM were selected using purposive and quota sampling. MSM participants had to represent the top cruising sites or venues of the 21 cities of the 2013 IHBSS. A total of 5 MSM participants per city were interviewed. The in-depth interviews were conducted by a team of psychologists.

The procedure for the study comprised six steps: (1) project design, (2) training, (3) data collection, (4) data management, (5) data analysis, and (6) report writing.

All interview data were transcribed by a team of transcribers. Individual and collective analysis of the data set produced a final thematic map of the drivers and barriers behind condom use and HIV testing among the MSM participants. To facilitate identification of key strategies for the different models, force field analysis was used to compare drivers and barriers.

Sampling Procedure

A total of 105 MSM participants were purposively sampled following the IHBSS definition for males who have sex with males or MSM as born male or assigned male at birth, 15 years old and above, and has engaged in oral or anal sex with a male within the past 12 months. The MSM participant must have frequented a top cruising site or venue from the 2013 IHBSS. Cruising sites or venues included public spaces such as streets, barangays, parks, courts, and carinderias; entertainment establishments such as bars, discos, clubs, spas, and massage parlors; general establishments or public places such as restaurants, coffee shops, internet cafes, malls, and convenience stores; places of work; and internet sites.

A total of 5 MSM participants were sampled from the 21 cities of the 2013 IHBSS. Participants were recruited through the research team's social networks of MSM; through referral from EpiBureau-DOH and local social hygiene clinics in the different cities of the IHBSS; and through direct recruitment at identified cruising sites or venues.

Table 1. Selected sites based from the 21 cities of the 2013 IHBSS

Metro Manila	Luzon	Visayas	Mindanao
Caloocan	Angeles	Cebu	Butuan
Makati	Baguio	Bacolod	Cagayan de Oro
Manila	Puerto Princesa	Iloilo	Davao
Marikina	Bacoor	Mandaue	General Santos
Pasay	Batangas		Zamboanga
Quezon	San Jose del Monte		

Instrument

An initial project design was conceptualized with EpiBureau-DOH. An initial interview guide, interview protocol, and template for data analysis were then developed.

A semi-structured interview guide was developed in consultation with key informants, the research team of psychologists, and the EpiBureau-DOH. An initial interview guide was developed and pilot-

tested. After the pilot test, a final interview guide was developed. The final interview guide was comprised of six parts:

- a) Cruising sites,
- b) Sexual encounters;
- c) Condom use negotiation;
- d) HIV status disclosure;
- e) HIV testing, and
- f) Access to HIV programs and services.

The section on cruising sites asked for a list of the cruising sites or venues visited by the participant, the types of MSM and the nature of activities in the venues, and differences and similarities across venues. The section on sexual encounters asked for a narration of episodes of sexual encounters and the sexual negotiation/talk between MSM from the beginning until the end of the sexual encounter. The section on condom use negotiation asked for a narration of how and why a condom was used in a particular sexual encounter as well as how and why a condom was not used in a particular sexual encounter. The section on HIV status disclosure asked about how and why HIV status was discussed in a particular sexual encounter as well as how and why HIV status was not discussed in a particular sexual encounter. The section on HIV testing asked for a narration of the participant's experience of HIV testing or not testing for HIV. The last section on access to HIV programs and services asked for the participant's knowledge or awareness of HIV programs and services and recommendations for HIV programs and services. Reflection and probe questions were included for each section.

Interview

A team of psychologists were trained to conduct the interview and analyze the qualitative data.

For each in-depth interview, the interviewer first built trust and established rapport with the participant through an informal conversation in a venue suitable for interviewing. Afterwards, permission for an interview following the principle of informed consent in conducting research was sought. The interviewer then explained the nature of the study and assured the participant of confidentiality at the beginning of the interview following the ethical principle of confidentiality in research. The formal interview then began. Each interview followed the semi-structured interview guide and ran an average of 1 hour to 2 hours. The participant was then debriefed at the end of the interview following the ethical principle of beneficence or the avoidance of risk or harm in research. Modest compensation or a token of appreciation was given to each participant after the interview. The interview was conducted in the language preferred by the participant (e.g. Tagalog, Taglish (mixed Tagalog and English), Bisaya, Cebuano, or Ilonggo).

The procedure for data collection, data management, and data analysis at the level of the team of interviewers began with the conduct of the interview. After each interview, the interviewer conducts an initial data analysis or quick analysis based on one's interview notes, a review of the audio recording, and one's recollection of the interview run. The audio recording is then submitted to the team of transcribers. Each interview is then transcribed verbatim. Once a transcription is completed, the raw data or interview transcript is returned to the interviewer for complete data analysis or slow analysis. The interviewer reads the raw data or interview transcript and conducts a complete data analysis or slow analysis based on a reading and re-reading of the transcript, a review of the audio recording, and one's initial data analysis or quick analysis. For interviews conducted in Tagalog and Taglish, the direct quotes were encoded as is. For interviews conducted in Bisaya, Cebuano, Ilonggo, and other languages, the direct quotes were translated into English. As part of data management, all audio recording, raw data or interviews transcripts, quick or initial analyses, and slow or complete analyses were stored.

Further data management was conducted by encoding selected data into master files as each initial analysis and complete analysis was completed. A master file for condom use and a master file for HIV testing were created. These files were coded following the themes from the individual analyses of the interviewers. These files were then validated and re-coded following the themes of the final thematic map. Details of the data analysis procedure and report writing are further discussed in the next section.

Data Analysis

Qualitative data analysis followed these three general steps: (a) transcription and data management; (b) coding and analysis; and, (c) writing up of the report. Analysis followed the specific steps for thematic analysis: (a) reading and re-reading initial notes; (b) generating initial codes; (c) searching for themes; (d) reviewing themes, generating a thematic 'map'; (e) defining and naming themes; and, (f) producing the report. Analysis involved individual analysis and group analysis.

Procedurally, the research team went through eight specific steps of data analysis: (a) open coding, (b) identification of initial themes, (c) mapping/clustering and re-coding of initial themes; (d) validation and re-coding of initial themes; (e) coding based on a coding guide of validated themes; (f) re-mapping and re-clustering of themes to produce the thematic map; (g) validation of the thematic map, and (h) writing up of the report.

In open coding, each interviewer conducted an initial analysis of the interview following the quick analysis or QA template. Open coding was conducted for the first 20 interviews from 4 cities (Cebu, Manila, Marikina, and Quezon City).

After open coding, the team of interviewers identified initial themes across the 20 interviews. This collective analysis by the team of interviewers produced a list of initial themes, sub-themes, and their descriptors. This list of initial themes was then analyzed by the team of analysts who went through iterations of mapping and clustering of themes. This step produced a list of clusters or categories of themes presented as the initial results to EpiBureau-DOH. The team of interviewers then conducted the complete analysis using the list of clusters or categories of themes and following the slow analysis or SA template. The initial analysis and complete analysis were then encoded into master files.

The complete analyses by the team of interviewers were individually validated by the team of transcribers. The master files were validated, this time collectively, by the team of transcribers. The master files were then coded using the validated themes. After individual and collective validation of the list of themes, a coding guide was developed using the validated themes.

All succeeding quick analysis and slow analysis were individually coded by the team of interviewers following the coding guide of validated themes.

The analysis team then reviewed the meaning of the themes from the QAs and SAs for 35 interviews in 7 cities (Cebu, Manila, Marikina, Quezon City, Cagayan de Oro, Davao, and Pasay). The analysis team went through iterations of re-mapping and re-clustering of the themes to arrive at the initial thematic map and storyline.

The initial thematic map and storyline was then presented to the team of interviewers for collective validation. A force field analysis of the drivers and barriers to condom use and HIV testing was also conducted to compare the strength of drivers vis-a-vis barriers. The validation of the thematic map

clarified the meaning of the themes and produced the revised thematic map and a set of recommendations. This thematic map and force field analysis was presented as initial results to EpiBureau-DOH.

The last step of data analysis was writing up the narrative report. In writing the report, the meaning of each theme was further clarified with the team of interviewers and the team of analysts. The report contains the final thematic map. Direct quotes from Tagalog-speaking participants appear in the original Tagalog or Taglish. Direct quotes from non-Tagalog-speaking participants appear in their English translation.

RESULTS

Profile of Participants

There were a total of 105 participants among males who have sex with males from the 21 sites. The age ranged from 17 to 53 years old, (median is 24 years). Similar to the IHBSS respondents, almost half (52%) of the MSM participants in this study belonged to the 18 to 24 age group. Fifty percent of the MSM participants had at least finished high school.

Table 2. Demographic profile of the MSM participants, N=105

Demographic Profile, frequency (percentage)	
Total Sample	105
Age in Years, range (median)	17-53 (24)
15 to 17 years old	1 (1%)
18 to 24 years old	55 (52%)
25 years and older	48 (46%)
Education	
Elementary	9 (9%)
High school	52 (50%)
Vocational/ College	40 (38%)

Note: 1 did not disclose age, 4 did not disclose educational attainment

This study had 79 (75%) participants who identified as male as compared to the 49% of the IHBSS. While there were only 20 (19%) participants who identified as female or transgender compared to the 31% of the IHBSS. There were 6 (6%) who gave other responses and identified themselves as gay, both, or confused.

In terms of sexual orientation, 41 (39%) identified as gay, 44 (42%) as bisexual, and 17 (17%) as heterosexual. In terms of sexual preference, 97 (92%) prefer having sex with males compared to the 57% of the IHBSS; only 2 (2%) prefer having sex with females compared to the 29% of the IHBSS; and, 6 (6%) prefer both males and females compared to the 14% of the IHBSS.

Table 3. Sexual orientation and gender identity of the MSM participants, N=105

Sexual Orientation & Gender Identity, frequency (percentage)	
Gender Identity	
Male	79 (75%)
Female	20 (19%)
Other (Gay, Both, Confused)	6 (6%)
Sexual Orientation	
Gay	41 (39%)
Bisexual	44 (42%)
Heterosexual	17 (17%)
Sexual Preference	
Male	97 (92%)
Female	2 (2%)
Both Male and Female	6 (6%)

Among the participants, 24 (23%) were anal inserters (top), 34 (32%) were anal receivers (bottom), 40 (38%) were both anal inserters and anal receivers (versatile), while 7 (7%) engaged only in oral sex. In this study, there were more MSM participants who were versatile compared to the 20% of the IHBSS, while there were very few MSM participants who only engaged in oral sex at 7% compared to the 33% of the IHBSS. The percentage of anal inserters and anal receivers were relatively similar compared to the 20% and 27% of the IHBSS respectively.

An overwhelming majority of 94 (90%) of the participants reported engaging in anal sex in the past 12 months. Only 11 (10%) reported never having anal sex. This is different than the IHBSS wherein only around 66% of the MSM respondents reported engaging in anal sex in the past 12 months and almost a third or 29% reported never having anal sex.

Of the 94 participants who had anal sex in the past 12 months, 55 (59%) used a condom during their last anal sex, while 39 (41%) did not use a condom during their last anal sex. The percentage of condom users in this study was higher compared to the 37% of the IHBSS. The percentage of non-condom users was lower than the 63% in the IHBSS, with 31% reported never using a condom.

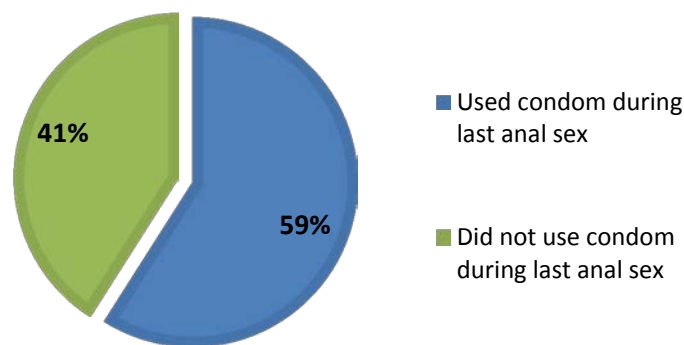


Figure 3. Percentage of MSM participants who used a condom during last anal sex, N=94

More than half (64%) had multiple sex partners in the past 3 to 6 months. Among those who had sex partners, around a third or 33 (36%) had 1 to 3 sex partners in the past 3 to 6 months, 39 (42%) had 4 to 9 sex partners in the past 3 to 6 months, and 20 (22%) had more than 10 sex partners in the past 3 to 6 months. Around a third of the participants or 39 (37%) had accepted cash or kind in exchange of sex, while 47 (45%) had paid for sex or bought sex.

The profile of the participants in terms of HIV testing for the present study departs significantly from the IHBSS. There were 72 (69%) of the MSM participants who got tested for HIV compared to only 15% in the IHBSS. Only a third or 33 (31%), had not been tested for HIV compared to the 85% in the IHBSS.

Among all MSM participants, 58 (55%) were HIV-negative, 7 (7%) were HIV-positive, 2 (2%) were tested but did not get the results from the facility, while 5 (5%) were tested but refused to disclose their status. For the IHBSS, 185 (2.93%) of the MSM respondents were HIV-positive.

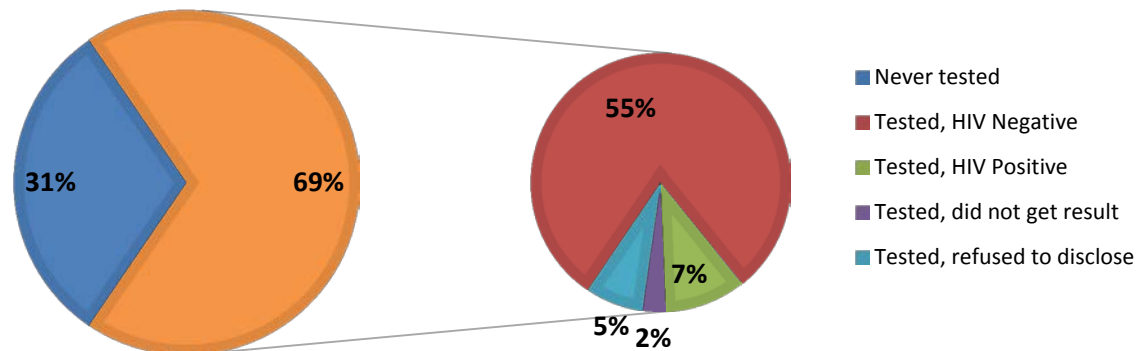
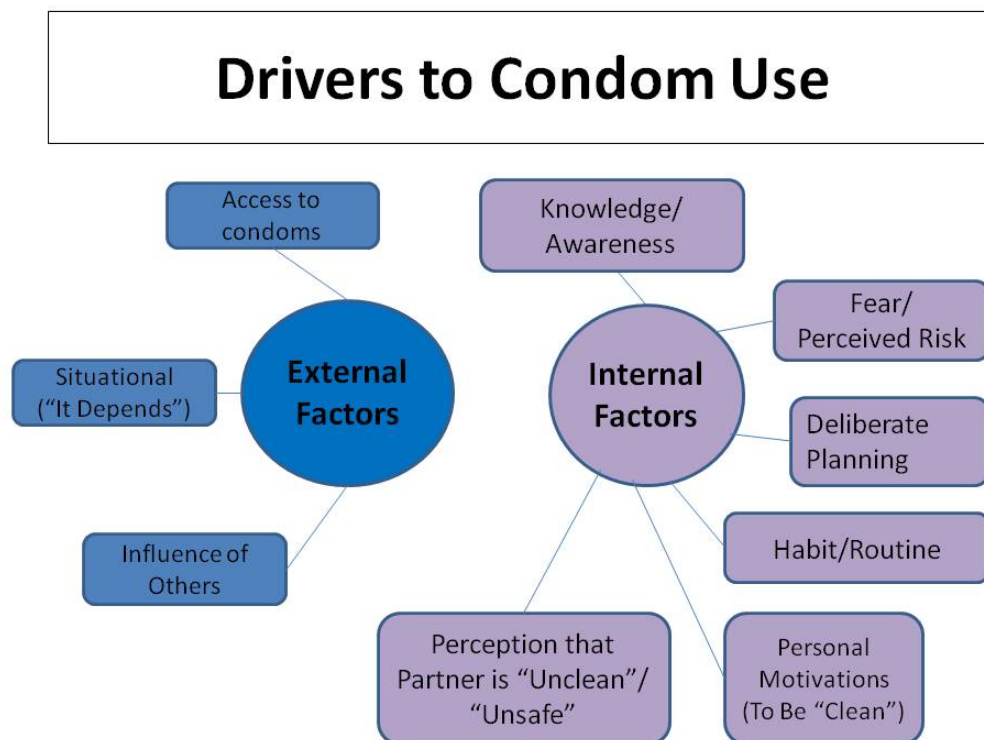


Figure 4. Percentage of MSM participants who got tested for HIV, N=105

Lastly, in terms of knowledge and awareness, a total of 62 (59%) MSM participants perceived that they were at risk of HIV. This is comparable to the 59% of MSM respondents in the IHBSS who felt at risk of HIV.

Thematic Maps

This section focuses on the drivers and barriers to condom use and HIV testing among MSM. Thematic maps of the drivers and barriers to condom use and HIV testing are presented. Further, each factor is discussed together with verbatim statements from the participants.



The thematic map of the drivers to condom use appears in the visual diagram above. On the left side are the external factors that drive MSM to use condoms: (1) access to condoms, (2) situational "it depends" factors, and, (3) the influence of others. On the right side are the internal factors that drive MSM to use condoms: (1) level of knowledge or awareness, (2) fear and perceived risk, (3) deliberate planning, (4) personal habit or routine, (5) personal motivations, e.g. "to be 'clean'" (*maging malinis*), and, (6) perception that one's sexual partner is "unsafe" or "unclean" (*hindi safe o hindi malinis*).

From the thematic map, the first key external factor that facilitates condom use is access to condoms. Condom use is possible if condoms are accessible either because they are given free or are inexpensive to buy. Once condoms are accessible and are readily available, situational factors come in. That is, "it depends" on the situation whether an individual will use a condom. For example, condoms are used only for anal sex. There is also the influence of others where other people motivate an individual to use condoms.

While external factors support condom use and access to condoms is necessary for MSM to use condoms, MSM need to be internally motivated to use condoms regularly or consistently. Internal motivation begins with one's level of knowledge or awareness of HIV, from a conceptual or general knowledge of HIV, to social awareness that HIV is a reality, or to personal awareness of people living with HIV.

With awareness of HIV comes the perception that one maybe at risk of HIV infection. For some participants, it is fear that drives them to use condoms. Whereas for other participants, it is

perceived risk of HIV infection derived from one's level of knowledge or awareness of HIV that motivates them to use condoms. Here, fear and perceived risk are clustered together as the evaluative component or the internal judgment that drives an individual to use a condom.

Also, deliberate planning takes place with awareness of HIV and the perception that one is at risk of HIV infection. This is exhibited when an individual make the conscious decision to use condoms by planning its use before a sexual encounter and bringing a condom to a sexual encounter. In time, this deliberate planning becomes part of one's personal habit or routine, and becomes more of an unconscious habit rather than a conscious decision. Thus, to create the habit of using condoms regularly, there has to be a certain level of knowledge or awareness of HIV, fear or perceived risk of HIV infection, and deliberate planning to use a condom during sex.

A unique internal factor for condom use has been labelled personal motivations. In this element, the motivation for condom use is not to prevent HIV infection. The motivation is unique to the individual. From the MSM participants, the most common motivation is to avoid "dirt" (*dumi*) often referring to fecal matter in the anal region. Other unique personal motivations were mentioned as well.

The last internal factor has to do with the individual perceptions that one's sexual partner is "unsafe" (*hindi safe*) or "unclean" (*hindi malinis*). Here, MSM make evaluations or judgments that a person is not safe based on one's sexual history, or that a person is not clean based on one's personal characteristics or appearance. Though this factor drives MSM to use condoms, it is based on a misconception that one can know if a potential sexual partner is safe based on the person's outward appearance, personal qualities, or what one knows about that person's sexual activities.

External Drivers to Condom Use

Access to condoms. Being able to access condoms can mean different things. Condoms can be accessible because they are given for free. Condoms can also be accessible because they are cheap or inexpensive to buy. They can also be easy to buy at pharmacies and convenience stores. Some also mentioned that condoms are readily available at cruising sites or venues.

"ayun ma'am, like yung nandiyan sa police station, mayroon diyang libreng condom... pupunta ka diyan, mayroong nakalagay doon. may libreng condom dito. papasok ka lang, hingi ka ng condom." (Bisexual, Top, Untested, Bacoor Cavite)

"nung nalaman ko kasi na sa sarili ko, nung nalaman ko na HIV positive ako, lahat ng mga gustong sinasabi nilang magpa-bottom, yan lagi ako, madami akong kinukuha... mayroon kasi sa health center, free condom, free lubricant. binigyan ako ng madami. as in talagang madami. talagang wow, libre to. di ka na bibili ng EZ. tsaka mahal-mahal pa naman ng EZ, trenta pesos. dito libre lang." (Bisexual, Versatile, HIV Positive, Batangas)

Situational "It Depends". MSM use condoms depending on the situation. One of the main situations identified for condom use is for anal sex. Some participants said that condoms are "only for anal sex". Another situation is "for anal to oral sex" or when there is a shift from anal sex to oral sex. Others reported using condoms "only with female partners" and not with male partners or MSM. Still, others used condoms "only with new sex partners" and not with previous male sex partners. Another situational factor is using condoms "only for sex work" or paid sex.

“once I meet with ____ or my partner, i always bring condom, whatever may happen. but if it’s oral sex only, it’s okay not to use condom. but once there is penetration, he wants me to penetrate him or when i want to penetrate him, i always use condom.” (Bisexual, Top, HIV Negative, Bacolod)

“pero pag hindi ko pa siya ka-mingle lang, I make him, once lang, mag-co-condom talaga ako.” (Bisexual Transwoman, Bottom, HIV Negative, Zamboanga)

“everytime nga akong mga client would like ask me to wear condom or whatsoever, if they want to use condom or if anal.” (Heterosexual Transwoman, HIV Negative, Cebu)

Influence of Others. Other people can motivate MSM to use condoms. This could be the influence of a romantic partner or a sexual partner, the influence of friends or peers, or the influence of awareness programs or information campaigns on STI, HIV and condom use. The influence of DOH programs particularly peer educators and social hygiene clinics was acknowledged by the participants.

“kasi, i mean, kung kung gusto niyang gumamit ng condom, pwede naman. so feeling ko wala namang pagkakaiba kung gumamit kami o hindi nung time na yun.” (Gay, Top, HIV Negative, Baguio)

“kasi ano siya, ma-ano talaga siya... lagi siyang nagpapagamit. ngayon, gusto niya pag ganon, mag-ganon. pag siya yung gaganunin, magpapapasok, gusto niya mayroong condom.” (Bisexual, Top, Untested, Bacoor Cavite)

Internal Drivers to Condom Use

Knowledge or Awareness about HIV. The first internal factor to condom use is one’s level of knowledge or awareness. Here, three levels of knowledge or awareness are made distinct. The first level is a general knowledge of HIV which refers to one’s conceptual understanding of what HIV is. This can be referred to as the scientific knowledge about HIV as a virus and as an illness or medical condition. Key information at this level is about HIV transmission. Though knowledge may be sufficient for some MSM to use condoms, participants shared how social awareness was a more potent driver for condom use. Social awareness is one’s awareness of the reality or prevalence of HIV, particularly in the country and in one’s context or locality. Participants shared how knowing about how prevalent HIV is in the country made them fear or perceive risk of HIV infection. The third level is personal awareness or personally knowing people living with HIV or people who have died of HIV/AIDS. Personal awareness of HIV as a reality was a clear driver for condom use. Participants shared how they started to use condoms regularly upon knowing a friend or acquaintance living with HIV. This personal awareness leads to fear of HIV or the perception that one may be at risk of HIV infection.

The three levels of knowledge or awareness are critical as some MSM may have the general or conceptual knowledge of HIV but still not use condoms regularly. For this group of MSM, building social awareness, “making HIV real”, and building personal awareness, “making HIV personal”, is what drives them to use condoms. Though there could be some MSM who are motivated to use condoms from conceptual knowledge of HIV alone, these three levels of awareness work together to create the perception of risk that drives MSM to use condoms.

“yes. kasi yun nga, yung nasabi ko sa yo before na naging government employee ako, eh sa family planning tinuturuan kung paano ginagamit, paano pinapasok ganun. so alam ko rin kung paano.” (Gay, Bottom, Untested, Angeles Pampanga)

“i was a nursing student. i’m kinda aware of what HIV is like and how it could affect people’s lives... it doesn’t mean that i was never careless but i mean i had that idea. so that’s why i bring lube and a condom... actually, curious din naman ako tapos sa medical profession pa ko. so i have a lot of opportunity to study about it.” (Gay, Bottom, HIV Negative, Quezon City)

“but for him that time, he was also afraid of getting infected. there were times that STI/HIV became popular. that was the first time also that I penetrated him using a condom.” (Heterosexual, Top, Untested, Cebu)

“kasi yung mahilig din ako manood ng mga balita sa mga news about sa Department of Health, ganyan. tsaka nakikipag-ano din ako sa kaibigan kong doctor. katulad sa boss ko, nurse siya.” (Bisexual, Oral Sex Only, HIV Negative, San Jose Del Monte Bulacan)

“they’re not aware. the thing is the reason na malaking factor ito sa akin is because i have friends who have HIV. i have met people with HIV. ang iba kasi, hindi nila alam or anecdotal lang ‘kasi ganyan, may ganito ganyan’. so hindi real sa kanila yung illness. hindi real, cause, so that’s why wala silang grasp masyado kung gaano siya... how it would affect their lives if ever may infection na.” (Gay, Bottom, HIV Negative, Quezon City)

“i had a friend who died (because of HIV/AIDS). that’s why we underwent HIV testing... we were afraid because it is highly probable that her partners could have been also our partners. after she died, i and my friends voluntarily underwent HIV testing.” (Heterosexual Transwoman, Versatile, HIV Negative, Davao)

Fear and Perceived Risk of HIV Infection. The key internal driver to use condoms is fear and the perceived risk of HIV infection. Fear is the more emotional or affective factor whereas perceived risk is the more rational or cognitive factor based on one’s evaluation or judgment of risk. It is clustered together as the evaluative component that drives an individual to use a condom. One has to be afraid of being infected from HIV or perceive that one is at risk of being infected from HIV in order to use condoms as a means of preventing HIV infection. It is the perception of risk that is necessary to motivate MSM to use condoms regularly. As such, participants said they used condoms to protect themselves from HIV, to protect their “romantic” partner from HIV, or to protect their sex partner from HIV. HIV prevention is linked to risk perception. Only when one feels at risk of HIV infection does one try to prevent it. Preventing HIV, STIs, and other diseases is part of a larger desire to live long and stay healthy.

“dahil po takot po kong magkasakit. like katulad po nung di ba nga po na-iisya na yung HIV at AIDS? kaya po ako po, ganun din po ko, natatakot din po ko sa ganung sakit. kahit ginusto ko mang gawin yung mga ganung bagay.” (Gay Transwoman, Bottom, HIV Negative, Caloocan)

“i am afraid of getting HIV. they said that the symptoms do not really show, so that is why i am so vigilant.” (Gay, Versatile, HIV Negative, Mandaue)

“masarap kasi alam mong safe. kaysa naman dun sa masarap nga pero after non matutulog ka pero may alinlangan, meron kang pag-a-alinlangan sa sarili mo kung safe ka pa ba kinabukasan. kung magiging ka pa ba kinabukasan...” (Bisexual, Top, HIV Negative, Bacoor Cavite)

“kasi lagi kong iniisip, mabilis lang yung sarap eh, pero pag nagkaroon ka ng sakit, you know, pang matagalan yan. so pinag-uusapan namin talaga before the sex na condom and let’s use a condom... so ako, though minsan sex addict ako, pero syempre gusto ko pa din laging maging safe ako and yung magiging ka-sex ko... ayun laging iniisip ko. safety.” (Bisexual, Top, HIV Negative, Baguio)

“oo, importante (mag-condom). kasi di ba minsan mayroong madumi... di mo masasabing malinis sila kasi sa loob nila di mo masasabi malay mo may sakit siya.” (Bisexual, Versatile, HIV Negative, Angeles Pampanga)

“kasi... hindi mo naman malalaman kung may sakit siya... at hindi rin naman niya siguro sasabihin na may sakit siya ... kaya siguro po, kaya nga sabi ko po, kailangan talaga (mag-condom) every time... kasi hindi ka rin po sure doon sa mga tao.” (Bisexual, Versatile, Untested, Pasay)

Deliberate Planning. With awareness and perceived risk, one begins to deliberately plan to use a condom during sex. Some participants reported planning to use a condom every time they engage in sex. They negotiate condom use with a sex partner before sex and bring condoms to planned sex encounters. Others always bring condoms “in case” there is a possibility that they may engage in sex. The important element here is the conscious decision to use a condom and the deliberate plan to bring a condom and use a condom during sex.

“i always prepare. i always prepare kahit hindi ko man yan iniisip o iisipin ko yan. atleast always may baon, yun ang importante sa kin. always may baon ako. kasi sabi nga nila, hindi mo masasabi yung pagkakataon o yung time, yung ambience na may mangyayari o wala. be ready, di ba?” (Bisexual, Versatile, HIV Negative, Makati)

“i bring condom and he also brings condom, because i know that when he comes here, i know already that we’re going to have sex. so i really prepare.” (Bisexual, Versatile, HIV Negative, Bacolod)

Personal Habit or Routine. With awareness, perceived risk, and deliberate planning, the conscious choice to use condoms eventually becomes a personal habit or routine. This implies that condom use can eventually become an unconscious habit.

I: would you say na dahil... nalaman mo tungkol sa importance ng condom use with regard to HIV, do you think this made you more inclined to use it?

P: no, it was a force of habit.... it’s like, kakain ka, kuha ka ng plato para kumain. ganun lang for me. para siyang routine.

I: kasi automatic nga?

P: oo, wala siyang reflection kung gagamit ba ko o hindi. wala akong ganun. like i said, force of habit siya.

(Gay, Bottom, No Response, Marikina)

“i have actually a condom right in my wallet. it’s like, it’s like the norm. uhm, it’s just you know, it’s in the heat of a thing or the heat of the moment you just bring it out

and then you put it in. and you just, you know, you will use. so that's, that's the 90% of it." (Gay, Top, HIV Negative, Baguio)

"automatic naman sa akin kapag may sex talaga may condom." (Bisexual, Versatile, HIV, Pasay)

Personal Motivations (To be "Clean"). While the first four internal factors lead to condom use towards preventing HIV, this next internal factor highlights that there are other reasons why MSM use condoms aside from HIV prevention. MSM can have their own personal motivations for using condoms. The most common reason shared by participants is to avoid "dirt" (*iwas dumi*). Though dirt often referred to "*tae*" or fecal matter in the anus or anal region, dirt also meant "*dumi*" in general. As such, avoiding dirt is linked to maintaining cleanliness or personal hygiene. Another reason for using condoms is to avoid pain or increase comfort during sex. A unique personal motivation for using condoms is to measure sexual performance through the amount of ejaculation in the condom. For sex workers, using a condom is linked to preserving the body as "capital" for earning a living.

"i am afraid, what if I defecate... it is unhygienic too. plus i don't like it because maybe the guy will be disgusted because i excreted some feces. it would be really disappointing." (Gay, Bottom, HIV Negative, Mandaue)

"yung parang, yung sperm, parang nadudumihan po ako pag ang kalat, minsan puputok sa loob." (Bisexual, Versatile, Untested, Puerto Princesa)

"gusto niya magpa-bottom. sabi ko 'sige, kaya lang magco-condom ako. ayoko ng wala.' kasi hindi ko naman pwedeng sabihing maglinis ka ngayon kasi wala naman akong labatiba rito sa bahay." (Bisexual, Top, HIV Negative, Bacoor Cavite)

"i really feel it is dirty not wearing a condom." (Heterosexual, Bottom, HIV Negative, Cagayan De Oro)

Perception that Partner is "Unclean" or "Unsafe". The last internal factor is based on a misconception that one can determine if a potential sex partner is "clean" ("*malinis*") or "safe" ("*malinis*") based on the person's personal characteristics, appearance, or sexual history. "Clean" and "safe" are both referred to in the Tagalog word "*malinis*" which literally means clean but is also used to mean safe. As such, being clean is equated to being safe. Only when a potential sex partner is evaluated or judged as "unclean" or "unsafe" do some MSM use condoms (if the sex partner is judged as clean or "safe, some MSM do not use condoms). Some believe that a person who looks dirty, who looks poor, or who looks ugly means that the person is unsafe. A seemingly more reliable basis for judgment is knowledge of the person's sexual history or past sexual activities. Knowing that a potential sex partner has had multiple sex partners or has a reputation for engaging in risky sex behaviors drives some MSM to use condoms. However, this knowledge or perception may not be based on entirely reliable information. Hence, it remains a misconception. Though the evaluation or judgment that a partner is unclean or unsafe can drive MSM to use condoms, it is still based on a misconception that can have negative repercussions. For while perceiving a partner as unclean drives one to use condoms, perceiving a partner as clean bars one from using condoms even when this perception may be baseless.

P: kapag may hitsura, nakakatakot...

I: pano yun?

P: pag may hitsura, sila yung mga prone eh. sa multi-partners, so... parang medyo feeler ako, na-fe-feel, feeling ko, alam ko kung paano kilalanin yung, kilalanin kung sino yung maraming experience sa...

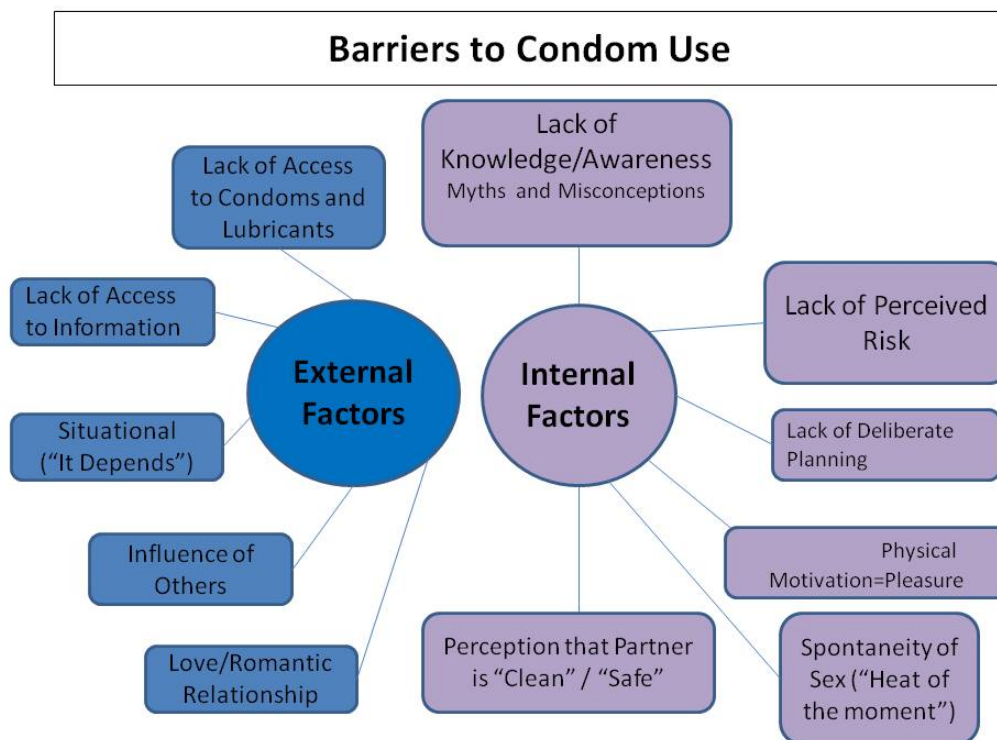
I: ah, okay. so parang ang basehan mo, kapag mukhang pro, kailangan naka-condom ako dito or naka-condom siya sa akin.

(Gay, Versatile, Untested, Puerto Princesa)

“you get to know, kung siya ba ay nag-cru-cruise around or kung sino-sino ng bakla ang tumitikim sa kanya. either i-terminate mo yung relationship or you have to use condom.” (Gay, Oral Sex Only, Untested, Bacoor Cavite)

“pero yung sa mga condom naman... siguro kung gagamit ako ngayon, ma’am... siguro yun yung sa mga taong madudumi, ma’am. yung alam kong talagang gasgas na yung titi, ma’am, sa kabaklaan. yung talagang talamak na sa bakla, ma’am.” (Gay Transwoman, Bottom, Untested, Quezon City)

“from head to foot, tinitingnan ko yung kuko niya, yung paa niya, yung kilos niya, yung pananamit niya, tsaka yung, minsan kasi sir, ayaw ko yung taong may amoy. kasi pag alam kong may ganun na, hindi ka maingat sa sarili mo.” (Bisexual, Oral Sex Only, HIV Negative, San Jose Del Monte Bulacan)



The thematic map of the barriers to condom use appears in the visual diagram above. External factors that bar MSM from using condoms include: (1) lack of access to condoms and lubricants, (2) lack of information about condoms and lubricants, (3) situational “it depends” factors, (4) the influence of others, and, (5) love or a romantic relationship. The internal factors that bar MSM from using condoms are: (1) lack of knowledge or awareness, (2) lack of perceived risk, (3) lack of deliberate planning, (4) the physical motivation for sexual pleasure, (5) the spontaneity of sex or the “heat of the moment”, and (6) the perception that one’s sexual partner is “clean” (*malinis*) or “safe”.

From the thematic map, the first external barrier to condom use is the lack of access to condoms. Aside from lack of access to condoms, lack of access to information about how to use condoms is also an external factor that hinders condom use. Also noted in these two external factors are the lack of access to lubricants and the lack of information on how to use lubricants. Once there is access to and information about condoms and lubricants, situational factors then come in. That is, “it depends” now on the situation whether an individual will use a condom or not. For example, condoms are not used when engaging in oral sex. Another external factor is the influence of others such as the pressure from one’s sex partner to not use a condom. Finally, a unique relational factor that hinders MSM from using condoms is being in a romantic or intimate relationship. Issues of love, trust, and fidelity come into play as using a condom with a romantic partner may signify a lack of trust whereas not using a condom is an expression of love and fidelity. As such, the degree or level of intimacy one has with one’s sexual partner can be a barrier to condom use.

Alongside the external factors are the internal factors that bar MSM from using condoms consistently or regularly. The first internal barrier to condom use is the lack of knowledge or awareness about HIV and condom use. There is a distinction between knowledge about HIV and knowledge about how to use a condom in relation to preventing HIV. With lack of knowledge and awareness about HIV comes the lack of perceived risk of HIV infection.

It is this lack of perceived risk that may be the integral factor that bars MSM from using condoms regularly. If one does not feel at risk of HIV, one does not have a reason to use a condom. Hence, perception of risk of HIV infection is a critical driver and barrier to condom use, with perceived risk driving MSM to use a condom and the lack of perceived risk barring MSM from using a condom. With lack of awareness and lack of perceived risk is lack of deliberate planning to use a condom during sexual encounters. This completes a model of risk-taking behavior wherein lack of knowledge or awareness (cognition) leads to lack of perceived risk (personal judgment or evaluation) and consequently lack of deliberate planning (decision-making) to use a condom when engaging in sex.

Outside of the model of risk-taking behavior that centers on the lack of perceived risk is a separate internal motivation to not use condoms during sex. The desire to experience sexual pleasure is one of the strongest internal barriers to condom use.

Another internal barrier to condom use is the spontaneity of sex or being “in the heat of the moment”. This factor highlights the physicality or bodily experience of sex and the possibility that decision-making once the sexual momentum has started is impaired or overridden by the physiological. Hence, the inability to use a condom once rational decision-making is overtaken by the physical or bodily experience of sex.

The last internal barrier to condom use is the individual perception or judgment made that a sex partner is “clean” or “safe”. Believing that being clean or safe from HIV can be determined through one’s personal characteristics, physical appearance, or sexual history, MSM choose to not use a condom when having sex with a sex partner that is perceived to be safe or clean.

External Barriers to Condom Use

Lack of Access to Condoms and Lubricants. The first external barrier to condom use is the lack of access to condoms and lubricants. Without access to condoms, condom use is not possible.

I: what came about that you did not use a condom?

P: there was no condom.
(Gay, Versatile, HIV Negative, Iloilo)

“parang di ko pa afford bumili ng magandang lubricant nun.” (Gay, Bottom, No Response, Marikina)

Lack of Information on HIV and Condom Use. The second external barrier to condom use is the lack of information about HIV and condom use. At one level, there could be lack of information about HIV in general and HIV transmission through sex in particular. At another level, there could be lack of information on the need to use condoms in relation to HIV prevention. And still another level, there could be lack of information on how to use a condom in a way that will be pleasurable. The lack of information available at these different levels bars MSM from using condoms.

“it is like I did not value it because I was not properly educated on its use.” (Bisexual, Versatile, HIV Negative, Butuan)

“kapag probinsya... di pa masyadong abot yang ganun.” (Bisexual, Versatile, Untested, Batangas)

Situational “It Depends” Factors. With access to condoms and information about condoms available, condom use becomes dependent on situational factors. There are certain situations that hinder MSM from using condoms. One situation is in relation to sex work or paid sex. In this situation, MSM who engage in transactional sex do not use condoms to follow the demand of the client, to please and satisfy them, and to ensure that their clients will meet their financial needs.

Another depends on the level of familiarity or intimacy with one’s sex partner which is also linked to another external barrier, being in love or in a romantic relationship. In this case, some MSM do not use condoms when having sex with a “regular” sex partner. Regularity of sex varies in meaning. “Regular” may simply mean having sex with the same person more than once; distinguishing a “regular” sex partner from a one-night stand. Some MSM do not use condoms when having sex with a “familiar” sex partner. Familiarity likewise varies in meaning. “Familiar” may mean a friend, an acquaintance, or a “regular” sex partner. Other situational factors include not using a condom for oral sex, or only using a condom for anal sex. Interestingly, heterosexual-identified MSM do not use a condom for anal sex and only use a condom for vaginal sex.

“if i am not familiar with my sex partner, i use condom. however, when I know him already, then i will not use condom.” (Gay, Bottom, Refuse to Disclose, General Santos)

“if he is my regular partner, I don’t use condom.” (Bisexual, Bottom, HIV Negative, Bacolod)

I: tell me the last time you had sex without using condom. what brought about the decision not to use?

P: he is my fuck buddy. he’s my regular sex partner.
(Bisexual, Bottom, HIV Negative, Bacolod)

“actually even now, same thing happens. if my partner wants to wear condom, yes we can. i can always cater to my client’s demands because i diligently bring a condom with me. and so if they wish not to wear condom then I’ll do anything to please them.” (Heterosexual, Bottom, HIV Negative, Cebu)

I: so it depends on the price?

P: yes. depends on the price.

I: but the default is really to use a condom.

P: yes. if you request for no condoms because you really want to feel the “skin to skin” then they will give a price. P3500! then it depends per person. if you cannot afford it, then you settle with him wearing a condom.

(Bisexual, Bottom, HIV Negative, Zamboanga)

Influence of Others. Other people may influence one from not using a condom. Others could include one’s sex partner, one’s romantic partner, one’s client in paid sex, etc. A sex partner in any given situation or circumstance may also refuse or resist using a condom. This implies that condom use has to be negotiated with one’s sex partner. Others also acknowledge cultural differences in using or not using condoms during sexual encounters such as those with partners of Muslim faith.

“sabi niya ‘baby ano sex tayo.’ sabi ko ‘o sige sigurado ka ba?’ kumbaga mapapalabas mo naman sa bunganga ng isang tao ang totoo kapag nakasama mo na siya ng matagal. i mean, naging open na siya sa yo. so siya ang nagsabi na huwag nang mag-condom... siya ang nagsabi. sabi niya ‘gusto ko lang maramdaman ka.’ okay sige. pero this is the first and the last...” (Bisexual, Top, HIV Negative, Bacoor Cavite)

“siguro wala sa training manual ng pagiging bading na ‘oh beks condom lang lagi’... it is really [not] part of the lifestyle na kinalakihan ko. like pagpasok ko sa mga gay bars, like yung mga friends ko... hindi naman din nila sinasabi kasi it is not even part of the training or boot camp.” (Gay, Bottom, No Response, Baguio)

I: why? how come?

P: it is because, they are anti-condom here.

I: oh?

P: yes. they are Muslims and it is forbidden to them. there is that culture here. they do not believe in it. they are really anti-condom here.

(Bisexual Transwoman, Bottom, HIV Negative, Zamboanga)

Love or a Romantic Relationship. The last external barrier to condom use is being in a romantic or intimate relationship. For many MSM, condoms are not to be used with a romantic or intimate partner. Not using a condom becomes part of the meaning of love or a romantic relationship as mentioned by the participants. Not using a condom signifies trust in and fidelity to one’s romantic partner. Using a condom then defies the meaning of love and can lead to issues of mistrust and infidelity. Some participants reported not using a condom in order to avoid conflict with their romantic partner. The degree of love, romance, sexual attraction, or emotional intimacy is again linked to the degree of sexual intimacy. Even when not in a romantic relationship, an individual may choose to not use condoms because of the perceived degree of attraction or intimacy with one’s sex partner.

“i trusted him because that's what he told me that i am the only one. but because we are, it has been almost three years since we did not use (a condom).” (Heterosexual, Top, Untested, Cebu)

I: when you are in a relationship and having sex with your boyfriend, do you wear a condom?

P: oh no! usually, i don't wear a condom during sex with my boyfriend. i am just honest!

(Heterosexual, Versatile, HIV Negative, Zamboanga)

"kapag nag-introduce ka nito, sa totoo lang ayaw ni kuya... at kalimitan ayaw nila kasi either ikaw yong pagsususpetsahan, o ikaw yong, ikaw yong nanunuspetsa."

(Gay, Oral Sex Only, Untested, Bacoor Cavite)

Internal Barriers to Condom Use

Lack of Knowledge or Awareness. The first internal barrier to condom use is lack of knowledge or awareness about HIV and condom use. Linked to the external barrier of lack of information about HIV and condom use, this internal barrier is the person's beliefs about HIV and condom use and whether one has the accurate knowledge or awareness about these. MSM may lack knowledge about HIV in general and the link between HIV and condom use in particular. They may lack knowledge about the importance of using a condom in preventing HIV and STIs. They may also lack knowledge about how to use condoms as well as using it in a way that is pleasurable. Some MSM carry myths and misconceptions about HIV and STIs including beliefs that one can diagnose if a sex partner is HIV-positive from one's physical appearance and that one can determine if a sex partner is clean or safe from one's personal qualities and physical appearance. This lack of knowledge or awareness about HIV leads to lack of perceived risk of HIV infection.

"hindi ko pa po kasi naririnig yung sakit na yan eh yung HIV." (Heterosexual, Top, Untested, Quezon City)

I: anong mangyayari sa yo kung mayroon kang HIV?

P: hindi ko po alam eh.

(Gay, Oral Sex Only, Untested, San Jose Del Monte Bulacan)

"kasi nga, i don't have any idea. or i don't study about HIV. i don't study about AIDS. so... akala ko mahirap makuha yung mga ganun." (Gay, Top, HIV Positive, Baguio)

"ang iniisip ko baka maiwan sa loob ng katawan ko. madumi. madumi yung condom kasi plastic yun eh." (Bisexual, Versatile, HIV Negative, Angeles Pampanga)

Lack of Perceived Risk. An opposite perception that one is not at risk of HIV infection bars some MSM from using condoms. It is this lack of perceived risk that may be the critical factor to non-condom use. If a person does not perceive risk of HIV infection, there is no reason to use a condom. Condom use then becomes irrelevant and unnecessary. Some MSM exhibited a false sense of security, believing that they do not need a condom and that they will not be infected with HIV. This false sense of security may be attributed to lack of knowledge about HIV, lack of social awareness that HIV is a reality, and lack of personal awareness of people living with HIV. If HIV does not exist or is believed to not exist in one's MSM community, the person may be unable to connect HIV to one's personal life. When HIV is perceived as not personally relevant or not personally real, condom use becomes irrelevant. The lack of perceived risk is tied to the lack of consciousness about the consequences of not using a condom as well as the lack of concern about HIV prevention.

"wala siyang importance sa akin. like i've mentioned before hindi ko pa nakikita ang importance of using condom. siguro hindi pa nag-si-sink in sa akin. kasi ang

kinalakihan ko panglalake lang yan para hindi mabuntis yung babae.” (Bisexual, Versatile, Untested, Batangas)

“sinasabi po nila sa ibang bansa [kumakalat ang AIDS]. sa babae lang din daw po nakukuha yun.” (Heterosexual, Top, Untested, Quezon City)

“sabi ko hindi ako na... never ako matatakot kasi syempre as long as parang sabi ko sa sarili ko na wala naman ako ng naaano na... mga lalaki din talaga na. kasi parang feeling ko na nakukuha yung HIV sa bisexual yan eh. lahat naman ng naaano na naka-sex ko every time siguro makalima ako ng lalaki sa gabi, sa mga ganyan. puro lalaki talaga sila. straight guy talaga.” (Transwoman, Bottom, HIV Negative, Puerto Princesa)

“hindi ko naman iniisip na baka mahawa sa akin yung asawa ko dahil sa nakikipagtalik ako sa mga lalaki. tapos maisalin ko sa babae ko, sa asawa ko. hindi ko rin iniisip na may sakit yung karelasyon, yung nakakatalik ko. hindi ko naiisip. kasi actually nagkaroon ako ng relasyon na babae, ibang babae. kaya sex dito, sex doon, sex diyan. parang ganoon. pero hindi ako gumagamit ng condom.” (Heterosexual, Top, Untested, Bacoor Cavite)

Lack of Deliberate Planning. With lack of knowledge and awareness and lack of perceived risk comes the lack of deliberate planning. Some MSM do not plan to use a condom and do not bring a condom when they do not see themselves at risk of HIV infection. Lack of deliberate planning completes a model of risk-taking behavior wherein lack of knowledge (cognition) leads to lack of perceived risk (evaluation) and consequently lack of planning (decision-making) to use a condom during sex encounters.

“kasi ano hindi ko na iisipin naman yun. basta alam ko lang, meron akong na-encounter at nakapagparaos ako. yun lang naisip ko ng mga oras na yon. hindi ko na naisip na kailangan mag-condom, kailangan magsuot ng condom, kailangan gumamit ng condom.” (Bisexual, Versatile, HIV Negative, Batangas)

“kasi yung time na yun, hindi ko ine-expect. hindi ko akalain na makikipagtalik ako sa isang lalaki. so hindi ko napaghandaan yun. dahil nga sa pangangailangan, at nagkasunduan na, hanggang sa nagkaayaan na, hanggang sa nauwi na sa loob, hanggang sa nasa kama na at nairaos na.” (Heterosexual, Top, Untested, Bacoor Cavite)

Physical Motivation for Pleasure. A separate internal barrier to condom use is the physical motivation or desire to experience sexual pleasure. The desire for pleasure counters the desire for protection. And with the absence of perceived risk, the desire for pleasure dictates not using a condom during sex. Participants shared that the physical sensation when having sex without a condom is heightened, is better, or is different compared to having sex with a condom. Sex without condoms is perceived to be more pleasurable. Participants also shared not using a condom to avoid pain, implying that sex with a condom can be painful. Some reported not using a condom to try new sexual experiences or in pursuit of greater sexual excitement or thrill.

“masyadong madulas. di ko lalo siyang maramdaman e, lalo na pag may condom. di siya enjoy... parang wala kang nararamdaman... parang nilulusot mo lang siya, pinapasok mo lang, nilalaspag mo. pero pag syempre, natural lang, yon mas okay. mas nararamdaman mo.” (Bisexual, Top, Untested, Bacoor Cavite)

“i think it's great when people always do the safety first thing. but for me, and i guess for my boyfriend as well, it's not like 'are we safe?' it's more like, 'are we... is this good? are we feeling good? is this pleasurable for us?” (Gay, Bottom, Untested, Makati)

“actually hmm, i feel the urge and lust... ah, i know it's important to use condom but what really matters most is sex and the satisfaction it brings to you and your partner; even without using condom.” (Gay, Oral Sex Only, HIV Negative, General Santos)

“may mga times na hindi...may mga times, pag trip ko yung lalaki, gusto ko ma-feel sa loob. yung gusto ko iba yung sensation.” (Gay, Versatile, Untested, Bacoor Cavite)

“tapos yung the mentality na hindi kami gumagamit ng condom, it's more sexy and erotic... kasi pag naka-condom ka, it's like you're having sex with a raincoat on you...” (Gay, Top, HIV Negative, Baguio)

Spontaneity of Sex (“Heat of the Moment”). The physical or bodily experience of sex is also an internal barrier to condom use. Some MSM shared that when one is at the “heat of the moment”, making the decision to use a condom is overtaken by the power of sexual desire. The “momentum” of sexual behavior overrides the ability to think rationally. One can argue that there is still a choice made in giving in to the heat of the moment or to the power of sexual desire. However, participants reported their experience of “forgetting” to use condoms because they were overtaken by the passion or desire for sex (“*nadala*”). Some may have the intention of using a condom but are unable to do so once the momentum of sex begins or once they are in the heat of the moment. Others shared not planning to engage in sex and that sex was at the “spur of the moment”.

“kasi nagkakapitan na kami. nagustuhan namin isa't-isa. tapos nag-___ hotel kami. tapos di pa nakapasok ng ___ hotel, halikan ng halikan. tapos hindi na nakapagsara ng pinto naghuhubaran na kayong dalawa. tas naalala mo na, wait, wait, may condom ako sa bag ko... sa sobrang lakas ng energy ng sex, nakakalimutan mo.” (Bisexual, Versatile, HIV Positive, Marikina)

“ang mahirap kasi sa paggamit ng condom is that when you're there already... tapos, pero dahil sobrang sexually excited na kayo, andun na yung peak, tapos biglang bababa kasi maghahanap ka ng condom or pagbukas mismo ng condom, yung moment na yun parang nakakawala ng gana. shit! we have to stop kasi kailangan mong magsuot ng condom.” (Gay, Top, HIV Negative, Baguio)

“well, parang it is important, pero it's your ano eh, parang, one factor, libog... kung gaano na ka-intense yung kalibugan mo sa ano. so you sometimes forget na paggamit... kahit meron ka...” (Bisexual, Bottom, HIV Negative, Bacolod)

Perception that Partner is “Clean” or “Safe”. The last internal barrier to condom use is the perception that one’s sex partner is “clean” or “safe” (“*malinis*”). This personal judgment or evaluation that one’s sex partner “looks clean” (“*mukhang malinis*”) leads to non-condom use. For instance, a sex partner can be judged clean if he looks decent, looks presentable, looks responsible, looks rich, looks educated, or looks handsome. Though this personal judgment is based on a misconception that one is “safe” from HIV if one looks “clean”, and safety is equated with personal indicators of decency or cleanliness, it is sufficient to motivate MSM to not use a condom. The judgment that a sex partner is “safe” can also be based on sexual behaviors, such as knowing that

the partner does not engage in risky sexual behaviors such as group sex or sex with drugs or has had very few sex partners. However, this judgment may still be based on unreliable information and may not be an accurate indicator of safety. These judgments or evaluations that a person “looks clean” (“*mukhang malinis*”) appear to be common among MSM, making these perceptions a socially or culturally shared barrier to condom use.

“...iniisip ko syempre kung presentable siya, mukhang aral naman, malamang wala siyang HIV... hindi mukhang jejemon... syempre you ask about the person’s background tapos kung paano siya magsalita. so parang iisipin mo, ano to, di naman siguro prostitute to... tapos responsible siyang tao dahil aral siya.” (Gay, Bottom, No Response, Marikina)

“titingnan mo yung part ng lalaki. pag malinis at feel mo, ay! malinis man tala tapos mabango man, okay go!” (Bisexual Transwoman, Bottom, HIV Negative, Zamboanga)

“if there is no use of condom, i perceive my partner as clean and has no sickness. when you look at the face, the cute face. you will see he seems healthy. i also look into the eyes if they’re clean. that also includes his face as well as his overall physique.” (Bisexual, Versatile, No Response, Davao)

“...the times when I don’t use condom is the time when I really know the person... ibig sabihin that i’ve spent time with him... i’ve learned about his work, his friends. is he good? may girlfriend ba ito? may asawa ba ito? ito ba ay cruiser? ito ba ay pokpok din? ito ba’y ilang bakla na ang dumaan sa kamay nito? pag na-check ko na yon, kunyari number 1, hindi siya dumaan sa maraming baklush. number 2, may asawa siya, may girlfriend, mas masarap yon eh di ha ha ha. kasi lalaki nga eh. i look for men. and i don’t look for another gay. okay, so check yan check. number 3, hindi siya pok pok, yung benta, benta, benta, benta... number 4, kilala ko na yung mga friends niya.” (Gay, Oral Sex Only, Untested, Bacoor Cavite)

“i mean hindi naman siya yung pakalat-kalat sa kalye. medyo nakita ko naman na ayun, nag-aaral.” (Gay, Bottom, HIV Negative, Manila)

“may mga times na hindi... and I feel na safe yung lalaki, that’s the time. hindi siya multiple partner, kilala mo, medyo kilala mo.” (Gay, Versatile, Untested, Bacoor Cavite)

“hygiene syempre, di ba? kung baga hygiene. (walang) bad breath, walang spots, walang spots... yun ang malinis. mabango, di ba? kapag tinikman mo, lasang skin, hindi lasang asin. ganun.” (Gay, Top, HIV Positive, Baguio)

Force Field Analysis for Condom Use

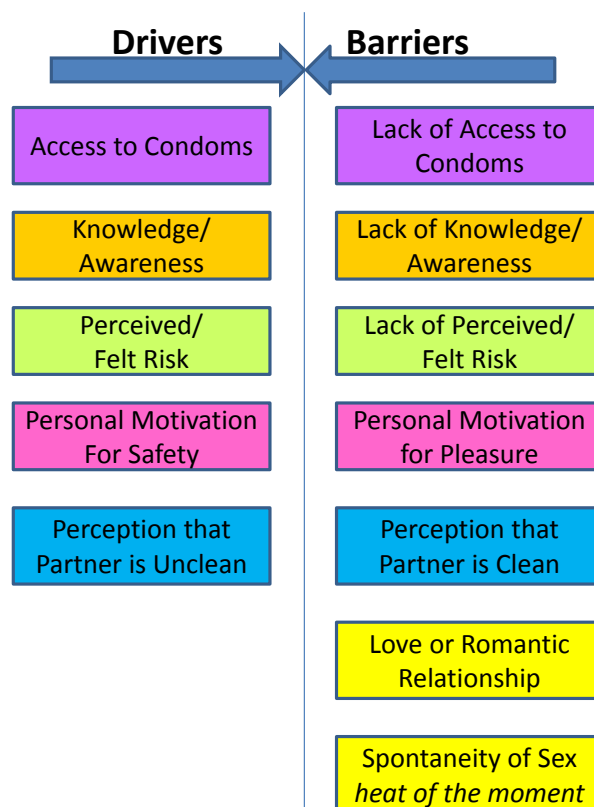
In summary, the force field analysis for condom use shows that there are more barriers than drivers to condom use. Access to condoms and lubricants is a driver to condom use while lack of access to condoms and lubricants is a barrier to condom use. Knowledge or awareness about HIV drives MSM to use condoms while lack of knowledge or awareness bars MSM from using condoms. Parallel to this, lack of perceived or felt risk bars MSM from using condoms.

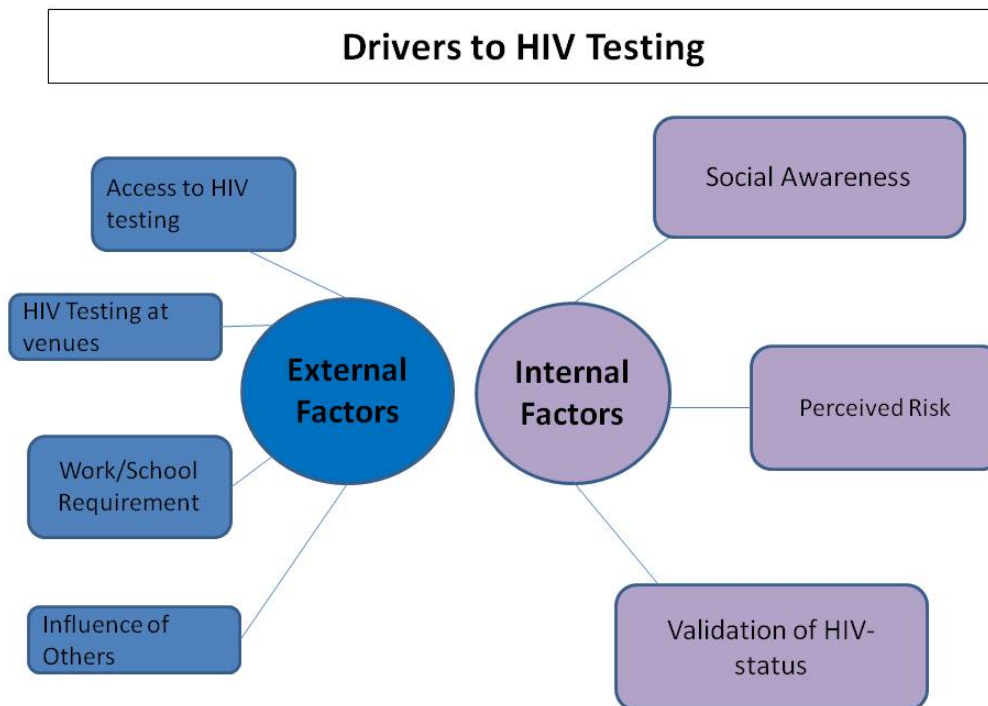
At the next level, personal beliefs and motivations are matched. On one side is the personal motivation towards cleanliness and safety. On the other side is the personal motivation towards sexual pleasure. The challenge at this level is how to increase the personal motivation towards safety vis-a-vis the motivation towards pleasure.

The driver and barrier at the level of social perceptions are likewise matched with the perception that one's partner is unclean or unsafe (*hindi malinis*) driving MSM to use condoms and the perception that one's partner is clean or safe (*malinis*) barring MSM from using condoms.

There are two other barriers that have no matching drivers. Love or a romantic relationship is a barrier to condom use. Here, the meaning of being in relationship and not using a condom to show trust and fidelity becomes the barrier to condom use. Another way of looking at this barrier is that the need for intimacy and love is not countered by the need for cleanliness or safety. This implies that the personal motivation toward safety as a driver is being countered by multiple barriers in terms of personal motivations for sexual pleasure, for love and intimacy, and other needs.

A final barrier is the spontaneity of sex or being "in the heat of the moment". The physicality of sex serves as a barrier to condom use. This may be a complex barrier to counter as this implies that the barrier to condom use is the physical urge or need felt during sex.





The thematic map of the drivers to HIV testing appears in the visual diagram above. External factors that drive MSM to test for HIV are: (1) access to HIV testing, (2) HIV testing at venues, (3) work/school requirement, and, (4) the influence of others. On the right side are the internal factors that drive MSM to test for HIV: (1) social awareness, (2) perceived risk, and, (3) validation of HIV-status.

From the thematic map, the first external factor is access to HIV testing in terms of cost and location. Linked to this is the second external factor that refers to access to HIV testing specifically at venues or cruising sites. Both the accessibility of HIV testing in general and HIV testing at venues in particular drive MSM to get tested for HIV. A third external factor is compliance with work or school requirements or mandatory HIV testing. A fourth external factor is the influence of others, especially friends or peers, in motivating MSM to get tested for HIV.

While accessibility of HIV testing is a key factor, MSM need to see the value of HIV testing in their own personal lives. The internal factors to HIV testing begin with social awareness, the knowledge or awareness that HIV is indeed a social reality. This social awareness creates a perception that one may be at risk of HIV infection or the perceived risk of HIV. It is social awareness with the perception of risk that drives MSM to get tested for HIV. An interesting internal motivation to get tested for HIV is to validate one's HIV-negative status. This implies that though MSM get tested for HIV when they perceive that they are personally at risk of HIV, some MSM take the test because they believe they will test negative.

External Drivers to HIV Testing

Access to HIV Testing. The primary external driver to HIV testing is the availability of HIV testing that is free and easily accessible. Access to HIV testing services drive MSM to get tested for HIV.

“may card, may health card ako galing sa government na parang libre. thanks sa gobyerno naman natin dahil naiisip yung mga ganyan... dun naman, may mga test-test naman sila. so bingyan nila ako card, ng health card, libre lang yung pagpa-check-up, libre lang.” (Transwoman, Bottom, HIV Negative, Caloocan)

“then I told him that there’s free HIV testing in the provincial hospital... that it’s free to have a status check up... we then immediately had a test.” (Bisexual, Versatile, HIV Negative, Bacolod)

“it’s a program action. government yata yun di ba. they go to yung nga mag hotspots ganyan where you would... yung mga maiingay na lugar. they have the people who work there tested. free naman yun.” (Gay, Bottom, HIV Negative, Manila)

HIV Testing at Venues. Aside from HIV testing services being free and easily accessible, some participants find HIV testing services specifically at cruising sites or venues a driver to HIV testing. It is the conducive atmosphere at cruising sites or venues that makes HIV testing acceptable for some MSM. There is a sense of anonymity at the venue as everyone takes the test and the feeling of non-judgment since everyone is getting tested. HIV testing at venues seems to create a “safe space” environment where HIV testing becomes a social norm or an acceptable behavior for MSM. Hence, it is able to break the stigma associated with getting tested for HIV.

“kukuhanan ka lang, normal lang naman sila na kukuhanan ka ng dugo eh... kasi lahat sila nagpakuha eh.” (Bisexual, Versatile, HIV Positive, Manila)

“mayroon talaga doon, confidential lang. tapos pagdating mo doon ayun alam mo magpapatest sa HIV.” (Bisexual, Versatile, HIV Negative, Pasay)

Work/School Requirements. Another external driver for MSM to get tested is work or school requirements. Here, getting tested becomes an act of compliance with mandatory HIV testing as required by certain institutions. As such, MSM do not really make the decision to get tested for HIV but are merely obeying institutional requirements.

“nagpa-HIV test ako non... kasi paalis na ko papuntang abroad. ang pinaka-finale ko na lang, medical. pagkuha ng dugo. so yun.” (Bisexual, Versatile, HIV Positive, Batangas)

“so at that time... they were saying that all peer educators must take the test.” (Heterosexual, Bottom, HIV Negative, Zamboanga)

“syempre wala ka namang magagawa eh, required. so nagpa-test... pangatlo ko lang ngayon. dito sa work naman... oo, required.” (Bisexual, Top, HIV Negative, Marikina)

Influence of Others. Another external motivator to get tested is the influence of others. MSM reported being most influenced by their friends or peers who encouraged them to get tested for HIV. The influence of social hygiene clinics and DOH programs particularly through peer educators who are also members of the MSM community were also noted.

"niyaya lang ako ng friend, yung friend kong nurse dun sa isang clinic sa RITM na nagko-conduct ng HIV testing so niyaya niya ako. sabi ko, 'sige'. eh di nagpunta ako. and then yung lang. it was voluntary. sobrang thankful ko." (Gay, Versatile, HIV Negative, Manila)

"...natutulog lang ako sa bahay non eh... tas biglang nagulat lang ako na pumunta ang kaibigan kong peer educator tas sabi niya "oy, _____ may visiting don sa RHWC sama ka. ano, tas ire-refer kita. ganon ganon.. 'o sige'..." (Heterosexual, Bottom, HIV Negative, Davao)

"kasi nga pumunta yung sa health center ng Marikina dun sa pamantasan. nag-room-to-room sila tapos nag-alok sila ng free HIV testing." (Bisexual, Top, HIV Negative, Makati)

Internal Drivers to HIV Testing

Social Awareness. Even if HIV testing services are accessible, MSM will not get tested without personally recognizing the need for HIV testing. The first internal driver to get tested is social awareness. The participants shared that it was the awareness that "HIV is real" and that "HIV is really happening" that pushed them to get tested. Knowing from media, for example, the alarming rates of HIV infections in the country, made some MSM take the test. This social awareness of the reality or prevalence of HIV in the country and in their own local context is what makes MSM realize that HIV could be personally relevant to them and that they could be at risk of HIV infection.

"siguro isang factor na yun nga uhm sa news... nakaka-alarm na." (Bisexual, Bottom, HIV Negative, Pasay)

"kasi late-bloomer ako. yung mga friends ko may mga kakilala sila na namatay sa HIV. nagka-TB. so as days go by, nagsi-sink in sa akin na bakit hindi ako magpa-test. na-expose na rin naman ako sa gay world." (Bisexual, Versatile, Untested, Batangas)

"kasi sila yung confirming reality that the idea of HIV is real. kasi... nakikita mo, nagma-manifest na doon sa mga taong nag-live with HIV and AIDS. they confirmed the reality. kasi if kung walang ganun, kunyari if wala talagang data na may tao or wala akong kilala, hindi talaga. hindi talaga ako maniniwala na mataas ang probability na magkaroon ako ng ganung sakit." (Gay, Top, HIV Negative, Baguio)

Perceived Risk. The social awareness that HIV is a reality creates the perception that one could be at risk of HIV infection. It is this perception of risk that is key to driving MSM to get tested. Perception of risk for some is linked with experiencing physical illnesses that they fear may be symptomatic of HIV. Perceived risk can also come from knowing people living with HIV or people who have died of HIV/AIDS. Perceived risk requires that MSM make that personal evaluation or judgment that they themselves are at risk of HIV infection. This can come from realizing that HIV is a reality in the MSM community one belongs to. It is this felt risk of HIV infection that leads to HIV testing and HIV prevention.

"yung ano, kaba, nung nagkaroon ako ng spotting. kinabahan ako nun... sabi ko i need to know kung carrier na ako ng HIV. at least i-aware ko yung sarili ko kung ano ba yung mga dapat gawin, kung ano yung mga bawal kaya nagpa-test na rin ako." (Bisexual, Versatile, HIV Negative, Marikina)

“natakot lang ako... hindi dahil totoo ang HIV kung hindi it is really enough to be close to you. i know someone... someone talaga na close ako sa kanya. mali siguro sabihin na dahil nangyari siya sa friend ko kaya ako magpapa-test pero malaking factor yun.” (Gay, Bottom, HIV Negative, Baguio)

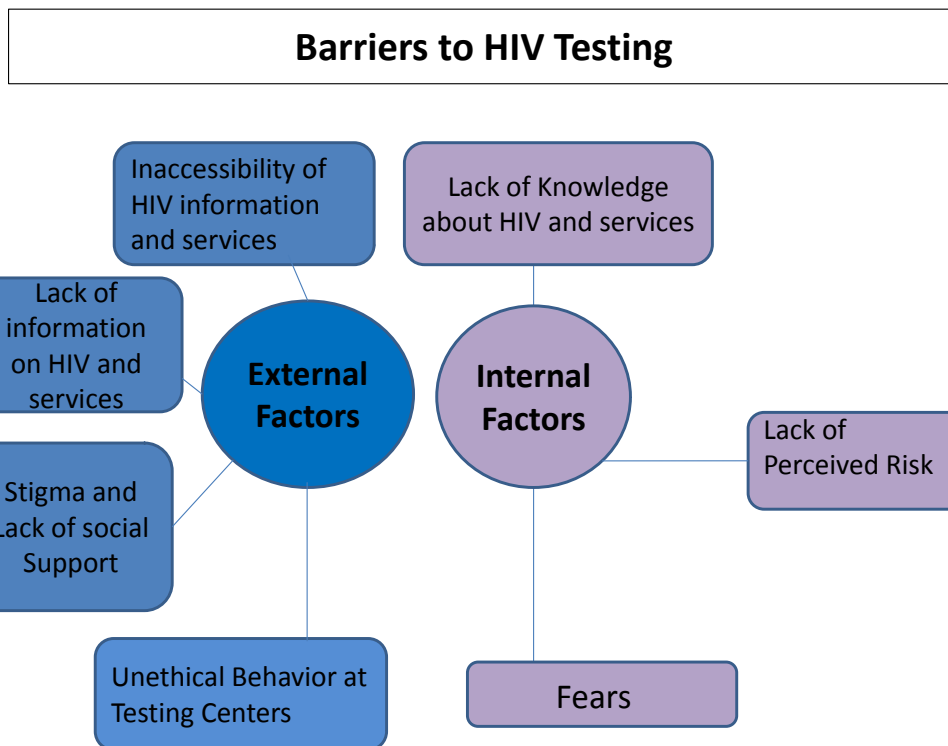
“well, it's because i'm sexually active. so, at dahil gusto kong malaman kung may sakit ba ko o wala.” (Gay, Top, HIV Negative, Baguio)

“because we will never know. for example, today negative, you will never know in the past few days, you are positive. because i am sexually active.” (Heterosexual, Versatile, HIV Negative, Zamboanga)

Validation of HIV-Status. A unique internal driver to HIV testing is validating one's HIV-negative status. While social awareness and perceived risk drives some MSM to get tested, other MSM take the test in order to prove that they are HIV-negative. As such, though there is perceived risk, there is also a sense of security that one will test negative. HIV testing then becomes a way of proving that one is “clean”, with the test results serving as evidence or proof that one is “safe” to engage in sex. HIV testing becomes a “sex clearance” for some MSM. For others, HIV testing is a matter of principle and that one needs to get tested as part of one's sense of responsibility.

“naging importante na. at least every 6 months, kung di every, every year ma-test. di naman kasi ako malinis na walang nakaka-sex. mas safe na ako pero kahit papano gusto ko pa rin na may documentation ako na nagpapatunay na wala ako nun.” (Gay, Versatile, HIV Negative, Quezon City)

“third is to show my potential male partners that i am not HIV positive.” (Heterosexual, Bottom, HIV Negative, Davao)



The thematic map of the barriers to HIV testing appears in the visual diagram above. On the left side are the external factors that bar MSM from getting tested: (1) inaccessibility of HIV information and HIV services, (2) lack of information about HIV and HIV services, (3) stigma and lack of social support, and, (4) unethical behaviors at HIV testing centers. On the right side are the internal factors that bar MSM from getting tested: (1) lack of knowledge about HIV and HIV services, (2) lack of perceived risk, and (3) fears.

From the thematic map, the first two external barriers to HIV testing are the inaccessibility of information about HIV and HIV services and the lack of information about HIV and HIV services. The primary barrier then to HIV testing is the lack of information about it or the inability to access the information about it if it is available. Without the information on how to get tested and without the access to this information, HIV testing will not be possible. A third external barrier is the stigma surrounding HIV and the lack of social support to get tested within the MSM community. A fourth external barrier is unethical behavior reportedly occurring at HIV testing centers.

Even when there is information about HIV and HIV services available, MSM may not get tested because of internal factors or barriers to HIV testing. MSM themselves may lack accurate knowledge about HIV and carry misconceptions about HIV transmission, diagnosis, and treatment. Also, they may carry incorrect information about HIV services such as how to get tested. The primary internal barrier to HIV testing is the lack of perceived risk that one could be HIV-positive. That is, some MSM believe that they are not at risk of HIV infection and do not see the personal relevance of getting tested for HIV. The third internal barrier to HIV testing is fear. Most primary is the fear of knowing that one is HIV-positive.

External Barriers to HIV Testing

Inaccessibility of HIV information and HIV services. The first external barrier to HIV testing is the inability to access HIV information and HIV services. The issue here is not the lack of information but the inaccessibility of information. Inaccessibility of information about HIV and HIV services could be in terms of the modes of communication used wherein certain types of media may only be accessible to certain groups of MSM. For example, the use of print media may only work for MSM groups who access print media or who regularly read print materials. Whereas television and radio may be more accessible to certain groups of MSM. Online media and online cruising sites is one platform through which HIV information and HIV services can also be made accessible. Inaccessibility of information about HIV and HIV services could also be in terms of the language used or the comprehensibility of the language used. For instance, the use of scientific language and terminology may not be readily understandable to ordinary people, particularly those with less education. On the other hand, inaccessibility of HIV services could be in terms of the cost of services, the location of services, and the schedule of services. HIV testing centers or social hygiene clinics could also be inaccessible when they are not presented in an accessible manner, that is, they are targeted only for specific groups of MSM. As such, even when HIV testing clinics are readily accessible, some MSM do not perceive them as services that cater to them. For example, heterosexual-identified MSM and transgender-identified MSM may not find HIV testing centers accessible because they are targeted for gay-identified MSM. Where the information is shared, in what form and language it is shared, and to which group of MSM it is targeted, contribute to making HIV information and services accessible.

“hindi ko pa... iniisip po yun... sinasabi naman nila sa ibang bansa lang yun nangyayari hindi naman dito sa... wala pa namang kumakalat dito na ganun, nababalitaan.” (Heterosexual, Top, Untested, Quezon City)

“kasi wala talaga akong idea. where’s the testing? wala. feeing ko wala akong pakialam sa HIV. kasi nga, wala akong naririnig. yun din. so, pass.” (Gay, Top, HIV Positive, Baguio)

“parang napanood ko lang yun. napanood ko sa tv yun, sa MMK po... na pati anak niya nahawa na rin. ex niya rin. mag-iina sila... yun lang po ang nakita ko po. yun lang po kasi... napanood kong palabas.” (Heterosexual, Top, Untested, Quezon City)

Lack of Information on HIV and HIV services. Linked to inaccessibility of information about HIV and HIV services is the lack of information itself about HIV and HIV services. This external barrier to HIV testing refers to specific types of information that is said to be lacking such as information about the nature of HIV as a condition; information about the reality or prevalence of HIV; information about HIV testing procedures; and, information about HIV testing centers.

Though there is general information about HIV, some participants reported the lack of specific information about HIV and how to get tested. For instance, some reported that there is no information about what happens or what to expect during HIV testing or the specific step-by-step procedure that can prepare one for HIV testing. Others noted that though there is information about HIV as a virus, about HIV transmission, and about HIV as a medical condition, the information about the exact nature of the illness that could lessen the stigma surrounding HIV and present HIV as a manageable condition is not as evident. For instance, information about people living with HIV and the lives of people living with HIV that can reflect the nature of HIV as a condition is not readily available. Knowing information or hearing stories about people living with HIV in the country or in their own local context and their own MSM community that could create awareness of the reality of

HIV is likewise not common. The lack of information about HIV noted by some participants points to the MSM community's need for a more diverse set of information surrounding HIV. For instance, some mentioned the need to clarify specific HIV testing policies such as testing minors (below 18 years of age).

"hindi ko pa po kasi naririnig yung sakit na yan eh, yung HIV." (Heterosexual, Top, Untested, Quezon City)

I: alam mo ba kung ano yung ibig sabihin ng virus?

P: hindi masyado.

(Bisexual, Versatile, Untested, Batangas)

I: but have you thought about that? that what if you already knew about your status, did you think that you can infect?...

P: no, because the initial explanation to me was different. they told me about the risk and cause, but there is no proper explanation that I can infect...

(Bisexual, Top, HIV Positive, Butuan)

"isip ko lang po may bayad po yun, mga ganyan. wala naman kaming pera at saka alam ko naman po wala naman akong sakit na ganyan." (Heterosexual, Top, Untested, Quezon City)

"actually I have the plan para magpa-test ng HIV, kaso naghahanap lang ako tsaka... eh di ba kasi mahal din naman yun kaya kailangan kong pag-ipunan yung mga bagay na yun." (Bisexual, Versatile, Untested, Caloocan)

Lack of Social Support. Another external barrier to getting tested is the lack of social support to get tested or during the actual process of getting tested. Discussing HIV in some MSM groups or communities is still taboo. Consequently, HIV testing is not talked about and not encouraged. This then leads to the lack of support from peers or friends to undergo testing.

I: so all things considered, why haven't you taken the test yet?

P: kasi I promised that I would take a test with this friend. kasi feeling niya mayroon daw siya. so parang samahan ko siya.

(Gay, Top, HIV Negative, Baguio)

"...naghahanap talaga ako ng kakilala kasi lalo na di ba? HIV. parang pag pumunta ka sa clinic, pag pupunta ka sa HIV, parang nakakadiri kasi di ba? 'ay HIV carrier to' ganyan ganyan. nakakahiya kung tutuusin na magpaganun ka." (Bisexual, Versatile, Untested, Caloocan)

I: so kung may kasama ka okay lang sayo?

P: siguro kung may kasama ako, okay lang sa akin... okay lang eh, kasi lahat naman kami magpa-test... okay lang siguro, kung marami kami, kung lahat kami... mas may chance to. may laban ako, parang ganun. so hindi ako nag-iisa."

(Gay, Versatile, Untested, Puerto Princesa)

Unethical Behavior at Testing Centers. The last external barrier to HIV testing is unethical behavior reportedly taking place in some social hygiene clinics or HIV testing centers. Some MSM reported experiencing negative judgment from the people at the HIV testing center. Others reported instances when confidentiality was breached such as when individual test results reached the MSM

community. Another unethical behavior reported was the lack of informed consent when getting people tested during the conduct of research.

“...the landlady of my boarding house knew it and the gossip was spread... what just happened was that the files were not kept and anyone can see the files. then the staff there would tell ‘that one, the gay who was with ____.’ it was during the second and third day when I went back there, then i realized that people here are gossiping about me. this is not right.” (Bisexual, Top, HIV Positive, Butuan)

Internal Barriers to HIV Testing

Lack of Knowledge about HIV and HIV Services. Hand-in-hand with the lack of information and the lack of access to information about HIV and HIV services is the lack of knowledge about HIV and HIV services. As an internal barrier to HIV testing, lack of knowledge reflects how some MSM remain unaware of the nature of HIV and how to access services related to HIV, in particular, HIV testing. Some participants shared beliefs about HIV such as diagnosing HIV from the condition of a person’s skin (e.g., *nagbibiyak-biyak*) or from the physical reaction to pain (e.g., if the person cries out or “*aray*” when gently hit at the stomach). There were myths as well that HIV could be treated by drinking laundry detergent such as *Tide* everyday for one month. The existence of myths and misconceptions among some MSM reflects the lack of accurate knowledge about HIV. Belief in these myths and misconceptions makes HIV testing unnecessary and irrelevant. Hence, lack of accurate knowledge about HIV is a barrier to getting tested.

“ang AIDS po may tulo ka na may sakit ka sa dugo... may sakit ka sa dugo tas may tulo ka pa.” (Heterosexual, Top, Untested, Quezon City)

“pag hindi umaray pagkatapos ng physical test... itutuloy na ho namin.” (Heterosexual, Top, Untested, Quezon City)

“wala ho kasing lason yung Tide. ayun ho ang gamit sa tulo. pag hindi mo kayang inumin yung Tide, hindi ka gagaling.” (Heterosexual, Top, Untested, Quezon City)

“...it's not something that's easily, uhm, advertised like, 'HIV testing here' ... unlike testing for your blood sugar or taking your blood pressure. it's not something that's common knowledge... you know where to get tested, and what it means to be tested, and what HIV means and stuff like that. so it's not common knowledge.” (Gay, Bottom, Untested, Makati)

Lack of Perceived Risk. The primary barrier to getting tested for HIV is the lack of perceived risk among MSM. Whereas social awareness of the reality of HIV leads to perceived risk that drives MSM to get tested, the lack of awareness and the consequent lack of perceived risk bars MSM from getting tested. Some participants believed that they will never be infected with HIV, that HIV does not concern them or is not about them. For instance, some think that they are not at risk of HIV infection because they only engage with sex partners they know or are familiar to them, or have a reputation of having very few sex partners. Others think that because they are presently in a monogamous romantic relationship that they are not at risk of HIV infection. Some heterosexual-identified MSM and transgender-identified MSM believe that HIV is a gay disease therefore only concerns gay men. This “false sense of security” reflects the lack of perceived risk of HIV infection. HIV testing then is perceived as not personally relevant, as unimportant, and as unnecessary.

“hindi pa. kasi hindi naman ako 100% na mahawaan ako nun. mas malakas yung kutob ko na wala ako nun... kasi nung nakikipagtalik ako diyan, wala namang sinasabi yung baka mahawaan ako.” (Heterosexual, Top, Untested, Bacoor Cavite)

“i’m not sick. i don’t feel I have symptoms in my body. if ever I have (HIV), i should feel symptoms that I can say this is it.” (Gay, Oral Sex Only, Untested, Iloilo)

P: ...i know myself. i know at least 90% that I’m safe.

I: 90% sure. so?

P: i don’t need it.

I: so for now, you don’t want to have a test?

P: yes. i don’t.

I: even if it’s free?

P: yes.

(Bisexual, Versatile, Untested, Iloilo)

I: why haven’t you had a test before? what do you feel about having a test?

P: maybe I’m afraid of the result. but actually, I’m confident of the partners I’ve met because I only meet those persons that I’m familiar with.” (Lines 1822-1832)

(Gay Transwoman, Bottom, Untested, Iloilo)

“actually, i am confident that my partner is clean. he has no disease for he really looks good.” (Gay, Oral Sex Only, HIV Negative, General Santos)

Fears. A primary reason among MSM for not getting tested is the fear and anxiety that one may test HIV-positive. Unlike lack of awareness about HIV and lack of perceived risk of HIV infection, fear is the opposite. Fear presents the possibility or the risk that one is HIV-positive. And the fear is the fear of knowing. Fear is a basic emotion. Linked to HIV, fear represents the emotional reaction to a scary future, to the possibility of death, and to an unimaginable life. As one participant shared, “I may feel that I have no sense of purpose in this world.” It is this fear that bars MSM from getting tested as testing means facing the possible reality of being HIV-positive and the imagined consequences of such a reality. Testing means having to confront the truth or face the reality that one may be HIV-positive. Though the meaning of fear is primarily in relation to life after knowing that one is HIV-positive, other fears were also identified. Among them, the fear of being labelled gay at the testing center, fear of negative judgment at the testing center, and fear of being personally recognized at the testing center. This set of fears reflects the social stigma surrounding HIV and the fear of being stigmatized when one gets tested for HIV. Addressing the real and imagined fears surrounding the future of being HIV-positive and what it means to live with HIV is one way to motivate MSM to get tested.

I: why did you not have yourself tested for HIV?

P: i’m anxious about it. the result may turn out to be positive and i also do not know where to go for HIV testing.

I: so if you got tested and the results are positive, what are you afraid of?

P: I may feel that I have no sense of purpose in this world.

(Heterosexual Transwoman, Bottom, Untested, Cebu)

“paano ka mabubuhay? o paano?... ang buhay mo after knowing na positive ka?... yung iisipin mo sa sarili mo na paano ka na kaya, di ba? parang yun talaga yung pinak-major na ano... yung para sa iba, na maaring iniisip nilang mayroon sila, anong klaseng pagtanggap? pagtanggap sa sarili nila, pagtanggap ng mga mahal

nila, at... pagtanggap ng tao. kasi yung takot, yung magiging pagtanggap after. at papaano ka? ikaw? physically? emotionally?... paano ka pa magsa-stand after knowing na nagkaganun ka na?" (Bisexual, Versatile, Untested, Batangas)

I: so you haven't been tested for HIV? you have thought about it recently?

P: i thought about it long before but I'm scared.

I: why are you scared?

P: because off course I had multiple sexual partners, and one of them might be positive already... i'm scared that I might be depressed because i'm HIV positive. i'm afraid to die. because once you are aware that you are positive, you will surely be depressed. you cannot avoid that.

(Gay, Bottom, Untested, Bacolod)

I: in case you are HIV positive, what will be your fears?

P: everything. i fear rejection.

I: who will reject you?

P: my family, my friends, and then my partner.

I: what are your other fears?

P: i fear that i will be misunderstood.

I: who will misunderstand you?

P: my friends. also, i am known at our place to be quiet and introverted. they might say, 'he is really quiet but deep down inside, he is doing something immoral.' also, i am afraid that others will know that I am doing such acts.

I: ...what are your other fears?

P: fear of death. if i will be HIV positive, there will be so many limits. but now i am still free.

(Gay, Versatile, HIV Negative, Mandaue)

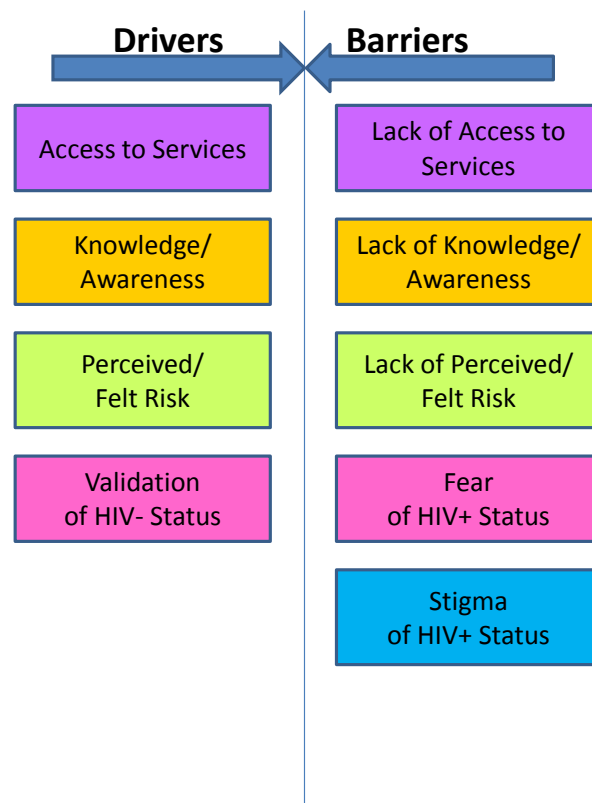
"i never went to city health again to get my result... because I was scared and nahihiya ako." (Gay, Versatile, HIV Negative, Cagayan de Oro)

"i felt shy... maybe they're thinking that I always have sex because I also go there frequently. this thought prevents me from going to the clinic." (Bisexual, Versatile, No Response, Davao)

"kasi, ma'am... baka mamaya i-test nila yung dugo ko tapos i-ano nila sa akin na positive ako. diyos ko, ma'am. ayoko, ma'am." (Gay, Bottom, Untested, Quezon City)

Force Field Analysis for HIV Testing

The force field analysis for HIV testing will show that the drivers and barriers are almost evenly matched. Access to services is a driver to testing while lack of access to services is a barrier to testing. Knowledge or awareness about HIV drives MSM to get tested while lack of knowledge or awareness bars MSM from getting tested. This knowledge or awareness creates perceived or felt risk of HIV that drives MSM to get tested. Parallel to this, lack of perceived or felt risk that bars MSM from getting tested. At the next level, personal beliefs and motivations are matched. To validate one's negative status is the motivation for testing while fear of knowing one's positive status is the motivation for not testing. A barrier to testing that is not matched is the stigma associated with HIV.



DISCUSSION

From the thematic map and force field analysis of the drivers and barriers to condom use and HIV testing, different models were created to provide program directions in promoting condom use and HIV testing among males who have sex with males or the MSM community.

A set of models on how to frame condom use as the primary HIV prevention strategy among MSM was developed. First is a perceived risk model that explains the general decision-making process regarding condom use among MSM. Second is a model of the levels of knowledge or awareness that describes the three types of information that can promote condom use among MSM. Third is a profile of three types of non-condom users among MSM that can be targeted in HIV prevention programs. Other unique factors relevant to condom use among MSM and possible strategies to address these factors in intervention programs are also discussed.

A set of models on how to frame HIV testing as the primary link to HIV care and treatment among MSM was also created. First is a perceived risk model similar to condom use that explains the decision-making towards getting tested for HIV among MSM. Second is a model of the three key barriers to HIV testing among MSM. Third is a profile of the three types of untested MSM that can be targeted by HIV testing programs.

Recommendations for Condom Use

Model 1. Perceived Risk Model



In this perceived risk model, knowledge or awareness (cognition) about HIV is what creates perceived risk of HIV infection (evaluation) among MSM which in turn leads to the decision to use a condom and deliberately planning to use a condom (decision) and eventual condom use (behavior). It is this awareness → perceived risk → deliberate planning → condom use model that explains rational decision-making among MSM. The mirror side of this model is that lack of awareness leads

to lack of perceived risk which in turn leads to lack of deliberate planning and consequently non-condom use or risk-taking.

Linking this model to programs, the recommended strategy is to focus on creating perceived risk among MSM. **Build** knowledge/awareness. **Develop** perceived risk. **Encourage** deliberate planning. **Promote** condom use. The starting point of a program that aims to develop perceived risk is building the knowledge base or awareness surrounding HIV among MSM. This leads us to the next model on the levels of knowledge or awareness.

Model 2. Levels of Knowledge/Awareness Model

Conceptual knowledge of HIV

- Make HIV understandable

Social awareness of the reality of HIV

- Make HIV real

Personal awareness of people living with HIV

- Make HIV personal

The model of levels of knowledge or awareness highlights three types of information that can create perceived risk of HIV infection among MSM. The first level is conceptual knowledge of HIV or the medical and scientific information about HIV. The second level is social awareness about the reality of HIV or the prevalence of HIV in the country and in one's community and the realness of HIV through seeing, hearing, and knowing Filipino people living with HIV and Filipino MSM living with HIV. The third level is personal awareness of people living with HIV in one's personal social network or MSM community.

Given this model of the levels of knowledge or awareness that creates perceived risk among MSM, programs can ensure that all three types of information are made available and accessible to MSM. The recommended strategy then is to: **make HIV understandable** at the level of conceptual knowledge; **make HIV real** at the level of social awareness; and, **make HIV personal** at the level of personal awareness. Making HIV real is to send the message that "HIV is happening" and "HIV is happening here". This can be done by showing the number of people with HIV, the faces of the people living with HIV, and through the advocacy of PLHIV organizations and communities. Making HIV personal is to send the message that "HIV can happen to you" and that "HIV can happen to you and your partner".

Model 3. Profile of Non-Condom Users

Lack awareness about HIV

- Group 1 lack awareness about HIV and therefore do not perceive that they are at risk of HIV infection (no risk)
- **THE UNAWARE GROUP** (driven by lack of awareness = lack of perceived risk)

Perceives risk but believes that "clean" means "safe"

- Group 2 are aware of HIV and perceive that they are at risk of HIV infection but believe in perceptions/judgments that "clean" (*malinis*) means "safe" (no risk)
- **THE MISPERCEIVING GROUP** (driven by misperceptions)

Perceives risk but chooses pleasure

- Group 3 are aware of HIV and perceive that they are at risk of HIV infection but choose to not use condoms for pleasure or other personal motivations
- **THE RISK-TAKING GROUP** (driven by pleasure)

The profile of non-condom users among MSM identifies three groups that can be targeted for HIV intervention program. The first group is the **unaware** group. Linked to the perceived risk model, this group lack knowledge or awareness about HIV. Hence, they do not perceive themselves as at risk of HIV infection. They do not use condoms out of lack of perceived risk of HIV infection that is based on lack of knowledge or awareness about HIV. The second group is the **misperceiving** group. Beyond the perceived risk model, this group are aware of HIV and perceive that they are at risk of HIV infection but believe that a person who is "clean" or *malinis* is "safe" or poses no risk of HIV. This group believes that they do not need to use condoms with sex partners who are perceived to be "clean" or "safe" or *malinis*. The third group is the **risk-taking** group. This group are aware of HIV and perceive themselves to be at risk of HIV infection but choose to not use condoms for pleasure or other personal motivations. Hence, this group of MSM are choosing to take the risk of HIV infection in pursuit of pleasure.

To target these three groups, the recommended strategy is to: **increase awareness** for the unaware group; **correct misperceptions** for the misperceiving group; and **recognize pleasure** for the risk-taking group. The second group highlights the need to address social, cultural, or community beliefs shared by MSM about perceptions of cleanliness and safety as linked to risk of HIV. Perceptions that a partner looks "clean" or seems "safe" (*mukhang malinis*) is equated with being free of risk of HIV infection. Examples of correcting these misperceptions is to create information campaigns to dispel these beliefs such as "*guwapo* ≠ clean/safe", "*mayaman* ≠ clean/safe", "*mabango* ≠ clean/safe", "*makinis* ≠ clean/safe", "*mukhang walang sakit*" ≠ clean/safe, "*kakilala* ≠ clean/safe", or "partner ≠ clean/safe". The third group shows how the motivation for pleasure can compete with the motivation for protection, safety, or health. Addressing this pleasure principle may require creating alternative scripts that can put pleasure alongside protection. For example, promoting a script to encourage sex that is both pleasurable and safe such as "S + S = satisfying and safe" or "S + S = sexy and safe" may be useful.

Other factors linked to non-condom use that can be addressed are the issue of love or intimacy, the spontaneity of sex or the “heat of the moment”, and unique situations such as sex work. One possibility is creating a script for couples or those in a romantic or committed relationship towards practicing safe sex, such as “safe sex for couples” or “love = safe”. Another possibility is to create a script for sex towards preparing to use a condom before reaching the “heat of the moment”, such as “think before sex”. A last possibility is to create a script for condom use as part of sex work, such as “safety at work”.

Recommendations for HIV Testing

Model 1. Perceived Risk Model



Similar to condom use, the perceived risk model for HIV testing follows the same path where knowledge or awareness (cognition) about HIV is what creates perceived risk of HIV infection (evaluation) among MSM which in turn leads to the decision to get tested for HIV (decision) and eventual HIV testing (behavior). It is this awareness → perceived risk → decision to get tested → HIV testing model that explains the rational decision or conscious choice to get tested among MSM. The mirror side of this model is that lack of awareness leads to lack of perceived risk which in turn leads to not making a conscious decision and not getting tested. Linking this model to programs, the recommended strategy is to focus on **creating perceived risk** among MSM towards the decision to get tested.

Model 2. Factors for Not Getting Tested Model

Fear of HIV

- Fears surrounding HIV
- "HIV as a death sentence"

Hiya (Stigma & Shame) of HIV

- Stigma and shame surrounding HIV
- "HIV as *nakakahiya*"

Lack of Information about HIV Testing

- Lack of information about HIV testing procedures
- What, where, when, how

The decision to not get tested among MSM has three key barriers that need to be addressed by HIV testing programs. The most significant barrier to HIV testing is fear. MSM do not get tested out of fear that they will be diagnosed as HIV-positive. Getting tested means facing the possible reality of being HIV-positive. With fears that becoming HIV-positive means losing one's present life, friends, partner, family, dreams, and future, MSM choose to not get tested. To get tested means to face the possibility of one's present life or how one knows it ending. Hence, "HIV is a death sentence". The key challenge then for program interventions is how to address these fears surrounding HIV and life with HIV. This may mean **developing an information campaign** on what life is like with HIV, that there is still meaning in life with HIV, and that there is access to care for people living with HIV. Messages of hope, of life, of living with HIV through the faces and the voices of PLHIV advocates, organizations and communities may be of help. The extra challenge is how to dispel the fears surrounding HIV that are real and how to address these fears through structural programs that can truly sustain the lives of people living with HIV, nurture their friends, partners, families, and communities, and re-build their dreams. The message is that there is access to care for people living with HIV.

The second barrier is the social stigma and the shame surrounding HIV. In the Filipino cultural context of *hiya* (shame), HIV is a source of *kahihiyan* or shame. To take the test means to face the stigma and the shame. The challenge then is to **create an environment of non-judgment and acceptance** in social hygiene clinics or HIV testing centers and to send the message that there is no shame in knowing one's HIV status by getting tested. An information campaign to address the culture of *hiya* and to address the stigma and shame surrounding HIV is a difficult challenge as it touches on cultural beliefs about the morality and immorality of sexual behaviors and sexual identities. Developing sensitivity among service providers and ensuring that there is sensitivity in HIV testing procedures and access to care becomes important. Sensitivity in handling messages about HIV and locating these messages in the unique contexts of the different groups of MSM (gay, bisexual, transgender, heterosexual) may also be relevant.

The third barrier is the lack of information about HIV testing procedures and how to access them. MSM may not get tested because they do not know where, when, and how to get tested. They may also be misinformed about where, when, and how to get tested. Perhaps the most straightforward and concrete of the three barriers, addressing this programmatically is to ensure that information

about HIV testing procedures are as specific and as widespread as possible. **Creating clear, accurate, and precise information** about HIV testing procedures and making this information as widely accessible as possible may be the key to encourage HIV testing. Making this information sensitive to the culture of *hiya* and responsive to the fears of MSM surrounding HIV may also help.

Model 3. Profile of Untested

Lack awareness about HIV

- Group 1 lack awareness about HIV and therefore do not perceive that they are at risk of HIV and need to get tested ("HIV testing is not necessary")
- **THE UNAWARE GROUP** (driven by lack of awareness, lack of perceived risk)

Perceives risk but is afraid of being diagnosed HIV-positive

- Group 2 has awareness about HIV and perceives they are at risk of HIV but are afraid of being diagnosed HIV-positive ("HIV is a death sentence")
- **THE AFRAID GROUP** (driven by fear)

Perceives risk but lack information about HIV testing

- Group 3 has awareness about HIV and perceives they are at risk of HIV but lack the information on what, where, when, and how to get tested
- **THE UNINFORMED GROUP** (driven by lack of information)

Finally, a profile of untested MSM shows three groups of MSM who can be targeted by HIV testing programs. The first group is the **unaware** group who do not perceive themselves to be at risk of HIV out of lack of knowledge or awareness about HIV. This group choose to not get tested because they do not think it is necessary. The program strategy for this group is to **provide knowledge** or awareness about HIV that can create perceived risk and the belief that HIV testing is necessary. The second group is the **afraid** group who know that they are at risk of HIV but are afraid to find out their HIV status. This group is driven by the many fears surrounding the possibility of finding out that one is HIV-positive. The program strategy for this group is to **address these fears** and dispel the belief that HIV is a death sentence. The challenge is to counter these fears by presenting an alternative reality of a good and meaningful life for people living with HIV and the availability and access to care for HIV-positive MSM. The third group is the **uninformed** group who simply lack the information on how to get tested. The program strategy for this group is to **provide the complete information** on where, when, and how to get tested and ensuring that this is as widely accessible as possible.

CONCLUSION, RECOMMENDATIONS, AND LIMITATIONS

With the expanding HIV epidemic in the Philippines that is influenced by risky behaviors among males who have sex with males, programs and services need to be more strategic and should specifically target the needs of the key population. Findings from this study show that factors such as access to services and information, and perceptions of risk have a large impact to condom use and HIV testing.

Drivers and barriers to condom use can be categorized into external factors, such as access to information, resources, and services; and internal factors, such as personal motivations, relationships, and perceptions of risk. A way to understand condom use and non-use therefore is to consider the conglomeration of factors involved and how these factors may be of consequence in any given sexual encounter. The complexity of the web of factors involved in sex and the decision to protect one's self and one's sexual partner from the risk of HIV implies that programs and interventions need to acknowledge the limitations of a purely rational approach to individual decision-making that assumes that knowledge predicts behaviors.

Program improvement must go beyond a knowledge-based paradigm and acknowledge that personal motivations (e.g. for sexual pleasure, intimacy, or love) and personal beliefs (e.g. of who is clean or *malinis* and who is not clean or *hindi malinis*) also determine the decision to use a condom for HIV prevention. The challenge then is to identify interventions that would be most strategic in promoting condom use given this complex web of factors.

Similarly, external factors to HIV testing such as access to services and information about these services are important drivers to getting MSM tested, internal factors such as fears and perceptions of risk are also critical. Many MSM continue not seeing themselves at risk, believing their sexual practices remained safe. The stigma and shame surrounding HIV alongside the fear of testing HIV-positive are the key barriers to HIV testing that need to be addressed. Hence, multiple strategies are needed to respond to the need for information and the need for services on the one hand, and the need to address the social stigma and personal fears of MSM on the other.

Summary of Key Findings. External factors such as access to condoms and lubricants, information about condoms and lubricants, the influence of others, and situational factors play a key role in the decision of MSM to use or not use a condom in a given sexual encounter. What is critical, however, is that MSM need to be internally motivated to use condoms regularly or consistently in every sexual encounter. This internal motivation lies primarily in the fear or perception that one may be at risk of HIV infection. Perception of HIV risk begins with one's level of knowledge or awareness of HIV, from a conceptual or general knowledge of HIV, to social awareness that HIV is a reality, to personal awareness of people living with HIV. To motivate MSM to use condoms consistently, these layers of knowledge and awareness need to create perceived or felt risk of HIV infection. This internal motivation towards health, safety, and HIV prevention has to be strong enough to counter competing personal motivations such as the desire for sexual pleasure and the need for love or intimacy. This internal motivation also has to override the bodily experience of sex or being in the "heat of the moment" and personal and social beliefs that one can determine if a sexual partner is clean or *malinis*. Interestingly, personal motivations such as avoiding dirt (*dumi*) and personal beliefs about a sexual partner being unclean (*hindi malinis*) can also drive MSM to use condoms. What may be important is to acknowledge how personal beliefs, perceptions, needs, and motivations can alter perceptions of HIV risk and the necessity to use a condom.

As for HIV testing, access to services, the quality of these services, the availability and accessibility of information about these services, and the influence of others including service providers do shape

the decision of MSM to get tested. This implies that there is space to encourage MSM to get tested through ensuring that information about services and access to services are adequate and are readily available. Similar to condom use, social awareness that HIV is a reality creates a perception that one could be at risk of HIV. This perceived or felt risk motivates MSM to get tested. However, this perception of risk can be clouded by fear of testing positive. It is the fear of knowing that one is HIV-positive that is the primary barrier to HIV testing. Motivating MSM to get tested therefore requires addressing the fears surrounding HIV and the possibility that one may be HIV-positive. It requires giving MSM a picture of what life can be like living with HIV and the care available for people living with HIV. Another major barrier to HIV testing is the social stigma and shame surrounding HIV. As such, motivating MSM to get tested also means removing the stigma of being HIV-positive.

Recommendations for Future Research. Given the results of this qualitative study, future studies can look into the following:

- Validate the qualitative results by developing a survey questionnaire or integrating the qualitative results into the IHBSS by using the factors as items and using scales to measure degree of salience, importance, regularity, and consistency to quantify the data.
- Conduct data mining and further qualitative data analysis to reveal patterns in the results according to sexual orientation and gender identity (SOGI) following self-identification of participants as gay, bisexual, heterosexual, and transgender.
- Utilize interpretative frameworks that can study in-depth the rich data set of individual narratives and surface new insights from the data such as conversation analysis, narrative analysis, discourse analysis, and grounded theory.
- Conduct qualitative research on the dynamics of the factors to condom use and HIV testing and how the factors interplay during specific sexual encounters for specific sub-groups and sub-populations of MSM.
- Follow theoretical sampling given the results of the present study by sampling according to desired behaviors or outcomes (i.e. MSM who use condoms consistently or “always use condoms”; MSM who get tested regularly for HIV) and undesired behaviors or outcomes (i.e. MSM who do not use condoms consistently and MSM who “never use condoms”; and MSM who have never tested for HIV).

Scope and Limitations. This study is limited in scope to MSM with the demographic profile outlined in the results. The data analysis was confined to the parameters of the study given the limitations in time and resources. As such, only aggregate data analysis could be performed that captures the overall pattern for the entire sample. Data analysis to surface patterns in the results according to sexual orientation and gender identity (SOGI) could not be conducted given time and resource constraints. Comparison by geographical location was also not warranted given the qualitative research design and the inability to match participants across cities. Nonetheless, this qualitative study was able to generate the map of factors to condom use and HIV testing among Filipino males who have sex with males using a purposive sample of Filipino MSM across the 21 cities of the 2013 IHBSS.

ANNEXES

Annex A. Interview Guide

CONSENT FORM

Maraming salamat sa iyong pagpapaunlak na gawin itong interview. Ito ay bahagi ng isang research para sa Department of Health (DOH). Ang pananaliksik na ito ay tungkol sa usaping pangkalusugan partikular na tungkol sa HIV at AIDS. Ang pagsagot mo sa aming mga katanungan ay makatutulong sa ating pamahalaan upang makapagplano ng mas maayos na mga serbisyong pangkalusugan. Ang interview natin ay may anim na bahagi. May mga tanong tayo tungkol sa mga lugar na pinupuntahan ng mga lalaking nakikipag-sex sa lalaki o MSM, tungkol sa mga episode ng sex dito samga lugar na nabanggit, tungkol sa paggamit o hindi paggamit ng condom, tungkol sa usapin ng HIV, tungkol sa HIV test, at mga mungkahi para sa mga programa ng HIV.

Ang interview ay boluntaryo. Maaari kang hindi sumagot sa kahit na anong tanong o maaari mo ring itigil ang interview kahit anong oras. Kami ay humihingi ng pahintulot na i-record and interview para magamit ang datos sa pananaliksik. Aming titiyakin na ang iyong identidad ay hindi matutukoy at lahat ng iyong ibabahagi at sasabihin ay ituturing naming confidential. Ang mga miyembro lamang ng research team at ang DOH ang makakakita ng datos. Gagamitin lamang ito sa aming research na hindi malalaman kung sino ang nagkwento o nagsalita. Hindi rin gagamitin ito para hanapin ang mga nagkwento o nagsalita.

Aabutin tayo ng mga isang oras o isang oras at kalahati. Sa pagkakataong ito, mayroon ka bang katanungan? Maaaring pumirma ka na lamang sa consent form na ito upang patunayan na ikaw ay boluntaryong sumasali sa interview. Maraming salamat.

Thank you for agreeing to this interview. This is part of a research being conducted for the Department of Health (DOH). This is a study on the issue of health particularly on the issue of HIV and AIDS. Your participation in this study will help our government to better plan its health services. Our interview will have six parts. There will be questions about places frequented by men who have sex with men or MSM, about episodes of sex in these identified places, about the use or non-use of condoms, about the issue of HIV, about HIV testing, and suggestions about programs for HIV.

This interview is voluntary. You may refuse to answer any question or stop the interview at any time. We are asking your permission to record this interview for research purposes only. Your identity and everything you will share in the interview will be kept confidential. Only members of the research team and DOH NEC will see the data. The interview data will only be used for research purposes only without identifying the persons interviewed. The study will also not be used to look for the persons interviewed.

The interview will take around one to one and a half hour. At this time, do you want to ask anything about the interview? Kindly sign this consent form if you are voluntarily agreeing to participate in this study. Thank you.

Lagda/Signature

Alyas or Pseudonym

Petsa/Date

INTERVIEW GUIDE

A. CRUISING SITES	Goal: Ethnographic Description of Each Site																		
<p>1. Venues visited by the participant</p> <p><i>Magsimula tayo sa mga cruising sites na napuntahan mo na. Saan ka ba pumupunta para makahanap o maka-meet ng sex partner?</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td><i>Ibigay ang buong pangalan ng lugar. (Identify the name of cruising site.)</i></td> </tr> <tr> <td>Streets?</td> <td></td> </tr> <tr> <td>Parks?</td> <td></td> </tr> <tr> <td>Gay bars?</td> <td></td> </tr> <tr> <td>Clubs?</td> <td></td> </tr> <tr> <td>Massage parlors?</td> <td></td> </tr> <tr> <td>Spas?</td> <td></td> </tr> <tr> <td>Cellphone? Internet sites?</td> <td></td> </tr> <tr> <td>Iba pang lugar?</td> <td></td> </tr> </table> <ul style="list-style-type: none"> • <i>Sa mga nabanggit mong cruising site, saan ka madalas pumupunta para makahanap o maka-meet ng sex partner?</i> • <i>Alin ang una mong pinaka pinupuntahan? Alin ang pangalawa? (and so on)</i> 		<i>Ibigay ang buong pangalan ng lugar. (Identify the name of cruising site.)</i>	Streets?		Parks?		Gay bars?		Clubs?		Massage parlors?		Spas?		Cellphone? Internet sites?		Iba pang lugar?		<p>Capture all the cruising sites and venues the participant has visited</p> <p>Identify the venues where participant has visited (ask for the exact name of the cruising site and its exact location)</p> <p>Capture the venues where participant most frequents</p>
	<i>Ibigay ang buong pangalan ng lugar. (Identify the name of cruising site.)</i>																		
Streets?																			
Parks?																			
Gay bars?																			
Clubs?																			
Massage parlors?																			
Spas?																			
Cellphone? Internet sites?																			
Iba pang lugar?																			
<p>2. Types of MSM and nature of activities in the venues</p> <p><i>Magsimula tayo sa pinakamadalas mong puntahan.</i></p> <ul style="list-style-type: none"> • <i>Sino ang kadalasang pumupunta dito sa (cruising site)?</i> • <i>Ano ang kadalasang ginagawa ng mga tao dito sa (cruising site)?</i> • <i>Ano ang “feeling” kapag nandito ka sa (cruising site)?</i> <p>REPEAT LINE OF QUESTIONING ABOVE FOR ALL OTHER CRUISING SITES VISITED</p>	<p>Capture (a) the types of MSM who frequent the venue, (b) the motivations of MSM for frequenting the venue, and (c) the general atmosphere of the venue.</p>																		
<p>3. Differences and similarities across venues</p> <ul style="list-style-type: none"> • <i>Anong pagkakaiba ng mga nakwento mong (cruising site)?</i> • <i>Anong pagkakapareho ng mga nakwento mong (cruising site)?</i> 	<p>Probe to capture differences and similarities across venues.</p>																		
B. SEXUAL ENCOUNTERS	Goal: Sexual Scripts for Paid Sex and Unpaid Sex																		
<p>1. Sexual encounter in specific venues: Negotiation for Sex</p> <p><i>Punta naman tayo sa sex na nagsisimula dito sa (cruising site) na pinakamadalas mong puntahan.</i></p> <ul style="list-style-type: none"> • <i>Ikuwento mo naman kung ano ang nangyari sa pinakahuling beses na may naka-sex ka mula dito sa (cruising site)?</i> • <i>Ikuwento mo nga kung paano nagsimula ang sex dito sa (cruising site)?</i> • <i>Lumipat ba kayo ng lugar para mag-sex? Kung oo, saan?</i> <p>REPEAT LINE OF QUESTIONING FOR SEXUAL ENCOUNTERS IN OTHER VENUES</p>	<p>Capture the sexual script or the sexual negotiation/talk between the participant and the sex partner for the last sexual episode in the cruising site the participant most frequents.</p>																		
<p>2. Sexual encounter in specific venues: Interaction right before Sex</p> <ul style="list-style-type: none"> • <i>Anong sinabi niya o sinabi mo bago kayo mag-sex?</i> • <i>Anong ginawa niya o ginawa mo?</i> <p>REPEAT LINE OF QUESTIONING FOR SEXUAL ENCOUNTERS IN OTHER VENUES</p>	<p>The sexual script has to be a complete account of a sexual episode in terms of what each person was saying, doing, not saying (non-verbal), from the</p>																		

<p>3. <u>Sexual encounter in specific venues: Interaction right after Sex</u></p> <ul style="list-style-type: none"> • <i>Anong sinabi niya o sinabi mo pagkatapos niyo mag-sex?</i> • <i>Anong ginawa niya o ginawa mo?</i> <p>REPEAT LINE OF QUESTIONING FOR SEXUAL ENCOUNTERS IN OTHER VENUES</p>	<p>beginning of the sexual encounter until the end.</p>
<p>C. CONDOM USE NEGOTIATION</p>	
<p>IF CONDOM USE WAS MENTIONED IN THE SEXUAL SCRIPT FOR PAID SEX OR UNPAID SEX, PROBE ON “HOW” AND “WHY” A CONDOM WAS USED (C1). THEN, ASK FOR NARRATION OF A SEXUAL EPISODE WITHOUT USING CONDOM (C2). IF CONDOM USE WAS NOT MENTIONED IN THE SEXUAL SCRIPT FOR PAID SEX OR UNPAID SEX, PROBE ON “HOW” AND “WHY” A CONDOM WAS NOT USED (C2). THEN, ASK FOR NARRATION OF A SEXUAL EPISODE WITH CONDOM USE (C1).</p>	
<p>1. <u>Used condom last sex or any sexual episode</u></p> <p><i>Pag-usapan naman natin ang paggamit mo ng condom habang nakikipag-sex.</i></p> <ul style="list-style-type: none"> • <i>Ikwento mo nga yung huling beses (o isang beses) na gumamit kayo ng condom. Paano nangyari na gumamit kayo ng condom?</i> • <i>Saan nanggaling ang condom?</i> • <i>Sino ang nagdala ng condom, siya ba o ikaw?</i> • <i>Paano nyo napag-usapan na mag-condom? Sino ang nagsabi na gumamit ng condom?</i> • <i>Anong naisip at naramdaman mo sa paggamit ng condom?</i> • <i>Ano kaya ang naisip at naramdaman niya (sex partner) sa paggamit ng condom?</i> • <i>Palagi ka bang gumagamit ng condom tuwing nakikipag-sex? Bakit oo? Bakit hindi?</i> <p>REPEAT LINE OF QUESTIONING TO CAPTURE CONDOM USE FOR PAID SEX OR UNPAID SEX IN OTHER VENUES.</p>	<p>Capture “how” a condom was used in a sexual encounter – the how can be the events that happened in the particular moment, situational factors, a narration of condom use negotiation or decision-making, etc.</p> <p>Capture “why” a condom was used in a sexual encounter – the why can be reasons for using a condom, the thoughts about using a condom, the feelings about using a condom, etc.</p>
<p>2. <u>Did not use condom last sex or any sexual episode</u></p> <p><i>Pag-usapan naman natin ang <u>HINDI</u> mo paggamit ng condom habang nakikipag-sex.</i></p> <ul style="list-style-type: none"> • <i>Ikwento mo nga yung huling beses (o isang beses) na <u>HINDI</u> kayo gumamit ng condom. Paano nangyari na <u>HINDI</u> kayo gumamit ng condom?</i> • <i>Sino ang nagsabi na <u>HINDI</u> gumamit ng condom?</i> • <i>Anong naisip at naramdaman mo sa <u>HINDI</u> paggamit ng condom?</i> • <i>Ano kaya ang naisip at naramdaman niya (sex partner) sa <u>HINDI</u> paggamit ng condom?</i> • <i>Palagi ka bang <u>HINDI</u> gumagamit ng condom tuwing nakikipag-sex? Bakit oo? Bakit hindi?</i> <p>REPEAT LINE OF QUESTIONING TO CAPTURE NON-USE OF CONDOM FOR PAID SEX OR UNPAID SEX IN OTHER VENUES.</p>	
<p>3. <u>Reflection questions about condom use and non-use</u></p> <p><i>Kung minsan gumagamit tayo ng condom at kuminsan hindi.</i></p> <ul style="list-style-type: none"> • <i>Sa anong mga panahon nagiging importante para sa iyo ang paggamit ng condom?</i> • <i>Sa anong mga panahon ba pinagdedesisyunan ang paggamit ng condom?</i> • <i>Sa mga pagkakataong hindi ka gumamit ng condom, ano kaya ang magpapabago sa pangyayari at sa desisyong huwag gumamit ng condom?</i> 	<p>Probe on (a) the importance and non-importance of using a condom, (b) decision-making or lack of decision-making in using a condom, and (c) factors that may lead to condom use</p>

<ul style="list-style-type: none"> • Sa iyong pananaw, paano nakaapekto ang lugar na iyong pinupuntahan sa paggamit o <u>HINDI</u> paggamit ng condom? • Base sa iyong karanasan, paano kaya mahihikayat ang mga MSM dito sa (<u>cruising site</u>) na palaging gumamit ng condom? 	<p>Capture variations in condom use across venues</p>
<p>4. <u>Access to condom</u></p> <p><i>Punta naman tayo ngayon sa pagkuha o pagbili ng condom.</i></p> <ul style="list-style-type: none"> • Ikaw ba ay regular na kumukuha o bumibili ng condom? • Kung oo at ikaw ay regular na kumukuha o bumibili ng condom, <ul style="list-style-type: none"> ○ Saan mo kadalasan kinukuha o binibili ang condom? ○ Anong nararamdaman mo sa pagkuha o pagbili ng condom sa (<u>specify where</u>)? • Kung hindi ka kumukuha o bumibili ng condom, <ul style="list-style-type: none"> ○ Ano ang naisip mo kung bakit hindi ka bumibili ng condom? ○ Ano sa palagay mo ang magpapahikayat sa iyo na kumuha o bumili ng condom? ○ Ano sa palagay mo ang magpapahikayat sa iyo na regular na kumuha o bumili ng condom? 	<p>Capture how the participant feels when getting or buying condoms, and where the participant usually gets condom.</p> <p>If participant does not get or buy condoms, capture what factors affect this.</p>
<p>5. <u>Learning how to use a condom</u></p> <ul style="list-style-type: none"> • Masasabi mo ba na marunong kang gumamit ng condom? • Paano ka natutong gumamit ng condom? • Paano ka natutong gumamit ng condom sa paraan na masarap pa rin ang sex? • Sa tingin mo ba, maaaring ituro kung paano gumamit ng condom? • Marunong ka rin ba kung paano gumamit ng lube o pampadulas? • Sa tingin mo ba, maaaring ituro kung paano gumamit ng lube o pampadulas? 	<p>Capture how the participant learned (or <u>NOT</u> learned) about how to use a condom, how to use a condom with pleasure, and how to use a condom with a lubricant</p>
<p>D. HIV STATUS DISCLOSURE</p>	<p>Goal: Motivations for HIV Status Disclosure and Non-Disclosure</p>
<p>IF HIV STATUS WAS TALKED ABOUT IN THE SEXUAL SCRIPT FOR PAID SEX OR UNPAID SEX, PROBE ON “HOW” AND “WHY” HIV STATUS WAS TALKED ABOUT (D1). THEN, ASK FOR NARRATION OF A SEXUAL EPISODE WHEN HIV STATUS WAS NOT TALKED ABOUT (D2).</p> <p>IF HIV STATUS WAS NOT TALKED ABOUT IN THE SEXUAL SCRIPT FOR PAID SEX OR UNPAID SEX, PROBE ON “HOW” AND “WHY” HIV STATUS WAS NOT TALKED ABOUT (D2). THEN, ASK FOR NARRATION OF A SEXUAL EPISODE WHEN HIV STATUS WAS TALKED ABOUT (D1).</p>	
<p>1. <u>HIV status disclosure to sex partner</u></p> <p><i>Punta naman tayo ngayon sa usapin ng HIV.</i></p> <ul style="list-style-type: none"> • May pagkakataon bang napag-usapan niyo ang tungkol sa HIV status? • Ikwento mo nga kung paano nyo napag-usapan ang tungkol sa HIV status. Sinabi o tinanong mo ba? Sinabi o tinanong ba niya (sex partner)? • Anong naisip at naramdaman mo sa pag-uusap nyo tungkol sa inyong HIV status? • Ano kaya ang naisip at naramdaman niya (sex partner) sa pag-uusap nyo tungkol sa HIV status? • Sinabi mo ba ang totoo mong HIV status? • Halimbawa ay HIV+ ka, sasabihin mo ba sa partner mo? 	<p>Capture “how” HIV status was talked about in a sexual encounter – the how can be the events that happened in the particular moment, situational factors, a narration of HIV status disclosure or non-disclosure, etc.</p> <p>Capture “why” HIV status was talked about in a sexual encounter – the why can be</p>

<ul style="list-style-type: none"> • Halimbawa ay HIV+ ang ka-partner mo, makikipag-sex ka pa ba sa kanya? • Anong maisip at mararamdaman mo kung HIV+ ang ka-partner mo? 	<p>reasons for talking about HIV status, the thoughts about talking about HIV status, the feelings of talking about HIV status, etc.</p>
<p>2. HIV status non-disclosure to sex partner</p> <ul style="list-style-type: none"> • May pagkakataon bang <u>HINDI</u> niyo napag-usapan ang tungkol sa HIV status? • Ikwento mo nga kung paano nyo <u>HINDI</u> napag-usapan ang tungkol sa HIV status. Paano nangyari na <u>HINDI</u> nyo napag-usapan ang HIV status nyo? • Anong naisip at naramdaman mo noong <u>HINDI</u> nyo napag-usapan ang HIV status ng isa't isa? • Ano kaya ang naisip at naramdaman niya (sex partner) noong <u>HINDI</u> nyo napag-usapan ang HIV status ng isa't isa? 	
<p>3. Reflection questions about HIV status disclosure and non-disclosure</p> <p><i>Kung minsan napag-uusapan natin ang HIV status at kuminsan hindi.</i></p> <ul style="list-style-type: none"> • Sa anong mga panahon nagiging importante para sa iyo na pag-usapan ang HIV status ng isa't isa bago mag-sex? • Sa anong mga panahon ba pinagdedesisyunan pag-usapan ang HIV status ng isa't isa bago mag-sex? • Sa mga pagkakataong hindi nyo pinag-usapan ang HIV status ng isa't isa, ano kaya ang magpapabago sa pangyayari at sa desisyong hindi pag-usapan ang HIV status ng isa't isa? 	<p>Probe on (a) the importance and non-importance of HIV status disclosure, (b) decision-making or lack of decision-making in HIV status disclosure, and (c) factors that may lead to HIV status disclosure</p>
<p>E. HIV TESTING</p>	<p>Goal: Motivations for HIV Testing or Non-Testing</p>
<p>1. Tested for HIV</p> <p><i>Pag-usapan naman natin ang pagpapa-HIV test.</i></p> <ul style="list-style-type: none"> • Nagpa-HIV test ka na ba? <p>IF PARTICIPANT HAS TESTED FOR HIV</p> <ul style="list-style-type: none"> • Ikwento mo nga kung ano ang experience mo ng HIV testing? • Paano nangyari na nagpa-HIV test ka? • Anong naisip at naramdaman mo bago ka nagpa-HIV test? • May nagbigay ba ng counseling bago ka nag-HIV test? Anong naisip at naramdaman mo pagkatapos ng counseling? • Base sa iyong karanasan, paano kaya mahihikayat ang mga MSM dito sa <u>(cruising site)</u> na magpa-HIV test? <p>IF PARTICIPANT HAS <u>NOT</u> TESTED FOR HIV</p> <ul style="list-style-type: none"> • Napag-isipan mo na bang magpa-HIV test? • Anong naisip at nararamdaman mo tungkol sa pagpapa-test? • Ano ang maghikayat sa iyo na magpa-HIV test? 	<p>Capture the reasons for HIV testing and non-testing</p>
<p>2. Got results from previous HIV test</p> <p>IF PARTICIPANT HAS TESTED FOR HIV AND GOT RESULT</p> <ul style="list-style-type: none"> • Alam mo na ba ang resulta ng iyong HIV test? • Anong naisip at naramdaman mo nang malaman ang resulta ng HIV test? • May nagbigay ba ng counseling pagkakuha mo ng resulta? Anong naisip at naramdaman mo pagkatapos ng counseling? • Base sa iyong karanasan, paano kaya mahihikayat ang mga MSM dito sa <u>(cruising site)</u> na kumuha ng resulta ng HIV test? <p>IF PARTICIPANT HAS TESTED FOR HIV AND DID <u>NOT</u> GET RESULT</p>	<p>Capture the reasons for getting or not getting the results from previous HIV test, how important it is for the participant</p>

<ul style="list-style-type: none"> • Anong nangyari at hindi mo nakuha ang resulta ng iyong HIV test? • Anong naisip at naramdaman mo tungkol sa iyong HIV test? • Ano ang magpapahikayat sa iyo para makuha mo ang resulta ng HIV test? 	
F. ACCESS TO HIV PROGRAMS AND SERVICES	Goal: Recommendations for HIV Programs
<p><i>Bilang pagtatapos, pag-usapan naman natin ang mga programa tungkol sa HIV.</i></p> <ul style="list-style-type: none"> • Ikaw ba ay kumukuha ng mga serbisyong may kinalaman sa STI o HIV? Anu-ano ang mga ito at saan mo madalas kinukuha? • Anu-ano ang mga alam mong programa dito sa (<i>cruising site</i>) para ma-prevent ang STI o HIV? Ano ang masasabi mo tungkol dito? • May napuntahan ka na bang Social Hygiene Clinic? Paano mo ito nalaman? Ano ang masasabi mo tungkol sa serbisyo sa Social Hygiene Clinic? • May mga mungkahi ka ba para maging mas epektibo ang HIV programs partikular dito sa (<i>cruising site</i>)? • May mga mungkahi ka ba para maging mas epektibo ang HIV programs sa bansa? 	<p>Capture experience of accessing the Social Hygiene Clinic and general recommendations for HIV programs</p>
<p style="text-align: center;">DEBRIEFING AND CLOSING THE INTERVIEW</p> <p><i>Dito nagtatapos ang ating interview. Malalim ang ating naging panayam. At nagpapasalamat kami sa iyong malayang pagsasalaysay. Asahan mo na malaki ang iyong naitulong sa aming research at gagamitin namin sa maayos na paraan ang iyong mga naibahagi. Muli, lahat ng iyong naibahagi ay mananatiling confidential at para lamang sa aming research. Makakatulong rin ito sa mga programa ukol sa HIV. Kung may gusto kang balikan o tanungin sa amin, maaari mo kaming ikontak sa _____. Kung magkaroon ka man ng alinlangan o nais kang kausapin na may kinalaman dito sa interview, maaari mo akong kontakin.</i></p> <p><i>May mga tanong ka ba sa ngayon? May mga gusto ka bang linawin?</i></p> <p><i>Maraming, maraming salamat.</i></p>	
END	

Annex B. Initial/Quick Analysis

QUICK ANALYSIS

File Name: City Site Interviewer#

Quick Information Sheet

Age: _____

Educational Attainment:

- Finished High School College Student Finished College

My sexual orientation/identity is:

- Heterosexual Bisexual Gay Other: _____

My gender identity is:

- Male Female/Transgender Other: _____

In general, the sexual orientation of my sex partner is:

- Heterosexual Bisexual Gay Other: _____

In general, the gender identity of my sex partner is:

- Male Female/Transgender Other: _____

In the past 3 to 6 months, how many sexual partners did you have? _____

During sexual intercourse, I predominantly identify as a

- Top (anal inserter) Bottom (anal receiver) Versatile (anal versatile)

Do you feel at risk of getting HIV?

- Yes No

In the past 12 months, have you sold sex or accepted cash in exchange for sex?

- Yes No

In the past 12 months, have you paid clients or bought sex from sex workers?

- Yes No

In the past 12 months, have you engaged in anal sex?

- Yes No

During your last anal sex, did you use a condom?

- Yes No

In the past 3 to 6 months, have you availed of HIV testing services?

- Yes No

Have you tested for HIV?

- Yes No

My sero-status is:

- HIV negative
 HIV positive
 Untested
 Refuse to disclose

Initial Analysis

List of Cruising Sites (Venues for Finding Sex Partners or Negotiating for Sex)

Paid Sex	Unpaid Sex
<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location 	<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location

List of Venues for Sex

Paid Sex	Unpaid Sex
<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location 	<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location

Highlight specific context or background of the participant

- Personal characteristics/background
- Personal characteristics/background

CONDOM USE

Drivers/Facilitators	Barriers/Hindrances
<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme 	<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme

HIV DISCUSSION

Drivers/Facilitators	Barriers/Hindrances
<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme 	<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme

HIV TESTING

Drivers/Facilitators	Barriers/Hindrances
<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme 	<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme

• [KEY WORD] Description of initial theme	• [KEY WORD] Description of initial theme
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SAFE SEX PRACTICES

Drivers/Facilitators	Barriers/Hindrances
<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme 	<ul style="list-style-type: none"> • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme • [KEY WORD] Description of initial theme

Personal Insights/Reflections/Observations.

What struck you while you were doing the interview (thoughts and feelings)? Based on your experience, what part of the interview is easy or difficult to manage? What are the relevant characteristics (including non-verbal, gender expression etc.) of the participant while doing the interview?

Annex C. Complete/Slow Analysis

SLOW ANALYSIS

File Name: City Site Interviewer#

Quick Information Sheet

**you can clarify in the end section relevant personal characteristics and social context of the participant that need further explanation*

Age: _____

Educational attainment:

- No formal education Elementary level Finished Elementary
 High School Level Finished High School College Level
 Finished College Other: _____

Job/Occupation: _____

Estimated monthly income: _____

Estimated socio-economic class:

- Low-Income Middle-Income Upper-Income

My sexual orientation/identity* is:

- Heterosexual Bisexual Gay Other: _____

My gender identity* is:

- Male Female/Transgender Other: _____

In general, the sexual orientation/identity of my sex (partner)* is:

- Heterosexual Bisexual Gay Other: _____

In general, the gender identity of my sex (partner)* is:

- Male Female/Transgender Other: _____

In the past 3 to 6 months, how many sexual partners did you have? _____

During sexual intercourse, I predominantly identify as:

- Top (anal inserter) Bottom (anal receiver) Versatile (anal versatile)
 Oral receiver only Oral giver only Oral receiver & giver only

Do you feel at risk of getting HIV?

- Yes No

In the past 12 months, have you sold sex or accepted cash in exchange for sex?

- Yes No

In the past 12 months, have you paid clients or bought sex from sex workers?

Yes No

In the past 12 months, have you engaged in anal sex?

Yes No

During your last anal sex, did you use a condom?

Yes No

In the past 3 to 6 months, have you availed of HIV testing services?

Yes No

Have you tested for HIV?

Yes No

My sero-status is:

HIV negative HIV positive Untested Refuse to disclose

If HIV-positive, do you disclose your HIV status when you have sex?

Always Most of the time Sometimes Rarely Never
(100%) (75%) (50%) (25%) (0%)

Do you use a condom when you have anal sex?

Always Most of the time Sometimes Rarely Never
(100%) (75%) (50%) (25%) (0%)

Do you talk about HIV status when you have sex?

Always Most of the time Sometimes Rarely Never
(100%) (75%) (50%) (25%) (0%)

Highlight specific social context or personal background of the participant

- Personal characteristics/background
- Personal characteristics/background
- Social situation/context
- Social situation/context

Complete Analysis

A. CRUISING SITES

A.1. List of Cruising Sites (Venues for Finding Sex Partners or Negotiating for Sex)

Paid Sex	Unpaid Sex
<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location 	<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location

A.2. List of Venues for Sex

Paid Sex	Unpaid Sex
<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location 	<ul style="list-style-type: none"> • Name of site, type, location • Name of site, type, location

A.3. Description of Cruising Sites

Cruising Site	Description (Type of MSM, Activities, "Feeling")

B. SEXUAL ENCOUNTERS

B.1. Sexual Script

Question	Answer
Sex Talk/Negotiation <i>(I say, he say)</i> Beginning: Middle: End:	
Condom Use? <i>(note if part of script or not)</i>	
HIV Talk? <i>(note if part of script or not)</i>	

C. CONDOM USE NEGOTIATION

C.1. Drivers/Facilitators to Condom Use

(complete QA)

Key Word/Theme	Description	Direct quote

C.2. Barriers/Hindrances to Condom Use

(complete QA)

Key Word/Theme	Description	Direct quote

C.3. Condom Use Script (Negotiation)

Question	Answer
Who brings a condom?	
Talk/Negotiation (<i>I say, he say</i>)	
Thoughts/Feelings (<i>I think/feel, he thinks/feels</i>)	

C.4. Condom Non-Use Script (Negotiation)

Question	Answer
Is there a condom available?	
Talk/Negotiation (<i>I say, he say</i>)	
Thoughts/Feelings (<i>I think/feel, he thinks/feels</i>)	

C.5. Access to Condoms

Question	Answer
Where do you buy/get condoms?	
Thoughts/Feelings why you buy condoms (<i>I think/feel</i>)	
Thoughts/Feelings why you don't buy condoms (<i>I think/feel</i>)	

C.6. Learning How to Use a Condom

Question	Answer
Did you learn how to use a condom? How?	
Did you learn how to use a condom with pleasure? How?	

D. HIV DISCUSSION

D.1. Drivers/Facilitators to HIV Discussion

(complete QA)

Key Word/Theme	Description	Direct quote

D.2. Barriers/Hindrances to HIV Discussion

(complete QA)

Key Word/Theme	Description	Direct quote

D.3. HIV Status Disclosure (Discussion)

Question	Answer
Who brings up HIV status?	
Talk/Discussion <i>(I say, he say)</i>	
Thoughts/Feelings <i>(I think/feel, he thinks/feels)</i>	

D.4. HIV Status Non-Disclosure (Discussion)

Question	Answer
Thoughts/Feelings <i>(I think/feel, he thinks/feels)</i>	

E. HIV TESTING

E.1. Drivers/Facilitators to HIV Testing

(complete QA)

Key Word/Theme	Description	Direct quote

E.2. Barriers/Hindrances to HIV Testing

(complete QA)

Key Word/Theme	Description	Direct quote

E.3. Experience of HIV Testing

Question	Answer
How did you get tested for HIV?	
Thoughts/Feelings before HIV testing <i>(I think/feel)</i>	
Thoughts/Feelings after pre-test counseling <i>(I think/feel)</i>	
Thoughts/Feelings after getting results <i>(I think/feel)</i>	
Thoughts/Feelings after post-test counseling	

(I think/feel)	
----------------	--

E.4. Not Testing for HIV

Question	Answer
Thoughts/Feelings about not getting self tested for HIV (I think/feel)	

E.5. Not Getting Results of HIV Test

Question	Answer
Thoughts/Feelings about not getting results of HIV test (I think/feel)	

F. HIV PROGRAMS AND SERVICES

F.1. Drivers/Facilitators to Safe Sex Practices

(complete QA)

Key Word/Theme	Description	Direct quote

F.2. Barriers/Hindrances to Safe Sex Practices

(complete QA)

Key Word/Theme	Description	Direct quote

F.3. Comments and General Suggestions on HIV Programs

Question	Answer
HIV Programs you know	
Comments on HIV Programs	
Comments on Social Hygiene Clinic	
Suggestions for HIV Programs	

F.4. Specific Suggestions for HIV Programs in Cruising Site

(specific to identified cruising site from the IHBSS where participant was recruited)

Question	Answer
Suggestions to encourage condom use among MSM	
Suggestions to encourage HIV talk among MSM	
Suggestions to encourage HIV	

testing	
Suggestions to encourage getting results of HIV test	

Reflexivity

Personal Insights/Reflections/Observations.

- What struck you while you were doing the interview? How did you feel after the interview? What were your thoughts after the interview?
- What were the relevant characteristics (including non-verbal, gender expression, etc.) of the participant, of yourself, and of your interaction with the participant, that may have shaped the interview process?
- What are your insights or reflections on the results of the interview?
- Any other comment or observation.

Annex D. An Analysis from an Individual Perspective

Focusing on the Filipino MSM: How the Person Assesses the Factors to Condom Use and HIV Testing

By
Gideon Bendicion

At its essence, the study is asking two questions:

1. What affects the condom use behavior of Filipino MSM?
2. What affects the HIV testing behavior of Filipino MSM?

This study has confirmed that the availability of condoms, social influence, and partner influence can affect condom use behavior. These factors are clearly external to the person, yet somehow interact with the person's internal processes to shape behavior. What is the nature of this interaction—between external situation and a person's internal processes?

Situations do not exist independently of the perception of the individual engaged in them. Specifically, for the situation to have some impact on an individual's behavior, the individual must have some appreciation, awareness, or perception of the situation. As such, an individual's behavior is not a response to an objective "out there" situation, but to the individual's subjective perception and assessment of that situation.

The way the Filipino MSM perceives and assesses the situations of sexual encounter and HIV testing is through sets of concerns or considerations, the satisfying of which are important to him. The behavior that ensues is the behavior he perceives that would fulfill the most predominant of his concerns at a particular moment of time.

Thus, to answer the questions of this study, one must look at the concerns that shape the Filipino MSM's perception and assessment of the situations of sexual encounter and HIV testing. Only by understanding *the way he understands* can one hope to make effective interventions for increasing protective behaviors and accessing testing services and care.

Outline

The analysis will follow this format:

1. Condom use behavior
 - a. The concerns that affect condom use behavior
 - b. The interaction of these concerns
 - c. Recommendations for impacting these concerns
2. HIV testing behaviors
 - a. The concerns that affect HIV testing behaviors
 - b. The interaction of these concerns
 - c. Recommendations for impacting these concerns

Condom Use Behavior

Before the concerns that drive condom use can be examined, condom use must first be understood from the perspective of the Filipino MSM. For him, condom use during sex is but one among several possible sexual outcomes. That is, a Filipino MSM who is looking for sexual contact has three possible outcomes: not having sex, having sex but with certain conditions, and having sex without any conditions.

Regarding sex with conditions, there are two kinds of conditions in a Filipino MSM's mind. The first kind of condition is a limitation on the body parts involved in the sexual contact. An MSM can limit sexual contact to only his hands, only his mouth, only his penis, only his thighs, only his anus, or some combination of these. For example, a participant reported limiting contact to his hands when his partner's genitals had a smell. An MSM can also limit the body parts of the partner with which he is willing to come in contact. Some participants reported, for example, being unwilling to insert into the partner's anus because they perceived it to be dirty.

The second kind of condition in the Filipino MSM's mind is the condition of using a condom. This is a condition that prevents him from coming in contact with something with which he is unwilling to come in contact. For example, an MSM who was previously hesitant to insert into a dirty anus may acquiesce if a condom would keep his penis from touching the dirt. A sex worker whose client had a cough might proceed with sex only because a condom could, in his mind, serve as some measure of protection from the cough. However, this condition is useful only insofar as the condom is perceived to be a sufficient barrier. Many participants, for example, reported being unwilling to have protected sex with a person they know to have HIV.

To summarize, the possible outcomes for sexual contact are:

1. No sex
2. Sex with conditions
 - a. Body-part limitations
 - b. Sex with condoms
3. Sex without conditions

It is important to see condom use in the context of overall sexual behavior, as one of several outcomes. The ultimate behavioral outcome is a product of the negotiation (including non-verbal negotiations) among partners. However, each partner negotiates for the range of outcomes that satisfy his concerns, or at least do not exceed what can be tolerated for each concern.

The behavior that addresses the most predominant of the partners' concerns or does not exceed what can be tolerated by both partners' concerns is the outcome that will ensue. Now then, what are the concerns or considerations that are important to the Filipino MSM? What has him not have sex in one situation, limit sexual contact to certain body parts in another situation, use condoms in another situation, and not use condoms in another situation?

Concerns that Affect Sexual Behavior

The following are the concerns or considerations that are important to the Filipino MSM and shape his sexual behavior:

1. **Cleanliness**
2. **Health**
3. **Comfort and pain reduction**
4. **Sexual satisfaction or pleasure**
5. **Intimacy**
6. **Being seen in a positive light**
7. **Not offending**
8. **Return of investment of time or effort**
9. **Available time for sexual encounter**
10. **Expected cost or income**

Cleanliness. Before and during sex, the Filipino MSM considers: “Does he look clean?” “Does he smell clean?” “Does *it* look clean?” “Does *it* smell clean?”

For some MSM, cleanliness is itself what is attractive about the partner. For others, what is important is that the partner is not *too* dirty. Either way, a severe lack of perceived cleanliness can be a deal-breaker and can result in the outcome of not having sex. A moderate lack of perceived cleanliness can result in the outcome of having sex with considerations.

Health. While the degree of concern for one’s own health may vary from individual to individual, everyone has some degree of concern for his well-being. Integral to the evaluative process, therefore, are the questions: “Does this person look okay?” “Will I put my health at risk by engaging in sex with this person?” “What types of sexual activities with this person will be okay?” “What types of sexual activities with this person will be risky?” “What types of sexual activities with this person will be *too* risky?”

It is important to note, however, that the concern for protecting one’s health can be satisfied even when the behavior engaged does not protect one’s health. The satisfaction of the concern for protecting one’s health is contingent upon the individual’s *perception* of what is risky, rather than what is *actually* risky. This is why even though most participants reported that using condoms is a way of avoiding STDs, many of those same participants also reported not consistently using condoms.

Part of the problem in the Filipino context is the very understanding of the meaning of “disease” or “illness.” The Filipino word for illness is “sakit” (pain) or “karamdaman” (something felt). Thus, the pre-existing model or understanding of illness is pain or symptom-based. That is, an illness exists when there is a symptom. When there is no symptom, there is no illness. This understanding is particularly true for the less educated population, which is the majority.

Participants have reported observing their sex partners for signs of illness. When no symptoms are observed, however, the partner is perceived to pose no risk to one’s health, thereby satisfying the concern for protecting one’s health. Thus, the Filipino MSM ceases thinking about using a condom to protect himself from illness; as far as he is concerned, there is no illness to begin with from which he needs to protect himself.

Similarly, participants reported insisting on condom use when the partner had a cold or cough. From a medical perspective, the condom is useless in protecting from a cough. Nonetheless, this shows that protecting his health is important to the Filipino MSM, even though the way he may go about it can be misguided.

Comfort and Pain Reduction. The Filipino MSM takes into consideration his level of comfort and tolerance for pain. While the acceptable level of comfort and tolerance for pain varies from individual to individual, each MSM does consider the amount of pain involved in any sexual activity, including condom use and non-use.

Some participants find anal sex uncomfortable, with or without condoms; as such, they do not engage in it. Other participants find anal sex without condoms tolerable, and anal sex with condoms too painful; as such, they will only engage in anal sex without condoms. Other participants find anal sex with condoms bearable; as such, they do not mind the use of condoms. Other participants find anal sex with condoms comfortable; as such, they prefer the use of condoms.

Sexual Satisfaction or Pleasure. Naturally, the Filipino MSM takes into consideration his and his partner’s sexual satisfaction and pleasure. The consideration for pleasure affects choice of sexual partner (penis size, capacity of anal orifice, height, other physical characteristics, sexual role). The consideration of sexual satisfaction also affects whether condoms will be used. If the MSM perceives that condom use reduces pleasure for him or his partner, condoms are less likely to be used.

Intimacy. Whether a Filipino MSM wants to feel intimate with a particular partner affects condom use. Since condoms are seen as protection, condoms are for people from whom one needs to be protected. Thus,

participants reported using condoms only for strangers, people who looked sick, or people they knew were “sluts.” But in their mind, “why would I need to protect myself from my romantic partner or crush?” This is why condoms are less likely used for romantic partners. Moreover, this lack of barrier creates the experience of being open and connected with each other, thereby reinforcing the sense of intimacy.

Being Seen in a Positive Light. The desire to be seen in a positive light is probably fundamental to human nature. People don’t want to look bad; they want to look good. People tend to resist being seen or labeled negatively, and actively behave in a way that defends against being seen negatively. Equally important, people want to see themselves in a positive light. This desire to be seen in a positive light, however, is amplified in the Filipino context, because of the cultural value *hiya* (shame). Filipinos are often raised to be mindful of *hiya* as a driver and barrier for behavior.

The desire to be seen in a positive light affects sexual behavior in several ways. The first is in the choice of partner: people look for partners that value them positively; people avoid partners that see them negatively. People may even look for partners that have others see them in a positive light; people may avoid partners that have others look down on them. People also look for the partners that have them see themselves in a positive light; they avoid partners that have them see themselves negatively.

Secondly, the desire to be seen in a positive light affects the kinds of behaviors in which Filipino MSM are willing to engage. For example, in some circles, “bakla” connotes something negative. And since being an anal-receiver is associated with being “bakla”, some MSM refuse to be anal receivers, even though the act itself is not for them painful.

Thirdly, the desire to be seen in a positive light affects condom use. If his asking to use a condom is perceived by his partner negatively (e.g. as being “maarte” or persnickety), a Filipino MSM is less likely to use it, even if that went against his judgment about health risk. Even worse, he is less likely to bring up the topic of condom use in future sexual encounters.

Filipinos are raised to be adept at scanning the social environment for nonverbal cues for acceptable and unacceptable behavior. Thus, even when condom use is not discussed, the Filipino MSM already has a perception or assessment of his partner’s willingness to use condoms. Many participants reported not bringing up condom use, because they *perceived* their partners to be unwilling. As such, condom use is often latently, rather than verbally, negotiated through the demeanor of the sex partners.

Fourthly, *hiya* can hinder the behavior of purchasing condoms. Because condoms are associated with sex and sex is seen as taboo, MSM are afraid to buy condoms.

The desire to see oneself in a positive light may even affect the behavior of stocking up on condoms. One participant reported that stocking up on condoms would for him be tantamount to admitting that he liked sex too much. Since he did not want to see himself that way, he refused to stock up on condoms. The consequence, unfortunately, is that he would often have sex without condoms because he would not have any when his libido struck. Thus, the desire to see himself in a positive light drove his behavior of not using condoms, even though he would have preferred using condoms for health reasons.

Not Offending. The Filipino MSM is also careful about not offending his partner. Since condom use is a way of protecting against disease, strangers, and dirt, a partner can feel offended when asked to use a condom. Participants reported a fear of hearing from the partners, “Mukha ba akong may sakit?” (Do I look sick?) As such, the Filipino MSM is often hesitant to ask.

Return of Investment of Time or Effort. Sexual encounters do not happen in a vacuum: considerable time and effort can be spent accessing a cruising site, sending and interpreting signals, acquire familiarity with the partner (especially his sexual history, fetishes, and preferences), and negotiating the specifics of the sexual encounter (venue, date and time if not immediate, condom use, cost in case of sex work, etc.).

An MSM may also prepare physically for the encounter: shaving certain body parts, trimming hairs, showering, cleaning, using an enema, freshening the mouth without brushing the teeth, and so on.

Furthermore, there is a measure of effort in acquiring condoms and other sexual paraphernalia, whether long before the sexual encounter, or immediately prior to the sexual encounter. This includes the effort of physically going to a location where a condom can be acquired, the effort of dealing with the psycho-social judgments of acquiring a condom, the effort of concealing the condoms, and in the case of purchased condoms, the effort of coming up with the money to purchase the condom.

Prior to a sexual encounter, then, a considerable amount of time and effort was already expended to set up the encounter. The consideration of this time and effort affects an MSM's willingness to pre-terminate a sexual encounter (the outcome of no sex) and could limit his outcomes to sex without conditions and sex with conditions. With fewer acceptable outcomes, the chances are greater that he would acquiesce to sex without conditions if his partner demanded it.

Available Time for Sexual Encounter. When an MSM has little time for sex, he is likely to engage in only a quickie or only in oral sex. Unless he already has a condom prepared, he is unlikely to bother acquiring one, given the limited time available for the sexual encounter.

Expected Cost or Income. While this concern is likely applicable to the entire population, it seemed to be most salient among lower income participants and sex workers. The concern of the cost can affect the pool of available sexual partners, the choice of partner, the venue of the sexual encounter, the use of sexual paraphernalia, and the use of condoms.

MSM who could spare cash or were willing to spare cash are the ones who can select from sex workers or money boys. The participants who could not afford or were unwilling to spare cash are limited to the partners who would have sex for free, or to the partners who would pay *them* for sex.

Some MSM select partners based on the partner's ability to shoulder the costs of the sexual encounter (cost of the motel, transportation to location of encounter, cost of condoms, lubricants, other paraphernalia, etc.). Some participants select partners who could give them an allowance or feed them for a period of time.

Some MSM avoid certain cruising sites because of cost, or would only go to that cruising site because a partner would pay for it. Some MSM do not have sex in a venue wherein they would incur a cost. Some cannot afford to use accessories, such as sex toys and fetish paraphernalia.

Some MSM do not acquire condoms because they *think* it will cost them too much money; others do not use condoms because there are no free condoms in their particular area. Some participants reported using lesser quality condoms because of the cost of the better condoms; others do not mind the cost of good quality condoms.

For professional and casual sex workers, the amount they will earn from the sexual encounter can be the main consideration for what conditions—if any—they can impose on the sexual encounter.

Pregnancy. For the sake of thoroughness, this concern is mentioned here even though it only applies to a subset—those who have sex with both men and women. Some participants reported avoiding pregnancy as a driver for having sex with other men. Some participants also reported that the fact that men could not get pregnant was a reason using condoms was not necessary for male to male sex.

Since this study is focused on males having sex with males, this finding has no further implications and will not be included in the charts and summary.

Interaction of the Concerns and Impact on Sexual Behavior

While these concerns seem to be shared by all Filipino MSM, the *weight* of each concern varies from individual to individual. For example, for one individual the concern for preventing sickness might be the most important; for another individual the concern for sexual satisfaction might be the most important.

Of course, none of these concerns operate alone in shaping behavior. All the concerns are part of the mental juggling act of evaluating every sexual opportunity and partner. Each concern is either satisfied or outweighed by other concerns. In this way, it is possible for one concern to predominate over other concerns, even though all concerns are at least latently considered. Behavior is always a product of the *interaction* of the concerns.

The concerns can interact in two ways. The first way is that they can work together. For example, an anal inserter could be knowledgeable about HIV transmission (concern for health gravitating towards condom use), could find a partner who looked dirty (concern for cleanliness gravitating towards condom use), and is holding a free condom given to him at the cruising site (concern for cost of condom use satisfied). In that instance, all his salient concerns work towards condom use for that sexual encounter.

However, concerns can also compete for predominance. For example, an anal receiver could be knowledgeable about HIV transmission (concern for health gravitating towards condom use), but had to commute from a nearby province (investment of time and effort making him not amenable to canceling the sexual encounter) and whose partner said “no condom, huwag kang maarte” (desire to be seen in a positive light gravitating towards no condom use). In this case, his salient concerns do not work together towards one clear outcome. The final outcome (sex without conditions, sex with conditions, or no sex) will be a function of the concern that predominated over the others.

This explains why the same concern might hold different weights for the same individual in different sexual situations. The same concern might even hold different weights for the same individual with the same partner in a different situations.

For this reason, increasing rates of condom use is not effectively achieved by only increasing HIV awareness. Programs that increase HIV awareness can only affect one (health) of the ten concerns that are important to the Filipino MSM. They do nothing for impacting the other nine concerns. Thus, if the only intervention a Filipino MSM receives is the increase of his HIV awareness, then the stakeholders in the fight against this epidemic are counting on the health concern by itself always outweighing all the other concerns. The history of the epidemic has more than enough evidence to show that the concern for health does not by itself reliably override all the other concerns.

A Note on Spontaneity. This model of predominating concerns can account for the reported “spontaneity” of sexual behaviors. Each of the ten concerns can accommodate a vast range of sexual behaviors (sex without conditions, sex with conditions, and no sex), so long as what is tolerable for each concern is not exceeded. Taking the concern for health as an example, an MSM can spontaneously have sex with a partner so long as that partner does not look *too* sick, or does not look like he could give the MSM a deadly disease. However, spontaneity can be interrupted when the potential partner suddenly reveals that he is HIV positive. Many participants have stated that they do not discuss HIV status because it would interrupt the flow or the heat of the moment.

The facts that (1) the participants think the heat of the moment can be interrupted, and (2) they deliberately do not do things to interrupt the heat of the moment show that being in the heat of the moment is not a foregone conclusion. The partners in a sexual encounter play an active role in the perpetuation of the “heat of the moment.” Granted that even though they do not have the ability to *cause* the experience of the heat of the moment, they do, however, have the power to *interrupt* the heat of the moment. This ability to interrupt the heat of the moment using the discussion of HIV status reveals that spontaneous sexual activity can be terminated, even when it already has momentum, when a threshold of perceived risk is exceeded.

Levels of HIV Awareness. The second reason that the health concern is weak at overriding the other concerns is that HIV awareness is not uniform throughout the population. There are three levels of HIV awareness:

1. Not knowledgeable or aware

2. Somewhat knowledgeable, but unable to perceive connection to personal sexual situations
3. Knowledgeable and able to perceive connection to personal sexual situations

On the first level are the people that completely lack awareness of HIV. They either have never heard of HIV or have heard the words “HIV” but do not know what it signifies. These people tend to have superstitious reasons for using condoms, if they use them at all, or use condoms to prevent other STIs. These are also the people who use condoms primarily out of a concern for cleanliness rather than health. Based on the study sample, very few Filipino MSM are in this group.

On the second level are the people who have heard of HIV. Their understanding of it varies, but what is common among this group is their inability to perceive the applicability or relevance of HIV to their personal sexual situations. Within this group are people who have a symptom-based model of illness. These people have heard of HIV—they understand it to be a grave illness. But because their understanding of illness is symptom-based, they cannot imagine a person who has a grave illness that has no symptoms. As such, they actively look out for symptoms in their sex partners. When they do not find any, they perceive their partners to be HIV-free. Their concern for health being thus fulfilled, they find no further need to take precaution, at least, for the sake of health.

It must be made clear that when this group of people does not use condoms, they do not do so because their concern for health had been predominated by their other concerns. On the contrary, these people do not use condoms *because* their concern for health was satisfied. Because they had actively looked for symptoms in their partners and were unable to find any, they perceive their sexual encounters to be safe and condom use to be unnecessary.

On the third level are people for whom HIV is real and relevant. These are the people who are able to perceive risk in their sexual encounters. They are the people that understand that unprotected sex with anyone—regardless of their appearance or lack of symptoms—opens them to risk of HIV transmission.

However, even in this group, condom use is not consistent. It is in this group where the concern for health can be predominated by other concerns, such as the concern for sexual satisfaction.

Recommendations for Increasing Condom Use

Level I

On the first level, the appropriate intervention is to inform the MSM about the existence of HIV. He must hear that a disease called HIV exists, that it can be serious if untreated, and that consistent condom use can reliably prevent transmission of the disease.

Useful avenues for disseminating this information include television spots, incorporating the message in a television series or episode, and increasing news coverage. Enlisting the help of barangay captains and councils to craft location-specific messages and inventions could provide depth of message and sense of urgency. A participant reported that the barangay is his source of information. He said that barangay officials would “rove” in cases of emergency. The fact that no one was making the rounds about HIV was an indicator for him that HIV wasn’t happening in his locality.

Level II

On the second level, hearing about HIV is no longer enough. The MSM has already heard of HIV; but is unable to connect it to his specific sexual situations. On this level, what is needed are one-on-one or small group conversations that allow the individual to discover the ways he has misunderstood HIV or to discover the insufficiency of his understanding of illness. Only when he realizes that HIV is beyond his current understanding illness will he realize its gravity and the risk it poses to his life.

Concurrently, it will take educators who understand that they are not merely presenting new information; they are presenting a new way of understanding sickness. The educators must be adept at guiding people through the process of realizing the inadequacy of the old understanding of sickness.

Aside from this, the educators also need to help MSM realize the inadequacy of the usual way of *dealing* with sickness. The usual way of dealing with other sicknesses is to deal with them when one already has symptoms. For example, no one deals with a fever before one has a fever. One only drinks medication after one comes down with a fever. This way of dealing with sickness is useful and practical for sicknesses like fever and colds, but for HIV is a roadmap for disaster. In the case of HIV, when one has symptoms (opportunistic infections), the disease has progressed. The best way to deal with HIV is to prevent it from reaching a stage where there are symptoms. As such, educators need to enable people to change even the very way they deal with sickness.

Educators thus need be patient, as they are helping their target demographic transition from two models of thinking. The participants in their programs will naturally undergo cognitive dissonance, confusion, and fear. For this reason, this type of information is not effective when presented in a large-group setting. Participants need to have the psychological “space” to undergo cognitive dissonance at their own pace, unencumbered by concerns of whether they are getting left behind by the group or what other people might think of them when they feel emotional. In one-on-one settings or small group discussions, the educators can slow down the discussion as needed to give the participants time to reflect, to ponder the implications on their lives, and to experience their emotions as they come up. The participants are not forced to suppress their concerns for the sake of keeping up with the group or maintaining appearances. In this way, HIV can become real and personally relevant to them.

It must be noted that in this level, training people to use condoms with pleasure will not make a difference. The primary barrier here is the inability of the MSM to perceive the risk of unprotected sex when his partner has no physical symptoms; it is not that the concern for sexual satisfaction predominated over the concern for health. Instead, the concern for health was perceived to be satisfied by the partner’s lack of physical symptoms.

Level III

On this level, further information about HIV will make no difference. The people in this level are very aware of HIV. The behavior of not using condoms is a function of the other concerns predominating over the concern for health.

On this level, training people to use condoms with pleasure may make a difference. This type of training will help satisfy the concern for sexual satisfaction without it needing to overrule the concern for health.

On this level, useful interventions might also include distributing thinner condoms, such that the experience of pain for anal receivers might be lessened. An even more radical approach might be devising a program that trains anal receivers to minimize pain during sexual encounter. This will satisfy the concern for comfort without jeopardizing the concern for health.

Addressing the concern for intimacy is more tricky, since perception of what constitutes intimacy can vary from person to person. However, since perceptions of intimacy are socially constructed, there must be some shared constructions of intimacy, and shared avenues where these constructions of intimacy are being presented. Further study and analysis is needed to discover the origins and avenues of these social constructions. If the conveying or presentation of this message can be decreased, an alternate model of intimacy can be presented through the same channels or through other channels. Over time, the association of “no condom” and “intimacy” can be weakened, and other ways of creating intimacy can be strengthened, without forgoing the use of condoms.

Thinking out of the box, providing couples’ counseling or seminars on improving communication might help wean intimacy from its perceived dependence on sex. It may be that people look solely to sex because of an inability to create and experience intimacy through communication.

The desire to be seen in a positive light is also tricky to address from a national or top-down perspective. There are a myriad of individual differences in terms of what might be considered positive and what might be considered negative. There are also a myriad of individual differences in terms of how people respond to being labeled negatively, or to the fear of being labeled negatively, and how people act to achieve being labeled positively, or how people act to achieve what they think will get them seen in a positive light.

It may be possible that, in satisfying the concerns of sexual satisfaction, minimizing pain, and enabling intimacy, and by strengthening the shared concern for health, that using condoms will be seen less as negative (e.g. “maarte”, “you don’t trust me?”) and more as positive (e.g. “responsible”, “I’m protecting you.”). A study might also be conducted on the source of the perception that condom use is negative. Similar to the recommendation on addressing the concern for intimacy, the presentations of the message that condom use is negative can be sought to be diminished, and new messages that present condom use in a positive light can be presented. When a “tipping point” has been reached, the new social construction or agreement will positively label condom use and negatively label lack of condom use. As such, the concern for being seen in a positive light will naturally work against unprotected sex and serve as a driver for condom use. In the same way, people will be less likely to be offended when a partner asks to use a condom.

Said another way, there are stimuli within the local social and cultural environment such that people who request and are requested for condoms are perceived in a negative light. If these stimuli can be correctly identified in future studies, then the government can develop useful interventions to prevent or reduce the presentation of these stimuli in the social and cultural environment.

The consideration of time and effort cannot be addressed from the national level. But if all the other concerns have already been satisfied in a way that does not compromise the concern for health, then it is unlikely that the consideration of time and effort alone will overcome all the other considerations and lead to unprotected sex.

The consideration for availability of time for the sexual encounter can be addressed by training people to plan ahead. It must be emphasized, though, that teaching people to plan ahead cannot be the only intervention. The interventions addressing the other concerns must also happen; otherwise, the desire to be seen in a positive light will more often than not predominate over any planning one might do.

Finally, regarding the consideration for cost, the national government is already doing a good job in providing and distributing free condoms. This may sufficiently address the consideration for cost. However, this program alone cannot substantially increase the rate of condom use because all the other concerns also need to be addressed. If all the other concerns can be satisfied alongside the programs for distributing free condoms, there is no doubt that condom use will dramatically rise and even become reliable among Filipino MSM.

Moving Forward on Condom Use: The Next Three to Six Years

If the majority of Filipino MSM are in the first and second levels, then the government already has the structures in place to do the appropriate interventions. Perhaps a little additional training might be needed for peer educators, and additional peer educators need to be hired. It will simply be a matter of budget, training, and will. If these educational interventions are successful, the majority of Filipino MSM will move to the third level within the short to medium term.

Meanwhile, the government needs to put in place the structures and programs for the Level 3 interventions. Appropriate studies need to be conducted; programs for pleasurable condom use, pain reduction, intimacy, and communication must be developed; facilitators must begin training to teach these modules; companies that can provide thinner condoms must be invited to bid; television or media spots must be prepared; and so on. If these are done now, the programs will be ready for roll out when the majority of Filipino MSM move to the third level in approximately three years. If this happens, the implementation of the Level 3 programs will be perfectly timed for the need of the majority of the population.

HIV Testing Behavior

HIV testing behavior can be defined according to two outcomes: got tested and did not get tested. Analysis of the themes reported by the participants yielded two sets of concerns that affect testing behavior. The concerns in the first set revolve around the HIV test itself. The concerns of the second set revolve around HIV status and what it meant to the Filipino MSM and his social network.

A. Concerns about HIV Testing

1. Cost of getting tested
2. Location and schedule
3. Procedure
4. Reputation and self-perception
5. Judgment and treatment at testing site
6. Confidentiality of results

B. Concerns about HIV Status

1. Health
2. Social and self identity
3. Relationships
4. Quality and meaning of life
5. Economic security

Concerns about HIV Testing

Cost of Getting Tested. The perception that the HIV test will cost money affects the testing behavior of the Filipino MSM. Especially for someone with low income, the perceived financial burden of getting an HIV test is too much. The money, in his view, should be used to provide for the needs of his family instead.

Participants reported not being aware of free HIV testing services. Some participants reported that HIV testing can only be free when one has a *kakilala* (contact) within the barangay health office. Nonetheless, making use of that contact is another issue altogether (see *Reputation*). The concern about money also includes the cost of traveling to a preferred HIV testing center, and the opportunity-cost of using one's time to get tested instead of going to work.

Location and Schedule. Participants frequently cited not knowing the location and schedule of HIV testing services as a reason for not getting tested. This is a purely logistical concern: "how do I get there and when can I get tested?" "Does the testing schedule match my current schedule?"

Procedure. Participants also cited being concerned about the testing procedure itself. Questions include: "What is the procedure for getting tested?" "How long is the testing process?" "Is there a line?" "Will there be other people?" "Is the procedure safe?" "Do they reuse needles?" "Can I get HIV from getting an HIV test?"

Reputation and Self-Perception. Getting an HIV test is not merely a matter of logistics though. Because of the negative social construction of HIV and persons living with HIV, the act of getting tested can be tantamount to an admission that one has done something bad. The logic goes, "if you think you have HIV then you know you must have done something bad." For this reason, the Filipino MSM is concerned about other people finding out that he got an HIV test.

Beyond reputation, knowing himself as someone who has not done something bad is important to the Filipino MSM. Because getting an HIV test is an admission of having done something bad, the desire to perceive himself in a positive light can prevent him from taking action.

Said another way, when a Filipino MSM puts off getting an HIV test, it is not necessarily because he is avoiding finding out his status (although that is also often the case). Rather, because the socially-imposed meaning of getting an HIV test is that one has done something wrong, putting off an HIV test is his way of resisting this negative, socially-imposed label.

The concern for reputation can also affect HIV testing behavior in the opposite direction. For those who see themselves in a positive light (e.g. responsible, faithful, clean), getting an HIV test is a way of confirming this

self-perception and proving it to the world. This is why people who know they will test negative are more likely to get tested than those who are afraid they might test positive.

Judgment and Treatment at Testing Site. It was clear in the condom use analysis that being seen in a positive light is a fundamental concern of the Filipino MSM. As such, the fear of being judged by the people at the testing site can affect whether or not he gets tested. This fear includes being judged by the medical team, the peer educators, staff of the clinic, other people getting tested, and even bystanders at the testing site.

This ties in closely with the earlier discussion earlier on *hiya*. It does not matter to the Filipino MSM that the people allegedly judging him are strangers whom he may never see again. The possibility of being judged and losing face are strong deterrents for getting tested.

Aside from the fear of being judged at the testing site, a related concern is how one will be treated at the testing site. “Are the staff nice?” “Will they treat me well?” “Will they be rude to me?” The way one is treated is important to the Filipino.

Confidentiality of Results. Related to the fear that others might find out he got tested, the Filipino MSM is also afraid that others might find out the results of his test, especially if he tests positive. “Am I the only one who will see the results of my test?” “Who else will be informed about my test results?” “Are the results really confidential?” “I know there is a law, but do people really follow the law?”

Concerns about HIV Status

Health. This as a concern is fairly obvious. Fundamentally, HIV is physiological. As such, some MSM get tested because they want to know the status of their health so they can do something about it if necessary.

What is not so obvious—and, in fact, surprising—is that HIV as a health concern was *not* the most important concern of the Filipino MSM. In fact, the majority of participants seemed to give more weight to the concerns that were not health-related. Money and schedule individually were among the most cited by participants as the most important justification for their testing behavior (or lack thereof). This could mean that, at least on a conscious level, the Filipino MSM thinks his budget or schedule is more important than his health.

Also, participants often cited being negatively perceived at the testing center as a valid reason not to get tested. This means that the Filipino MSM would rather risk his health than risk being judged by people he doesn’t know and may never interact with again.

Given this, it is not surprising that the intervention of informing people about the importance of HIV Testing for their health is not substantially increasing the national testing rate. For the Filipino MSM, health is but one of his concerns and not even the most important.

Social and Self-Identity. If one looks at HIV from a purely medical perspective, the concern about the impact of social and self-identity is surprising. However, it must be remembered that the majority of Filipino MSM lack the medical understanding to see HIV as merely a physiological issue. For the average Filipino, HIV is primarily a *social* issue, with implications on the kind of person a person must be to have contracted HIV and on the way one must relate to that person so as not to contract HIV for oneself. For the MSM considering getting tested then, these questions arise: “how will people see me if I turn out to be positive?” “How will people treat me?”

Given that the Filipino self-identity is socially derived, these effects on his social identity also impact his sense of himself, his self-esteem, and his self-worth. This may explain the seemingly perplexing behavior of some MSM, who know they could be infected but are unwilling to get tested. They are not avoiding HIV itself; rather, they are avoiding the negative label society imposes on people living with HIV. Again, given that Filipinos are

raised to value *hiya*, should it be any surprise that a Filipino MSM would prioritize his social identity over his health?

Relationships. The Filipino MSM is especially concerned about the way HIV status will affect his key relationships—family, friends, colleagues, romantic partner, and sex partners. “Will anyone take care of me?” “Will anyone still want me?” “Will my partner accept me?” For those who do not have a partner, “will I be able to find a partner?”

Quality and Meaning of Life. The Filipino MSM is concerned about the impact HIV will have on the kind of life he can still lead. “Will I still have a life?” “Will I be able to live the kind of life I want?” “Will I be able to move on?” “What kind of person will I become?”

His concerns also include losing his sense of purpose. “Will life still have a point?” “What will be the point of my life if I have HIV?”

Economic Security. Finally, the Filipino MSM is concerned about his economic security. “Will I be able to stand up again?” “Can I afford treatment?” “Can I take care of myself?” “Will I be able to meet my financial needs?” “Will I lose my job?” “Will I be able to find employment?”

The fact that the government provides free ARTs partially satisfies this concern. It is important to note, though, that many MSM are *unaware* that the government provides free ARTs.

Interaction of the Concerns and Impact on HIV Testing Behavior

Again, none of these concerns operate alone. The concerns may either work in tandem or compete for predominance to shape HIV testing behavior.

For example, an MSM may be suffering from a severe skin rash (concern for health gravitating towards getting tested). He hears about a reputable testing center (concern for procedure satisfied) in a different municipality where he is sure he will not run into anyone he knows (concern for reputation satisfied). This is an example where all his salient concerns working towards the same outcome—getting tested.

An example of concerns competing for predominance: an MSM may be suffering from a severe skin rash (concern for health gravitating towards getting tested). He hears about a reputable testing center (concern for procedure satisfied), but it is near the basketball court where his barkada usually plays (concern for reputation gravitating towards not getting tested there). Because he is the only one among his siblings to have finished college, his parents are counting on him to put food on the table (concern for opportunity cost gravitating towards not getting tested). These concerns do not work towards a clear outcome. Whether he gets tested or not will depend on which of the concerns end up predominating.

For this reason, attempting to increase rates of HIV testing is not effectively achieved by only increasing HIV awareness. Programs that increase HIV awareness can only affect the health concern, which is but one of the many concerns that affect HIV testing behavior. The government must address the issue from a total perspective, so that the majority of the Filipino MSM’s concerns can work towards increasing HIV testing behavior.

Levels of HIV Awareness and HIV Testing

Level I

This is the group that has no awareness of HIV. They don’t know the sickness exists, the nature of the sickness, its symptoms, or the method of diagnosing, it. They do not know to look out for it.

When they are asked to get tested, they typically report barriers connected to the concerns on cost of getting tested, location and schedule, and procedure. The logic goes, “Why should I spend money, time or effort on something I don’t even need?”

When people on this level do get tested, it is usually due to some social influence or pressure. Alternately, they can get tested because of mandatory testing requirements for work or blood donation.

Level II

This is the group of people that have some awareness of HIV, but are unable to perceive its relevance to their personal situation. These are the people that, because they had actively looked for sexual partners that looked clean and healthy, they in their mind have not done anything that puts them at risk of contracting any illness, including HIV.

When they are asked to get tested, then, they typically report barriers similar to those on the first level—connected to the concerns on cost of getting tested, location and schedule, and procedure. In addition, they are also affected by the concerns about reputation and self-perception, and judgment and treatment at testing site. The logic goes, “I don’t want to be seen at the testing site. Anong iisipin ng mga tao dun sa testing site—baka isipin nila ganito ganiyan ako! (What will people at the testing site think of me? They might think I’m like that!)”

When people on this level do get tested, it is also often due to social influence (usually peer or partner influence) or to mandatory testing requirements for work or blood donation.

Level III

This is the group of people that are very aware of HIV and are able to connect the risk of HIV to their own situations. They are knowledgeable about the transmission of HIV and know whether they have engaged in behavior that puts them at risk. These people may or may not know where and how to get tested, but they do know the test exists. These are people that can find a way to get tested the moment they choose to.

These are also the people that are internally-driven to get tested (whether it is to know for sure that they are negative, or because they know they are positive and they want to seek treatment). This does not mean that social influence does not play a role for the people on this level. However, the way social influence affects them is different from the way social influence affects the people in the previous two levels. In the previous two levels, because those people do not see the relevance of HIV in their own lives, they would have little internal drive to seek testing for themselves. Thus, social influence can be the main or only driver for them. For the people on the third level, however, an internal drive to seek testing already exists. When there is also social influence, it acts as a facilitator rather than as the driver for testing behavior.

It is important to note that social influence alone is probably not a desirable driver for testing behavior. When it is a person’s only driver for getting tested, issues may arise after the test regarding accessing and adhering to treatment. Social influence works best when it works in tandem with an internal drive to seek testing.

The barriers to getting tested for the people on the third level can include all the concerns that affect the previous levels—cost, location and schedule, procedure, reputation and self-perception, and judgment and treatment at testing site. Where this group is distinct from the people in the previous two levels is that this group is also concerned about the confidentiality of results, and the impact of HIV status on health, social and self identity, relationships, quality and meaning of life, and economic security.

Recommendations for Increasing HIV Testing Behavior

Level I

The recommendations here are similar to the recommendations to increase condom use. The appropriate intervention is to inform the MSM on this level about the existence of HIV. He must hear that a disease called HIV exists, that it can be serious if untreated, and that early detection is the best way to ensure quality of life.

Useful avenues for disseminating this information include television spots, incorporating the message in a television series or episode, and increasing news coverage. Enlisting the help of barangay captains and councils to craft location-specific messages and inventions could provide depth of message and sense of urgency.

Level II

The recommendations on this level are also similar to the recommendations to increase condom use. On this level, presenting more information about HIV is not effective. The MSM has already heard of HIV, but is unable to connect it to his specific sexual situations. Needed are one-on-one or small group conversations that allow the individual to discover the ways he has misunderstood HIV or to discover the insufficiency of his understanding of illness. Only when he realizes that HIV is beyond his current understanding illness will he realize its gravity and the risk it poses to his life.

Emphasis must also be placed on helping the target demographic transition to a new way of dealing with sickness. The best way to deal with HIV is the proactive way—early detection and treatment prior to the onset of symptoms.

Level III

On this level, further information about HIV or the need to get tested will make no difference. The people in this level are very aware of HIV. Their behavior of not getting tested is a function of the other concerns predominating over the concern for health.

Since the government is already providing free basic treatment for HIV, the next step is to *inform* the public that it is doing so. The concern regarding the cost of treating HIV can only be satisfied when the MSM is *aware* that the treatment is free.

In the same way, the MSM needs to be made aware of the locations, schedule, and procedure of HIV testing. Informing him about these, however, can be tricky. If he perceives a location to be too well-known as a place for HIV positive people, his concern about his reputation and self-perception will prevent him from going to that testing center. Information campaigns about location and schedule must thus be discreet and specifically targeted for the intended audience.

The government must also make sure that all testing centers are well-maintained and appear inviting. This can help address concerns about how one is seen when one goes to a testing venue. This can also send a subtle but strong message that the health of the people is important to their government and that there is no shame in finding out one's status.

An easy step that can be taken immediately is to have all clinic staff (including receptionists and security guards) undergo some kind of sensitivity training. If this has already been done, the next step is to *promote* this fact to the public. The public must know that it can expect friendly service at all accredited HIV testing centers. This can address the concern about how one will be treated at the testing center.

More challenging is ensuring the confidentiality of test results. Breaches of confidentiality are happening even though there are laws that protect the confidentiality of HIV test results. The next step is to identify in which locations these breaches are happening and the reasons they are happening. They are likely happening in

close-knit barangays, where everyone knows everyone and where the oral culture is stronger than the adherence to written law, to which most people don't have access anyway.

Breaches of confidentiality are also likely happening because of the social connectedness of Philippine society. For example, a staff member of a clinic might know that the patient is entitled to medical confidentiality. But because the staff member is a relative of the patient's boyfriend, the staff member might feel a social obligation to warn his relative. This puts him in a difficult and morally ambiguous situation, torn between ethics and a social obligation.

This is where the government should take an honest look at the enforceability of its HIV laws. Who is tasked to discover, report, or address breaches of confidentiality? Is the victim supposed to report the breach himself? But if he had to report it himself, would he not be in effect telling more people about his status? What steps can be taken to protect the confidentiality of HIV testing results without resorting to a report and recourse mechanism? Can procedures or systems at testing sites be altered such that staff will not be put in a situation where they had to choose between ethics and perceived social obligation?

The biggest challenge lies in addressing the negative social labels being imposed on people who get an HIV test and people who have HIV. These labels and the perspective that underlies them are not conveyed through media or the law. Rather, they pervade the informal channels of oral culture and permeate the various strata of Philippine society. Countering these negative labels requires judiciously using oral culture and transforming the perspective that underlies it.

Said another way, HIV is not merely a problem of the physiological. Beyond its medical definition, "HIV" also has a social meaning, which affects the people constructing that meaning. The social construct "HIV" is what is impacting behavior, identity, relationships, and quality of life, and is doing so in ways the physical virus cannot. Only when HIV is addressed as a social construct can substantial gains be seen in the fight against the epidemic.

Finally, the target demographic must be made aware that it is possible to have HIV *and* have high quality of life and economic security. Currently, the public only hears about HIV when somebody dies from it or is suffering horribly because of it. The public does not hear about all the HIV positive people leading healthy, successful lives. If the public can be given role models for people living positively, then the perception that HIV is a death sentence may disappear. This may also influence MSM to be more accepting of the possibility that they are positive, which can increase the willingness to get tested.

In line with this, treatment needs to move away from a purely medical focus, to a total or holistic approach that includes emotional, psychological, social, spiritual and even financial well-being. This will address the social construction of the epidemic and ensure that more positive people experience a high quality of life. This will in turn produce more positive role models that are embedded throughout society, increasing the public's personal awareness of positive living.



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